REPORT

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Training Standards for Personal Care Aides Across States: An Assessment of Current Standards and Leading Examples

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Executive Summary

Background

Constituting the largest occupational group in the United States (when combined with home health aides), personal care aides (PCAs) support millions of older adults and individuals with disabilities and serious illness to live with optimal health and wellbeing in their own homes and communities.

Despite the complexity and importance of their role, there is no national standard for PCA training. As a result, PCAs are not equitably or consistently prepared for their roles and in many cases are unable to translate their knowledge and experience from one state, setting, or employer to another—which undermines care quality for consumers as well as career mobility for workers. A first-ever report on PCA training standards published in 2014 found that 11 states had no PCA training requirements across any Medicaid program, while another 11 had training requirements in some of their programs, and only 19 had uniform requirements across all programs.1

The past decade has seen various efforts to improve PCA training standards, most notably through the federally funded Personal and Home Care Aide State Training (PHCAST) demonstration program in six states.2 More recently, several states have begun envisioning and building more coherent, universal direct care training systems that include stronger training for PCAs. In the context of this renewed interest in PCA training—and the imperative to build the capacity of this workforce to meet growing and increasingly complex needs—this study aimed to develop an updated understanding of the landscape of PCA training standards across the United States.

Aims

The specific aims of this research were to:

1. Identify training requirements in Medicaid state plans, home and community-based services (HCBS) waiver programs, and home care licensing rules for every state and the District of Columbia;
2. Assess training requirements in each state with regard to the consistency and rigor of those requirements and the portability of the required training;
3. Describe “leader states” with the most consistent, rigorous, and portable requirements and portable credentials.

Data and Methods

Data were gathered through systematic online searches of Medicaid provider manuals, HCBS waiver documents, and relevant state administrative code, focusing on services that PCAs deliver to older adults and people with physical disabilities. (Although beyond the scope of this study, the report flags other services, primarily those for individuals with intellectual and developmental disabilities, that warrant review as well.)

In the review, we assessed training requirements in terms of consistency, rigor, and portability. Consistency refers to the variation or uniformity of training requirements for agency-employed PCAs across each state’s Medicaid programs and waivers. States could earn between 0 and 1 point, increasing in one-third increments, for consistency. Rigor refers to the individual components of a state’s training requirements, assessed according to the following indicators (for a maximum of six points): no training requirements or agency assurance only; training hours; specified competencies; a competency evaluation or exam; a state-sponsored training curriculum; training instructor qualifications; and continuing education

hours. Portability refers to whether PCA training and credentials can be transferred between employers, roles, and settings, as indicated by recognized credentials and/or a centralized training registry (for up to two points).

We also noted training requirements for independent providers and those for PCAs employed by private pay home care agencies. States could score up to 11 points for consistency, rigor, and portability and these two additional criteria.

Results

Five states (New Jersey, New York, Oregon, Rhode Island, and Washington State) and Washington D.C. emerged as "leader states," garnering the highest training requirements scores across all the states.

The majority of states (32 states and Washington D.C.) had consistent training requirements, defined as uniform training requirements for agency-employed PCAs, while seven states had no training requirements at all.

The average rigor score for states was 3.5 points. Twenty-five states and Washington D.C. specified a minimum number of training hours, ranging from 4 to 125 hours, and 42 states and Washington D.C. specified skills or competencies in at least one set of training requirements. Thirty-four states and Washington D.C. required competency evaluations or exams as part of their training requirements, and 12 states and Washington D.C. had state-sponsored or endorsed training curricula. Twenty-eight states and Washington D.C. had minimum requirements for PCA instructors, primarily requiring instructors to be licensed nurses. Lastly, 32 states and Washington D.C. required continuing education, with 24 states and Washington D.C. specifying hours that ranged from 4 to 15 hours. Just 15 states and Washington D.C. met both portability criteria, while nearly half (25 states) met neither; 26 states and Washington D.C. had a recognized portable credential, and 15 states and Washington D.C. had a centralized training registry.

Over one-third of states (18 states) had training requirements for independent provider PCAs who serve self-directing consumers, with 7 of those states requiring the same training as for agency-employed PCAs. Almost half of states (24 states and Washington D.C.) had training requirements for PCAs employed by private-pay home care agencies.

Discussion

Training standards are important for supporting consistent knowledge and skills for all PCAs (regardless of employer or role) and, more broadly, for enhancing professional recognition of this essential workforce.

Although 32 states and Washington D.C. have consistent training requirements, there is still significant variation in training requirements across states. While six states emerged as leader states, earning 10 to 11 points, seven states have no training requirements at all. Over 60 percent of states received four or more points for training rigor, but only 15 states met both criteria for portability. In broad terms, these findings indicate that training requirements for PCAs are somewhat more robust across states than in 2014 when the first scan of PCA training requirements was conducted (although the findings do not directly compare due to methodological differences).3 Whereas that original study found 11 states with no training requirements for PCAs, we found only seven—but some states actually rolled back their training standards in the same timeframe, suggesting uneven progress in the field.

