Acurate as of May 2026

Executive Summary

Several states are facing a shortage of in-home caregivers as demand for long-term care services continues to increase due to the state's aging population and high rates of disability. Workforce shortages are driven by low wages, high turnover, and challenges with rural access. Although workforce shortages persist, in-home care remains significantly less expensive than institutional nursing home care and is generally preferred by care recipients. This memorandum reviews workforce and fiscal trends nationally and regionally, and it highlights policy options used in other states, including Medicaid reimbursement increases, workforce training initiatives, caregiver tax credits and grants, rural service delivery improvements, and caregiver assessment tools.

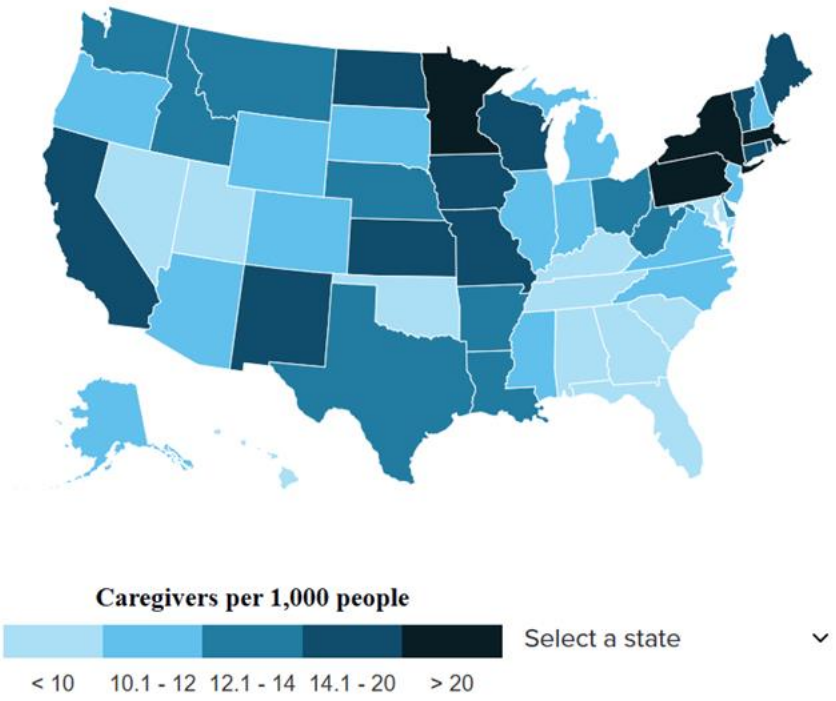
Research Methods

The data used in this analysis were retrieved from each states' Department of Human Services (or equivalent) and in-home care service provider group databases.

Findings and Analysis

It is estimated that in the United States, 20 million seniors and people with disabilities require long-term services and support, and surveys suggest that most would prefer to receive services at home or in the community, as opposed to in an institution, such as a nursing home.[i] Despite the high demand for this specialized labor, the nation is facing a shortage of home health direct service providers. By 2028, it is projected that there will be a shortage of approximately 39,500 caregivers.[ii] Furthermore, according to the Bureau of Labor Statistics, the nation will need about 740,000 new home care workers by the end of the next decade due to an increasingly aging population.[iii] Figure 1 below shows the number of caregivers per 1,000 people in each state.

Figure 1. Caregivers per 1,000 People by State



SOURCE: Mesothelioma Center[iv]

The labor shortage is due to several factors. Many point to post-pandemic burnout, staffing turnover, and failed recruitment strategies as the primary drivers of the shortage. In fact, direct support professionals working with adults with intellectual and developmental disabilities had an average national turnover rate of 43% in 2019.[v] While these factors have certainly contributed to a large share of the shortage, other subtler challenges compound their effects. For example, a specific community may have the workforce provide care to the baseline number of individuals in need of services, but if the workforce is not trained to address a specific need, there is still a workforce shortage and inadequate access to care. Therefore, barriers like training and matching the caregiver to the care recipient make the shortage even more complex and difficult to remedy.

