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Home and Community-Based Services Improve Outcomes While Reducing Costs

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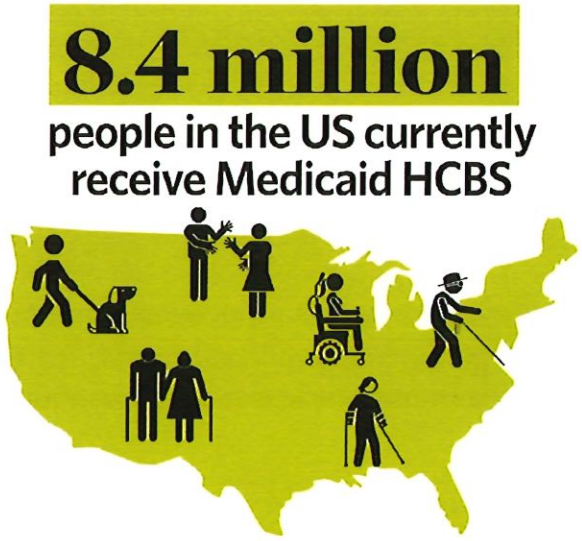
April 2026

Long-term services and supports (LTSS) refer to a wide range of health and social services provided to individuals who need help with activities of daily living, such as eating, bathing, and dressing, or with instrumental tasks, such as medication management, meal preparation, community participation, and employment.[1]

An estimated 17.6 million adults in the US (approximately 6.2%) have functional needs for LTSS.[2] Nearly half of adults currently needing LTSS are under the age of 65.[2] However, the number of older adults needing LTSS is rapidly growing as the US population ages. Many children also have developmental and functional needs for LTSS.[3]

Medicaid, a joint federal-state healthcare program, is the primary payer of formal LTSS in the United States. Within LTSS, Medicaid Home and Community-Based Services (HCBS) help support individuals across the lifespan to live, work, and engage in their communities with choice and control over how they receive services and supports. HCBS includes a wide range of supports, such as personal assistance, day services, employment supports, transportation, home modifications and enabling technologies, family caregiver supports, health and behavioral supports, and service coordination and navigation.[4]

Approximately 8.4 million individuals currently receive Medicaid HCBS,[5] however, there remains significant unmet needs. Over 600,000 individuals are on waiting lists or interest lists for Medicaid HCBS waivers.[6] Only about 24% of children and 48% of adults with intellectual and developmental disabilities (IDD) are known to state IDD services agencies.[7] Most individuals rely on unpaid support from family caregivers. Over 63 million family caregivers provide care to individuals with disabilities and older adults,[8] with an estimated economic value of over $1 trillion annually.[9]



Moreover, there is a long-standing "institutional bias" within Medicaid, where nursing homes and other institutional services are mandatory benefits that states must provide, while HCBS are optional.[10] This forces many individuals with disabilities and older adults into more costly institutional settings when their needs and preferences could be better met in the community.

Shifting away from systems that rely on institutional care towards HCBS is often referred to as "rebalancing." Bipartisan efforts at the national and state levels have contributed to significant progress in rebalancing over the last several decades. However, wide variations in HCBS access exist across states and different populations needing HCBS.[5]

This brief highlights research on the value of Medicaid HCBS. It summarizes major findings from decades of research which demonstrates that access to high-quality HCBS not only improves outcomes but can also reduce overall healthcare costs.

Medicaid HCBS on average cost less than nursing homes and institutional settings

- In 2023, average annual Medicaid LTSS expenditures were $17,298 per person for individuals receiving HCBS and $54,462 for individuals in institutional settings.[5]
- Among individuals with IDD in 2021, average annual expenditures were $51,835 per person for individuals receiving Medicaid HCBS waiver services and $146,050 for individuals residing in ICF/IIDs[7] (Intermediate Care Facilities for Individuals with Intellectual Disabilities).