Future research should explore additional aspects of training standards, such as language access, training modalities, and training quality. There is also a need for research on training requirements for direct support professionals (DSPs), a segment of this workforce that supports people with intellectual and developmental disabilities, and on the associations between training standards and workforce and

consumer outcomes.

In terms of policy implications, this research underscores the need for more consistent PCA training standards within and across states. The Centers for Medicare & Medicaid Services (CMS) could lead the way by establishing a minimum federal training standard for PCAs, ensuring equity with home health aides and nursing assistants.4 CMS should also take steps to ensure that entry-level training and certification costs are covered

through Medicaid for all direct care occupations, including PCAs. States should also consider improving their PCA training standards as part of more comprehensive efforts to build universal direct care training and credentialing systems.

Background

Personal care aides (PCAs) support older adults and individuals with disabilities and serious illness to live with optimal health and wellbeing in their own homes and communities. Their role includes assistance with activities of daily living (ADLs, such as bathing, toilet care, and mobility), as well as support with other activities of independent living, from housework and meal preparation to shopping, attending appointments, and participation in education, employment, and/or community life.

Workforce Growth and Challenges

Along with home health aides, PCAs constitute the largest occupational group in the United States according to the Bureau of Labor Statistics (which quantifies these two roles together)—comprising 3.7 million workers in 2023.5 Given population aging and consumers' desire to age and receive services in place,6 demand for the PCA workforce is continuing to increase—with this workforce projected to add nearly 805,000 new jobs from 2022 to 2032.7

Yet long-standing job quality challenges for PCAs and other direct care workers (including home health aides and nursing assistants8) undermine workforce recruitment and retention, resulting in a worsening workforce crisis. Turnover among these workers is estimated at 79 percent, according to the most recent industry benchmarking report,9 and every state reported a shortage of PCAs in 2023 according to a national KFF survey.10 Recent research shows that PCA workforce pressures are even more pronounced in certain states, primarily in the South and certain parts of the Midwest, and in the most rural areas across states.11

Persistently low wages—estimated at a median of $16.13 per hour in 2023 by the Bureau of Labor Statistics (again, combining PCAs with home health aides)—drive workforce instability and shortages. However, insufficient entry-level and ongoing training for many PCAs likely also plays a role, by perpetuating the false assumption that these are "low-skill" jobs, discouraging job seekers from considering them, and leading to turnover among workers who feel under-prepared to care for an increasingly complex population of home care consumers.[12,13 14,15,16]

Inconsistent and Inadequate Training Standards

Home health aides and nursing assistants, the other two segments of the direct care workforce, are subject to federal minimum training requirements through the conditions of participation in Medicare. Specifically, home health aides and nursing assistants must complete at least 75 hours of entry-level training (though many states have set higher standards) according to a minimum set of training topics for each occupation, and nursing assistants must pass a standardized competency exam to become certified.17,18 While these federal requirements have long been considered insufficient,19 they do at least establish some consistency and oversight in training for home health aides and nursing assistants across all states and employers.

In contrast, there are no federal training requirements for PCAs. Instead, most PCA training requirements and any associated credentials are set at the state level, primarily through Medicaid home and community-based services (HCBS) authorities. Given the overwhelming number of these authorities—with more than 250 active 1915(c) waivers across the country, among other waivers and state plan amendments20—this approach has led to a complex patchwork of training requirements (and gaps) for PCAs depending on where they live, how they're paid, and who they serve.

As a result, PCAs are not equitably or consistently prepared for their roles and in many cases are not able to translate their skills and experience from one state, care setting, or employer to another—with implications for both job quality and care quality. A first-ever report on PCA training standards across

states, published in 2014, found that 11 states had no training requirements across any Medicaid program, while another 11 had training requirements in some of their programs, and only 19 had uniform requirements across all programs.21 Among other findings, only 18 states specified the number of training hours in any of their PCA training requirements, and fewer than half (21) required a competency exam.

Past Efforts to Strengthen PCA Training Standards

Stronger and more standardized training for PCAs is not a new priority. The most significant federal investment in this area remains the Personal and Home Care Aide State Training (PHCAST) program, which was created as part of the Affordable Care Act in 2010 and funded by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.22 The six PHCAST states—California, Iowa, Maine, Massachusetts, Michigan, and North Carolina—took steps to develop core competency-based curricula and implement training and certification programs for PCAs with the goal of enhancing the visibility and recognition of these jobs. Evaluation results indicated modest success, with low attrition rates among trainees and 50 to 60 percent of all trainees being employed as PCAs upon completion. However, there was no requirement for training and certification to be consistent across the six states, and the lasting impact of the program was fairly limited. The original goal of national PCA training standards remains unrealized.