The South bears a greater share of the workforce shortage due to lower overall health and wages.[vi] The South reports the highest concentration of adults with self-care needs and a significant shortage of home care workers.[vii] Though the cost of in-home care is lower than that of residential care, because of lower average wages across industries in the region, the cost burden is still notably large for payers (in this case, primarily Medicaid).[viii],[ix]

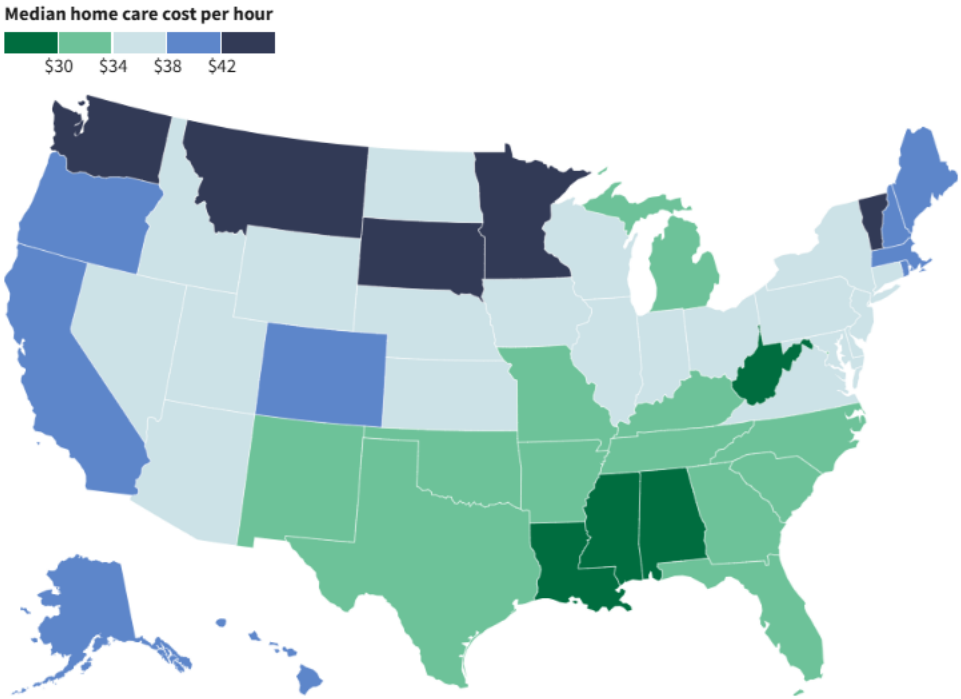
Presently, an estimated 18,123 individuals in West Virginia receive home health services, and as of 2025, there were 6,086 home health employees in the state.[x] It is important to note that 1 in 4 West Virginians serves as a caregiver for a family member, meaning in addition to the noted workforce shortage, there is also a large population that, for several reasons, has decided to forgo home health services, leave the labor market themselves, and care for a family member.[xi]

States that are demographically similar to West Virginia, such as Alabama, Arkansas, Kentucky, Missouri, and Tennessee, are also experiencing a shortage, but not at the rate at which West Virginia is. This is in part due to the large rurality and geographic terrain of West Virginia. Rural areas and areas that are generally more difficult to access pose a challenge for providing services simply because of the time and resources needed to provide the necessary services.

Fiscal Context

Though in-home care costs can accumulate rapidly, they are substantially lower than residential care. Figure 2 shows the median home care costs per hour in each state.

Figure 2. Median Home Care Cost per Hour by State



SOURCE: Investopedia[xii]

Table 1 shows the cost of a private room versus the cost of a shared room in a residential care facility across seven cities in West Virginia. It is estimated that for 2026, the national average daily cost of a shared room is $327, and the average annual cost is $119,340.[xiii] Table 2 shows the cost of several home care services per hour in all West Virginia counties. The counties of the cities listed in Table 1 are highlighted in yellow. The annual cost of in-home care depends on the type and frequency of services provided, but comparing the costs listed in the tables below shows that in-home care is more fiscally tenable than long-term residential care. Medicaid is the primary payer for both types of services because these services are considered long-term care.[xiv]

Table 1. 2026 Nursing Home Costs in Seven West Virginian Cities

Region	Private Room - Annual	Private Room - Daily	Shared Room - Annual	Shared Room - Daily
Beckley	$159,140	$436	$154,030	$422
Charleston	$167,535	$459	$165,345	$453
Huntington	$129,670	$355	$93,075	$255
Morgantown	$156,950	$430	$149,650	$410
Parkersburg	$146,365	$401	$144,175	$395
Weirton	$132,130	$362	$128,480	$352
Wheeling	$114,975	$315	$104,025	$285

SOURCE: American Council on Aging[xv]

Table 2.