Transitioning individuals from nursing homes and institutional settings back to the community improves outcomes and achieves cost savings

- The Money Follows the Person (MFP) program is a proven Medicaid demonstration that helps states transition older adults and people with disabilities back to the community. Forty-seven states have participated in the program at some point, assisting more than 127,000 individuals.[11]

- The national evaluation of the program found that after returning to the community, individuals' quality of life significantly improved and costs were lower.[12] Individuals reported outcomes included improved life satisfaction, reduced unmet needs and barriers to community participation, decreased depression, and enhanced feelings of being treated with dignity and respect.[12] In addition, average per-person Medicaid health and LTSS costs were 23-30% lower following transitions to the community.[12]
- State-specific evaluations of MFP programs in Connecticut, Georgia, and Washington have found similar cost savings.[13-15]
- One analysis found that states with robust MFP programs were more likely to show declines in nursing home utilization, occupancy, and expenditures.[16]

Shifting systems away from reliance on nursing homes and institutional settings and improving access to HCBS reduces costs over time

- Analyses of state spending over a 15-year period found that investments in HCBS often result in short-term spending increases, but over time lead to reduction in institutional spending and long-term cost savings.[17-20]
- Other state-specific and national studies[21-23] have also consistently demonstrated that rebalancing helps states contain overall LTSS costs and produce cost savings:
    - A recent study examining HCBS for older adults (65 years and over) found that expansion of HCBS was associated with more older adults receiving services and lower costs.[21]
    - Another study examining dually-eligible individuals with IDD across five states found that higher levels of HCBS spending were associated with reduced institutional placements.[22]
- Cuts to Medicaid HCBS could drive more individuals with disabilities and older adults into nursing homes and institutional placements, increasing costs to states. A recent economic analysis of California estimated that if just 3% of current HCBS beneficiaries ended up in nursing homes, it would result in a net spending increase of $57 million in the first year and $1.17 billion over the next five years.[24]

Unmet needs for HCBS contribute to worse community living and health outcomes, driving higher overall healthcare costs

- There is growing recognition that social determinants of health play a key role in health outcomes and costs. HCBS provide essential social supports that improve health and social outcomes.[25-27] Individuals with LTSS needs are significantly more likely to experience housing, food, and job insecurity, transportation barriers, and unmet healthcare needs.[28,29] They also report higher levels of stress, social isolation, and loneliness compared with individuals without LTSS needs.[28,29]
- A population-based study in Texas found that unmet needs for HCBS were associated with negative physical and mental health outcomes, including suicidal ideation.[30]
- One study of older adults and individuals with physical disabilities receiving Medicaid HCBS across 13 states found that 80% reported unmet needs in areas including assistance with daily activities, assistive technology, home modifications, transportation, and other services.[26]
    - Unmet needs for HCBS were consistently associated with worse community living outcomes, including limited community participation, fewer interactions with friends and family, and less control of life.[26]
    - Unmet needs were also related to worse health outcomes, including less routine preventive physical and dental care and higher emergency department visits and hospitalizations.[26]
- A body of emerging research has similarly found that access to HCBS can reduce avoidable emergency department visits and hospitalizations, which can contribute to higher overall healthcare costs.
    - A recent study following older adults in 11 states over time found that initiation of HCBS was associated with decreased hospitalizations and emergency department visits.[31]
    - Prior studies have found that greater amount and generosity of HCBS were associated with a lower risk of hospitalizations, including potentially avoidable hospitalizations.[32,33]
    - Another study found that the scope of HCBS was associated with increased chance of being discharged from a skilled nursing facility to a community setting.[34]

High-quality person-centered planning and care coordination more efficiently meet needs and desires of HCBS beneficiaries, producing better health and community living outcomes

- Person-centered planning is a facilitated approach to planning services and supports that prioritizes the needs, goals, and values of the individual.[35] This approach is an ongoing process that is directed by the person who receives the support.[35] Regulations require person-centered planning in all federally funded HCBS programs, including Medicaid HCBS.[36] However, the extent to which individuals report that their planning and service coordination is person-centered varies significantly across states and by individual service user characteristics.[37]
- An emerging body of research has found that high-quality person-centered planning contributes to improved health and community living outcomes.
    - A study of individuals with physical disabilities and older adults receiving HCBS across 12 states found that high-quality person-centered planning was associated with reduced unmet needs and more positive community living outcomes, including greater community participation, feelings of control, and satisfaction with how days were spent.[38]
    - Similarly, studies of individuals with IDD receiving HCBS across 36 states found that high-quality person-centered planning was associated with greater social inclusion, reduced unmet needs related to community participation, and more positive health outcomes –including lower unmet mental health needs, better self-reported health, and fewer emergency department visits.[39,40]
- Programs that effectively provide integrated care coordination across health and LTSS have demonstrated impacts on reducing avoidable hospitalizations, readmissions, and institutional placements.[41,42]