New Momentum to Improve PCA Training

More recently, however, there has been an upsurge in state attention on PCA training in the context of a broader push toward reducing siloes between direct care occupations and programs. This momentum has been fueled, in large part, by the federal funding available to states to “enhance, expand, or strengthen HCBS” through Section 9817 of the American Rescue Plan Act of 2021 (ARPA).23 Overall, states have documented $4.3 billion in planned spending of Section 9817 funds on workforce training initiatives, with 30 states promising a “new standardized training program” (the top activity in this category).24 Many states are exploring universal training programs and credentials for direct care workers across HCBS programs and settings using these funds.

In the context of this renewed interest in PCA and other direct care worker training and credentials—and the imperative to build the capacity of this workforce to meet growing and increasingly complex consumer needs—this study aimed to develop an updated understanding of the current landscape of PCA training standards across the United States.

Aims and Methods

Aims

The specific aims of this research were to:

1. Identify training requirements in Medicaid state plans, HCBS waiver programs, and home care licensing standards for every state and the District of Columbia;
2. Assess training requirements in each state with regard to the consistency and rigor of those requirements and the portability of the required training;
3. Describe “leader states” with the most consistent and rigorous requirements and portable credentials.

Methods

To identify and assess PCA training requirements in each state, we conducted systematic online searches of Medicaid provider manuals, HCBS waiver documents, and relevant state administrative code. Where details were unclear or unavailable online, we reached out directly to experts in those states for clarification.

We focused the research on personal care services for older adults and people with physical disabilities. We did not include services for people with intellectual and developmental disabilities, which are provided by a segment of the direct care workforce known primarily as "direct support professionals" (DSPs). Although DSPs are formally classified and quantified as PCAs in most cases (due to the lack of a separate standard occupational classification for DSPs25,26), they fulfill a distinct role with an emphasis on community inclusion, particularly through employment and education supports.27 A separate study is warranted on the consistency, rigor, and portability of DSP training requirements. We also excluded training requirements in waivers that serve individuals with traumatic brain injury (TBI), AIDS/HIV, and other specific populations, given the distinct training required for these roles and the smaller service populations.

In reviewing Medicaid regulations, waiver documents, and other materials, we assessed indicators of consistency, rigor, and portability of training for agency-employed PCAs, as defined in Table 1 and further described below. We also noted whether states had training requirements in place for PCAs employed as "independent providers" in Medicaid-funded consumer-directed/self-directed programs and/or for PCAs employed by private-pay home care agencies.

Consistency

Consistency refers to the variation or uniformity of training requirements for agency-employed PCAs across each state's Medicaid programs and waivers for older adults and individuals with physical disability. Consistent training requirements across all programs and waivers set an equitable standard for PCA job preparedness and clients' quality of care.

To assess consistency, we grouped states into four categories:

- No training requirements in any Medicaid program or waiver (0 points)
- Training requirements in some programs or waivers (.33 points)
- Training requirements in all programs and waivers, but with variation in those requirements (.66 points)
- Consistent training requirements across all programs and waivers (1 point)

The highest possible score a state could earn for consistency was one point.

Rigor

Rigor refers to the individual components of a state's training requirements. More rigorous, or in other words more specific, training requirements can reduce ambiguity and inequity across PCA training programs and practices, ensuring that all PCAs have commensurate preparation for their role.

To assess rigor, we identified whether the following requirements were present in *any* set of training requirements within a given state:

- Specified training hours (1 point)

- Specified competencies (1 point)
- Required competency evaluation (1 point)
- State-sponsored curriculum (1 point)
- Minimum instructor qualifications (1 point)
- Continuing education requirements (1 point)

States could earn a total possible score of 6 points for rigor. States that only required agencies to assure that they were providing sufficient training to PCAs to meet their clients' needs—with no further requirements in place—were categorized as "agency assurance only" and grouped with states that had no training requirements in any program or waiver (for a score of 0).

To note, states were scored on the various components of rigor if at least *one* set of PCA training requirements included those components; they were not assessed for rigor across all requirements. In other words, states may score highly on rigor due to one set of rigorous training requirements but may have less rigor in another set of training requirements. Rigor should, therefore, be considered in tandem with the first domain (consistency).

Portability

Portability refers to whether PCA training and credentials can be transferred between employers. Portability allows more career mobility for PCAs while also reducing costs associated with retraining. We assessed portability according to the following two indicators:

- Training results in a recognized, verifiable credential that is recognized across employers (1 point)
- The state has a centralized registry that records training completion (1 point)

The total possible score for portability was 2 points per state.