	Provider Reimbursement Code				
County	**Aide 0571**	**OT 0431**	**PT 0421**	**SN 0551**	**SP 0441**
Fayette	64.94	157.86	156.79	143.45	170.43
Raleigh	64.94	157.86	156.79	143.45	170.43
Boone	59.01	143.44	142.47	130.35	154.87
Clay	59.01	143.44	142.47	130.35	154.87
Kanawha	59.01	143.44	142.47	130.35	154.87
Berkeley	67.29	163.57	162.46	148.64	176.60
Morgan	67.29	163.57	162.46	148.64	176.60
Cabell	66.60	161.89	160.79	147.11	174.78
Putnam	66.60	161.89	160.79	147.11	174.78
Wayne	66.60	161.89	160.79	147.11	174.78
Monongalia	61.81	150.25	149.23	136.53	162.21
Preston	61.81	150.25	149.23	136.53	162.21
Wirt	61.45	149.36	148.36	135.73	161.26

Wood	61.45	149.36	148.36	135.73	161.26
Brooke	57.45	139.64	138.69	126.89	150.76
Hancock	57.45	139.64	138.69	126.89	150.76
Marshall	58.49	142.17	141.21	129.20	153.50
Ohio	58.49	142.17	141.21	129.20	153.50
Hampshire	69.39	168.65	167.51	153.25	182.08
Barbour	56.75	137.93	137.00	125.34	148.91
Braxton	56.75	137.93	137.00	125.34	148.91
Calhoun	56.75	137.93	137.00	125.34	148.91
Doddridge	56.75	137.93	137.00	125.34	148.91
Gilmer	56.75	137.93	137.00	125.34	148.91
Grant	56.75	137.93	137.00	125.34	148.91
Greenbrier	56.75	137.93	137.00	125.34	148.91
Hardy	56.75	137.93	137.00	125.34	148.91
Harrison	56.75	137.93	137.00	125.34	148.91
Lewis	56.75	137.93	137.00	125.34	148.91
Logan	56.75	137.93	137.00	125.34	148.91
Mc Dowell	56.75	137.93	137.00	125.34	148.91
Marion	56.75	137.93	137.00	125.34	148.91
Mason	56.75	137.93	137.00	125.34	148.91
Mercer	56.75	137.93	137.00	125.34	148.91

Mingo	56.75	137.93	137.00	125.34	148.91
Monroe	56.75	137.93	137.00	125.34	148.91
Nicholas	56.75	137.93	137.00	125.34	148.91
Pendleton	56.75	137.93	137.00	125.34	148.91
Pleasants	56.75	137.93	137.00	125.34	148.91
Pocahontas	56.75	137.93	137.00	125.34	148.91
Randolph	56.75	137.93	137.00	125.34	148.91
Ritchie	56.75	137.93	137.00	125.34	148.91
Roane	56.75	137.93	137.00	125.34	148.91
Summers	56.75	137.93	137.00	125.34	148.91
Taylor	56.75	137.93	137.00	125.34	148.91
Tucker	56.75	137.93	137.00	125.34	148.91
Tyler	56.75	137.93	137.00	125.34	148.91
Upshur	56.75	137.93	137.00	125.34	148.91
Webster	56.75	137.93	137.00	125.34	148.91
Wetzel	56.75	137.93	137.00	125.34	148.91
Wyoming	56.75	137.93	137.00	125.34	148.91
Jackson	56.98	138.48	137.55	125.84	149.51
Lincoln	56.98	138.48	137.55	125.84	149.51
Mineral	59.90	145.58	144.59	132.29	157.18
Jefferson	74.53	181.16	179.93	164.62	195.59

SOURCE: West Virginia Department of Human Services: Bureau of Medical Services[xvi]

Policy Considerations

To improve the state of the in-home care provider workforce, policymakers may consider several actionable strategies ranging from financial adjustments to assessment tools.