Other Training Requirements

We also identified the following two requirements:

- Any training requirements for independent providers supporting older adults or people with disabilities through Medicaid-funded consumer direction programs (1 point)
- Any training requirements for PCAs employed by private-pay home care agencies, typically through licensure requirements (1 point)

The total possible score for other training requirements was 2 points per state.

Scoring

We scored states across the three domains of consistency, rigor, and portability and on the basis of training requirements for independent providers and/or private-pay agencies employing PCAs. The highest possible score was 11 points, as noted in Table 1.

Results

Two states (Washington State and Oregon) scored 11 points in total, while the District of Columbia, New Jersey, New York, and Rhode Island all scored 10 points. These "leader states" are spotlighted throughout this report. (Note that D.C. is characterized as a "state" in all tables.)

State Spotlight: Washington State (11 points)

Washington State is a leader in PCA training standards thanks to the sustained efforts of champions within the state's Aging and Long-Term Support Administration (within the Department of Social and Health Services) in collaboration with SEIU775 and, as of 2019, Consumer Direct Care Network of Washington (CDWA; CDWA serves as the employer of record for Washington's 45,000 independent providers). The state requires all agency-employed PCAs and independent providers to complete standardized training and certification, with abbreviated requirements for certain paid family caregivers, respite providers, and others. SEIU775 provides a "Caregiver Welcome Guide" that clearly defines these training and certification requirements as well as offering other useful information about the challenges and benefits of the role. When trained and certified, independent providers have the option to join Carina, a statewide "matching service registry" designed to connect self-directing consumers with available workers.

Consistency

As described above, we assessed consistency as the variation or uniformity in agency-employed PCA training requirements across Medicaid programs and waivers, including personal care services for older adults and individuals with physical disabilities.

Thirty-two states and Washington D.C. (65 percent) had consistent training requirements in place, while 16 percent had training requirements across all programs, but with variation across those requirements. Three states (6 percent) lacked training requirements in some programs and seven states (14 percent) had no requirements in any program.

Rigor

We assessed states' PCA training requirements for the following components of rigor: no requirements or agency assurance only; training hours; specified competencies; a competency evaluation or exam; a state-sponsored training curriculum; training instructor qualifications; and continuing education hours. As noted, states received a point for each component of rigor in any set of training requirements (for a possible total of 6 points); see Table 2 for details.

The average total rigor score across states was 3.5 out of 6. Six states and Washington D.C. (14 percent) received 6 points, 12 states received 5 points, and another 12 received 4 points. At the lower end, seven states (14 percent) received 3 points, three states (6 percent) each received 2 points and 1 point, and, as above, seven states (14 percent) did not have any training requirements in place or they required agency assurance only; see Table 3 for details.

Looking more closely at the findings, 25 states and Washington D.C. (51 percent) specified a minimum number of training hours in at least one set of PCA training requirements, with the number of training hours ranging from 4 to 125 hours. The median required number of training hours was 37.5 hours. Eight states specified different minimum training hours across their training requirements, while 17 states and Washington D.C. specified training hours in only one set of training requirements.

State Spotlight: New York (10 points)

Like other leader states, New York offers a credential for PCAs upon completion of a standardized curriculum, thus recognizing PCAs with their own professional designation. The state's PCA curriculum, which has been in place since 2006, comprises 12 broad training modules that cover most aspects of home care. The state also offers clear guidelines for PCA training programs, with the most recent update released in May 2022. Finally, the state has operated a home care registry for over 15 years, allowing employer agencies to check job seekers' existing training and PCA credentials.

Most states (42 states and Washington D.C.) specified a list of skills or competencies in at least one set of training requirements for agency-employed PCAs under Medicaid. The number of competencies ranged from only one up to 31 topics. (The single competency requirement was found under California's Home and Community Based Alternatives waiver, which specifies that training for all waiver service providers "shall include information in any one or more" of seven topic training areas, namely "companionship services, activities of daily living, basic first aid, bowel and bladder care, accessing community services, basic nutritional care, and body mechanics.") The median number of competencies was eight.

We found little consistency in how competencies were defined. For some states, competencies were broad, while other states provided detailed lists. For example, Nebraska's training standards listed out 10 personal care services, such as "skin care" and "bowel and bladder care." In contrast, New Hampshire's training requirements encompassed all those services under one competency (among others), namely "personal care and nutrition."

State Spotlight: New Jersey (10 points)

New Jersey requires all PCAs to complete a state-specific curriculum and become Certified Homemaker-Home Health Aides (CHHAs), a credential that meets the federal home health aide training requirements. Those who have certified as home health aides in other states are automatically certified as CHHAs (providing they meet certain criteria), which reduces the need for retraining. Other notable features of New Jersey's training program are its accessibility to Spanish speakers, as the training can be offered in Spanish by a bilingual training instructor and trainees can take the oral competency evaluation in either Spanish or English.

With regard to competency evaluations, 35 states and Washington D.C. required PCAs to pass an evaluation or examination, though with variation in the format. Some states required both written tests and skills demonstrations, while others required one or the other.

Twelve states and Washington D.C. had state-sponsored or endorsed PCA training curricula, though not all states required that the curricula be used as-is. Illinois, for example, provided a "Department-approved online training" but noted that agency employers could use that curriculum or create their own.

Twenty-eight states and Washington D.C. specified minimum requirements for PCA instructors. Most of those states required that instructors be registered nurses or other licensed nurses (20 states and Washington D.C. specified some type of licensed nurse(s)) or other professionals (such as social workers, physicians, occupational therapists, or pharmacists). A few states named specific qualifications rather than credentials for PCA instructors, such as having a high school diploma or equivalent.

State Spotlight: Rhode Island (10 points)

In Rhode Island, PCAs are required to complete 80 hours of classroom education and 40 hours of practical skills training in six broad skill areas to become certified nursing assistants. Self-directed PCAs are exempt from these requirements, but instead must take a 13-hour training course if they work for more than one consumer. When a self-directed PCA has completed the 13-hour training, they have the option of joining a centralized Personal Care Attendant Registry run by the Rhode Island Executive Office of Health and Human Services.

Finally, approximately two-thirds of states included a continuing education requirement in at least one set of PCA training requirements. Of those, 24 states and Washington D.C. specified a minimum number of continuing education hours, ranging from 4 to 15 hours, with a median of 8 hours and mode of 12 hours (as specified by 12 states).

Portability

As described above, *portability* refers to whether credentials are recognized and transferrable between employers and/or roles or settings. The indicators comprising this domain are recognized credentials and a centralized training registry.

States could score a maximum of two points for portability, with 14 states and Washington D.C. (29 percent) receiving two points, 11 states (22 percent) receiving one point, and 25 states (49 percent) receiving zero points. As shown in Table 4, 25 states and Washington D.C. (51 percent) have a recognized credential or certification that is portable between employers. Some states required that employers keep a record of completed training that PCAs can take with them to new employers, whereas other states awarded PCAs a specific credential. Examples of credentials include “qualified service provider” (QSP; North Dakota), “personal care attendant” (PCA; Oregon), and “home care aide” (HCA; Washington State). Two states (New Jersey and Ohio) and Washington D.C. required PCAs to have home health aide certification, and three states (Hawaii, Rhode Island, and North Carolina) required PCAs to be certified as nursing assistants. Two states, Wyoming and Florida, required PCAs to have one of those two certifications.

State Spotlight: Oregon (11 points)

Oregon created a Home Care Commission nearly 15 years ago to support PCAs (known as homecare workers and personal support workers in Oregon) and consumers. The Commission plays a key role in defining workers’ qualifications, providing training, and hosting a statewide worker registry, among other responsibilities. In 2018, Oregon lawmakers passed Senate Bill 1534, which required the implementation of a statewide home care curriculum covering a minimum of six broad topic areas, with oversight by the Home Care Commission. Originally offered in person, this three-part training was moved online due to the COVID-19 pandemic in 2020. As of 2023, the first part of the training now includes an in-person skills component, while the other two parts can be taken online within 120 days of receiving a care provider number.

Other Training Requirements: Independent Providers

Eighteen states (35 percent) had training requirements for PCAs employed as independent providers through at least one Medicaid-funded consumer-direction program. Seven of those states (Kentucky, Maryland, Michigan, North Dakota, Washington, West Virginia, and Wisconsin) had the same training requirements for independent providers as for agency-employed PCAs.

Other Training Requirements: Private-Pay Agencies

Twenty-four states and Washington D.C. (49 percent) had training requirements for PCAs employed through private-pay home care agencies. Typically, those training requirements were listed in the states' licensure rules for home care agencies. (Thirty-one states and Washington D.C. require home care agencies to be licensed, but not all of those states include training requirements in their licensure rules.)

State Spotlight: Washington D.C. (10 points)

In Washington, D.C., agency-employed personal care aides must train and certify as home health aides, which involves completing a curriculum from the DC Board of Nursing that covers 28 competencies and 125 hours of instruction (far exceeding the 75-hour federal minimum). For PCAs working under the waiver program for older adults and people with disabilities, training must also cover person-centered thinking, supported decision-making, and community integration. Certified nursing assistants (CNAs) can also work in home care by completing an abbreviated 32-hour training. D.C. lawmakers recently passed a law to create a universal credential for all PCAs, home health aides, and CNAs in D.C., Maryland, and Virginia—an innovative approach to establishing core competencies and career mobility across long-term care.