Reimbursement Rate Adjustments

Adjusting Medicaid reimbursement rates is an option for incentivizing the caregiver workforce. While the precise estimated cost depends heavily on state budgets and the scale of the rate hike, it would require a significant investment of public funds. The main pro of this approach is that it directly addresses low compensation, which is a leading cause of high caregiver turnover. Conversely, the primary con is the substantial strain it places on state budgets, coupled with the risk that agencies might not fully pass the rate increases to the direct care workers. For successful implementation, states should consider rate-enforcement or wage-pass-through oversight measures.

Workforce Development and Training Strategies

States can strengthen the workforce by funding structured training programs, such as tuition assistance, mentoring networks, and formal apprenticeships, alongside agency-led upskilling initiatives. The estimated cost for these programs is moderate, requiring upfront fiscal allocations for tuition subsidies and program administration. A pro is that it builds a highly skilled, professionalized workforce, which improves patient care and creates clear career pathways that boost long-term retention. However, a notable con is that training requires time commitments that agencies and workers may struggle to accommodate. Implementation considerations include partnering with community colleges or local workforce boards to design standardized curricula.

Incentives and Financial Relief

Financial incentives, such as tax credits and direct grant bonuses, provide crucial relief to both professional and family caregivers. Recent legislation from the CSG South region highlights varying models for these initiatives. Below are three examples:

- Oklahoma House Bill 1029 (2023) introduced a family caregiver tax credit with an estimated annual cost capped at $1.5 million.
- Georgia (O.C.G.A. § 48-7-29.2) offers a tax credit covering 10% of qualified caregiving expenses, which historically maxed out at a low cost of $150 per year.
- Tennessee House Bill 1443 (2026) enacted the 'Caring for Caregivers Act,' creating a pilot grant program with an estimated cost of up to $6,000 per year per eligible participant to support low-income family caregivers of individuals with Alzheimer's disease or related dementia.

The primary pro of these incentives is that they alleviate immediate financial burdens, reducing burnout and delaying the need for expensive institutionalization. The con is that tax credits only benefit those with sufficient tax liabilities unless made refundable, and grant programs face sustainability challenges once pilot funding expires. For effective implementation, states need clear eligibility verification processes, user-friendly application portals, and scalable funding mechanisms to transition successful pilots into permanent programs.

Rural Service Delivery Solutions

Deploying targeted workforce solutions to rural areas addresses severe geographic disparities in care access. The estimated cost is highly variable, often demanding enhanced travel reimbursements, stipend programs, or technology infrastructure investments. The chief pro is that it ensures equitable access to care for isolated, vulnerable populations who would otherwise be left without support. On the downside, the con is a high per-capita cost due to low population density and extensive travel times, which can quickly deplete local program budgets. Implementation considerations require states to restructure reimbursement formulas to account for travel time and mileage, while expanding telehealth integration to maximize the efficiency of the existing rural workforce.

Data-Driven Caregiver Assessments

Implementing caregiver assessments allows states to identify specific needs, allocate resources efficiently, and justify program spending. The estimated cost includes moderate administrative and software licensing fees, which are likely to be offset by long-term savings. Below are examples of four states that have used assessment tools to evaluate the state of their caregiving workforce and the tool used:[xvii]

- **Georgia** utilizes the Bakas Caregiving Outcomes Scale within its non-Medicaid home- and community-based services and the National Family Caregiver Support Program (NFCSP) to track changes in caregiver health and well-being. Georgia uses this data to build customized service plans and match caregivers to tailored interventions.
- **Illinois** uses the Tailored Caregiver Assessment and Referral (TCARE) system to build person-centered care plans. Their assessments revealed that 50% of care recipients suffered significant memory loss, prompting Illinois to deploy targeted Alzheimer's training, burnout resources, and support groups.
- **Wisconsin** uses a checklist-formatted needs assessment via local aging units for its NFCSP and Alzheimer's Family Caregiver Support Program. Wisconsin used this data to pinpoint program gaps, leading them to successfully braid different funding sources to maximize service accessibility.

The pro of using these assessments is the ability to generate hard data that proves cost savings, reduces caregiver burnout, and optimizes resource allocation. This produces a baseline dataset that can be used in the future to assess the efficacy of policies. The con is the increased administrative burden placed on local agencies and the potential for initial system deployment delays. Before implementing, states should consider which assessment tool to use, thoroughly train local staff on the system, and establish data-sharing protocols.

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