Discussion

This study assessed personal care aide training standards in and across all 50 states and the District of Columbia. Training standards are important for supporting strong, consistent job preparation for all PCAs (regardless of employer or role) and for enhancing professional recognition of this essential workforce.

While 65 percent of states have consistent training requirements across Medicaid programs, this research reveals wide variation in these requirements across states. Conversely, seven states (Indiana, Iowa, Kansas, Nebraska, Tennessee, Texas, and Vermont) have no training requirements for PCAs at all. Six states emerged as "leader states"—Washington, D.C., New Jersey, New York, Oregon, Rhode Island, and Washington State—based on their high cumulative scores for consistency, rigor, portability, and other training requirements (each receiving a total of 10 or 11 points). Like other states, however, those states can still do more to boost PCA training access and quality. For example, Oregon and Washington State have tiered systems that allow PCAs to accrue more training and progress into advanced roles, which offers career opportunities for workers while also maximizing their contributions—while the other four states do not have such career ladder opportunities built into their state training systems. As another example, Washington D.C. is moving toward a combined PCA/home health aide/certified nursing assistant credential with local interstate reciprocity, setting a consistency and portability standard that other states could emulate in the future.

Over 60 percent of states received four or more points (out of a possible total of 6 points) for the rigor of at least one set of training standards, and seven states (Washington D.C., Massachusetts, New Jersey, New York, Oregon, Virginia, and Washington) earned all six points. We found that most states specified

training competencies and required some sort of evaluation or examination, but only about a quarter of states promulgated a specific PCA training curriculum. Just over half of states require a minimum number of training hours, with considerable variation from four to 125 hours. Even the top-scoring leader states varied from six hours of training in Oregon and Rhode Island to as many as 125 hours in Washington D.C.

Fourteen states and Washington D.C. met both criteria for portability. However, nearly half of states did not meet any portability criteria, which means that workers in those states may be limited in their career mobility and progression. In other words, in states without a recognized credential, PCAs may be required to complete duplicative entry-level training each time they are hired by a new employer. We also found that six states and Washington D.C. required PCAs to be certified as either home health aides or certified nursing assistants, even when they are employed in PCA-specific roles. Further research could explore whether these certification requirements support the professionalization of the PCA workforce—or serve as barriers to entry for those who do not have the resources to complete the training prior to employment as PCAs.

In broad terms, training requirements for PCAs appear somewhat more robust across states than in 2014 when the first scan of PCA training requirements was conducted. Whereas that original study found 11 states with no training requirements for PCAs in any Medicaid HCBS program or waiver, we found only seven. These findings cannot be directly compared due to differences in methodology between the two studies, but nonetheless suggest some progress in the field. As one example, Connecticut did not have any PCA training standards in 2014, but as of July 2018, has been requiring all agency-employed PCAs to complete a standardized competency-based training program within 90 days of their first hire. Conversely, some states weakened their standards in the past decade. Iowa, for instance, formerly required PCAs to complete an orientation on six specified topics, pass a competency exam, and engage in continuing education—but has since rolled back those requirements. These examples point to uneven improvement in training standards across the country. And, of course, the PCA training landscape continues to evolve, with other efforts underway to revise and improve training standards that were not captured by this point-in-time snapshot.

Research and Policy Implications

Several research and policy implications arise from this review.

Future studies should explore other elements of the PCA training landscape, including language requirements (i.e., the extent to which training programs and/or competency exams are allowed and offered in languages other than English); training modality flexibilities (i.e., whether training can be completed online or in a hybrid format versus in-person only); and training program quality (e.g., whether training programs adhere to adult learner-centered principles).

As mentioned earlier, future research should also explore training requirements for DSPs supporting individuals with intellectual and developmental disabilities. This research could assess consistency, rigor, and portability in DSP training standards as well as comparing them to training standards for PCAs supporting older adults and people with physical disabilities.

Going further, more research is needed to examine the associations between different training requirements and key workforce and consumer outcomes. For example, little is known about how different training requirements are associated with PCA workforce recruitment and retention, the ratio of PCAs to potential consumers, and care access and quality. This research would build on the existing literature on the benefits of enhanced training programs for PCAs[28]; for example, a recent quasi-

experimental intervention study with independent provider PCAs in California found that training for these workers was associated with reduced emergency department visits and inpatient hospital stays for participating consumers.[29] This research reflects findings from other reports on how training for home care workers can contribute to reduced emergency room rates.[30]

Regarding policy implications, these findings suggest the need for more consistent PCA training standards to reduce inequity and barriers to mobility within and across states. The Centers for Medicare & Medicaid Services (CMS) could lead the way by establishing a minimum federal training standard for PCAs, ensuring better consistency with home health aides and nursing assistants. This recommendation is included in the Long-Term Care Workforce Support Act introduced in Congress in April 2024.[31]

CMS should also take steps to ensure that entry-level training and certification costs are covered through Medicaid for all direct care occupations, including for PCAs, and support efforts to compensate for training time, such as through apprenticeship and other earn-while-you-learn programs. Self-funding training costs is not possible for many prospective PCAs given their resource limitations, nor do many employers have additional resources available to build out their training programs, hence the need for public investment. In addition, federal leaders should support states in strengthening their direct care workforce training infrastructures. For example, federal leaders can provide funding and technical assistance to develop competency-based training standards and design, deliver, and evaluate adult learner-centered training programs in different training modalities and languages. The American Rescue Plan Act Section 9817 provided a valuable but short-term example of this type of federal support. Another example of federal support is the Direct Care Workforce Strategies Center, funded by the Administration for Community Living (ACL) to support workforce recruitment, training, and retention efforts across states.[32] Sustained investments beyond these short-term efforts will be needed.

At the state level, states should assess their current PCA training requirements and service delivery landscape, using the criteria provided in this report, to identify opportunities for improvement. As mentioned in the Introduction, many states are already assessing and revising their training requirements—including through the Direct Care Workforce Strategies Center—and several states are taking steps toward a more consistent training and credentialing approach, whereby all PCAs can complete the same core competency-based entry-level training and in some cases complete bridge training to become certified in other direct care roles (e.g., nursing assistant) and/or accrue additional setting- and population-specific training and credentials that allow them to progress along career lattices and ladders.

Wisconsin's WisCaregiver Careers Certified Direct Care Professional (CDCP) program provides an instructive example.[33] This new program qualifies CDCPs to work across HCBS settings at the entry level, with access to further training and associated micro-credentials and bridge training opportunities (not yet formalized) into other roles such as certified nursing assistant. As another example, Washington State requires all home care workers to complete a specified training and certification program, then also offers an Advanced Home Care Aide Specialist Training for those who want to specialize further and boost their earning potential.[34]

Another specific recommendation for states is to create centralized registries that provide proof of training (which are only present in 16 states, according to our review)—and to further build out the functionality of those online platforms. For example, such online registries can be used to provide potential job seekers with information about direct care careers and channel them into associated training opportunities. Moreover, they can be used to connect job seekers and employers (including agency and individual employers) through job-matching functionality. States can look to existing

platforms for guidance and possible replication, for example Carina in Washington State and Oregon[35] and Direct Care Careers in Colorado, North Dakota, and Texas,[36] among others. Of note, CMS promoted the value of direct care worker registries through a Center for Medicaid & CHIP Services (CMCS) bulletin in December 2023, emphasizing that registry development and maintenance can qualify for an enhanced federal match through Medicaid.[37]

Limitations

This research was limited by what was available in the public domain. Although we spoke directly to experts in a selection of states for clarification purposes, the majority of research was conducted through document analysis using publicly accessible websites. In a few instances, we found inconsistent documentation or outdated links that could not be verified.

An additional limitation in this research was the inconsistent terminology used for PCAs within states, which sometimes made it difficult to decipher if different sources were discussing the same program or occupational position. When ambiguity existed, we carefully reviewed the materials and discussed them as a research team. We also made our best efforts to reach out to experts within states but did not receive a response to every query.

Finally, as noted, we scored states for examples of rigor and portability across any set of training requirements, not across all requirements. Consequently, high scores for those domains do not mean that all training requirements are rigorous and portable in those states. Much more progress is needed on boosting training standards consistently across all PCA programs and employers.

Conclusion

This report is the first update to a nationwide scan of PCA training standards in a decade. The findings show where states are leading the way while also underscoring the considerable variation in training standards that still exists across the nation. Continuing to raise the bar on training and career pathways for PCAs is critical for professionalizing this workforce and maximizing their valuable contribution to the lives of older adults and people with disabilities and serious illness

Table 1. Training Requirement Domains, Indicators, and Scores

Indicator	Definition	Scoring
Domain: Consistency (total possible score = 1)		
No Training Requirements in Any Program	No training requirements for agency-employed PCAs in regulatory text or other materials. This category includes requirements for CPR and/or first aid training only.	0
Training Requirements for Some Programs	Training requirements specified for some, but not all, agency-employed PCAs, depending on the Medicaid program or waiver.	.33
Training Requirements for All Programs	Training requirements for all agency-employed PCAs across Medicaid programs and waivers, but requirements vary.	.67
Consistent Training Requirements Across All Programs	Consistent training requirements for all agency-employed PCAs across Medicaid programs and waivers.	1
Domain: Rigor (total possible score = 6)		
None or Agency Assurance Only	No training requirements, or regulatory text or other materials specify only that responsibility for training lie solely with the employing agency (with no further specifications or guidance).	0
Hours	Minimum number of training hours is specified in at least one set of training requirements	1
Competencies Specified	Regulatory text or other materials lists the specific skills or competencies for which PCAs must receive training.	1
Competency Exam	PCAs required to complete a competency evaluation or exam before providing services. The exam may be designed and administered by the employing agency or standardized statewide.	1
State-Sponsored Curriculum	PCAs must be trained according to a state-sponsored curriculum; curriculum may be mandatory as-is or adaptable by providers with state approval.	1
Instructor Qualifications	The regulatory text or Medicaid guidelines for the state sets baseline requirements for PCA training instructors.	1
Continuing Education	Requirements in place for minimum in-service/continuing education training for PCAs.	1
Domain: Portability (total possible score = 2)		
Recognized Credential/Certification	PCA training results in a recognized certification or credential that is portable between employers.	1
Centralized Training Registry	The state hosts or supports a centralized training registry where training is logged and verifiable by other employers.	1
Domain: Other Training Requirements (total possible score = 2)		
Requirements in Self-Direction	Training requirements are in place for PCAs employed as “independent providers” through self-direction/consumer-direction programs.	1
Requirements for Private Pay Agencies	Training requirements are in place for PCAs employed by private pay home care agencies.	1
Total possible score = 11		

Table 2. Consistency of Training Requirements

	Number of States	Percentage
No Training Requirements	7	14%
Training Requirements for Some Programs	3	6%
Training Requirements for All Programs	8	16%
Consistent Training Requirements Across All Programs	33	65%

Table 3. Rigor of Training Standards

Component of Rigor	Number of States	Percentage
None or Agency Assurance Only	7	14%
Hours	26	51%
Competency Exam	43	84%
Competencies Specified	35	69%
State-Sponsored Curriculum	13	26%
Instructor Qualifications	29	59%
Continuing Education	33	65%

Table 4. Portability of Training

Component	Number of States	Percentage
Recognized Credential/Certification	26	51%
Centralized Training Registry	16	31%

Appendix

State	Consistency is (0-1)	Rigor (0-6)	Portability (0-2)	Independent Providers	Private Pay	Overall Score (0-11)
Alabama	.3	1	0	0	0	1.3
Alaska	1	4	1	0	0	6
Arizona	1	5	2	1	0	9
Arkansas	.7	5	1	0	1	7.7
California	1	3	2	0	1	7
Colorado	1	3	0	0	1	5
Connecticut	1	3	0	0	0	4
Delaware	1	3	0	0	1	5
District of Columbia	1	6	2	0	1	10
Florida	1	5	2	0	1	9
Georgia	1	4	0	0	1	6
Hawaii	.3	5	2	0	1	8.3
Idaho	1	3	1	0	0	5
Illinois	.7	5	1	0	1	7.7
Indiana	0	0	0	0	0	0
Iowa	0	0	0	0	0	0
Kansas	0	0	0	0	0	0
Kentucky	1	4	0	1	0	6
Louisiana	1	4	1	0	1	7
Maine	1	4	2	1	0	8
Maryland	1	2	0	1	1	5
Massachusetts	.7	6	1	1	0	8.7
Michigan	.3	2	0	1	0	3.3
Minnesota	1	4	2	0	0	7
Mississippi	1	5	0	1	0	7
Missouri	.7	5	0	0	0	5.7
Montana	1	5	0	0	0	6
Nebraska	0	0	0	0	0	0
Nevada	1	4	1	1	1	8

State	Consistency is (0-1)	Rigor (0-6)	Portability (0-2)	Independent Providers	Private Pay	Overall Score (0-11)
New Hampshire	1	1	0	0	1	3
New Jersey	1	6	2	0	1	10
New Mexico	1	4	0	0	0	5
New York	1	6	2	0	1	10
North Carolina	.7	4	2	0	1	7.7
North Dakota	1	3	2	1	0	7
Ohio	.7	5	1	1	1	8.7
Oklahoma	1	4	2	0	1	8
Oregon	1	6	2	1	1	11
Pennsylvania	1	4	1	1	1	8
Rhode Island	1	5	2	1	1	10
South Carolina	1	4	1	1	1	8
South Dakota	1	2	0	0	0	3
Tennessee	0	0	0	0	0	0
Texas	0	0	0	0	0	0
Utah	1	1	0	0	1	3
Vermont	0	0	0	0	0	0
Virginia	1	6	0	0	1	8
Washington	1	6	2	1	1	11
West Virginia	.7	4	0	1	0	5.7
Wisconsin	.7	3	0	1	0	4.7
Wyoming	1	5	2	1	0	9

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