Self-direction, including flexibility to hire family members, contributes to better outcomes and helps address workforce shortages

- Self-direction is a model in which people receiving HCBS hold greater control over their services and supports than in traditional arrangements.[43] When a person self-directs, they decide how, when, and from whom their services and supports will be delivered. As a model, self-direction prioritizes participant choice, control, and flexibility. This contrasts with "traditional" services received from an agency, where the agency controls most aspects of service delivery.[43]

- Self-direction is one of the most evidence-based models of HCBS delivery. Most notably, the Cash and Counseling demonstration tested a budget authority model with a randomly selected control group of Medicaid beneficiaries not self-directing. Evaluations found that self-direction resulted in reduced unmet needs, greater satisfaction with services, positive health outcomes, and improved quality of life outcomes for participants as well as family caregivers.[44-46]
- Other studies of self-directed programs within states have supported similar outcomes across a wide range of disability populations receiving HCBS.[47-53] Many individuals within self-directed programs have hired family and friends, which has also been associated with better outcomes.[54] Hiring family members and friends can help address workforce shortages[52,54,55] and improve delivery of more culturally and linguistically, person-centered supports.[56]
- Veteran-Directed HCBS (Veteran-Directed Care Program since 2018) are for individuals enrolled in Veterans Administration Health Care and at-risk of nursing home placement.[57] One study examined beneficiaries' perspectives on Veteran-Directed HCBS. Participants described the program as promoting freedom and choice and improving their mental health and community participation.[51]

An adequate direct care workforce is essential to ensuring access to HCBS and achieving better outcomes

- There is a longstanding direct care workforce crisis that is driven by many structural forces, including low wages and lack of benefits, economic and demographic shifts, labor and immigration policies,[58] and demanding work conditions. Individuals, families, and providers face growing challenges to recruit and retain workers.
    - Recent studies have found that upwards of 69% of agencies serving HCBS beneficiaries report that they have stopped accepting or turned away new referrals due to staffing issues.[59,60]
    - Studies have consistently found high turnover rates and low tenure for direct care workers.[60,61]
- An inadequate direct care workforce limits the ability of states to expand access to HCBS, reduces quality, and jeopardizes safety of individuals. Experts project that more than 1.3 million new direct care workers will be needed by 2030.[62]
    - One study found that direct support professional turnover was associated with increased emergency room visits, incidents of abuse and neglect, injuries, and behavioral events for individuals with IDD.[63]
- While additional research is needed on outcomes, states and providers are actively undertaking a wide range of strategies to strengthen recruitment and retention of the direct care workforce.[64-66]

Conclusion

Home and Community-Based Services (HCBS) support individual well-being and strengthen the broader LTSS healthcare system. By enabling individuals to receive services in their communities rather than institutional settings, HCBS promotes choice, independence, and social connection. These services are associated with improved health outcomes, including fewer emergency department visits and hospitalizations, which can decrease overall healthcare costs. At the same time, HCBS result in greater cost savings than institutional care. "Rebalancing" systems away from institutions and toward HCBS benefits consumers, families, healthcare systems, and taxpayers.

Funding Statement

This resource was created with funding by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR, grant number 90RTGE0009). The content is solely the responsibility of the authors.

How to Cite This Brief

Caldwell, J. , Bixby, L., Siegel, R., Pickern, S., Stober, K., & Cahn, D. (2026, April). *Home and community-based services improve outcomes while reducing costs* [Research Brief]. Community Living Policy Center, Lurie Institute for Disability Policy, Brandeis University.

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References

1. Centers for Medicare & Medicaid Services. (2026, March 10). *LTSS overview*. CMS. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/tribal-leaders/ltss-overview
2. Community Living Equity Center. (2024). *Who needs LTSS?* [Data dashboard]. The Lurie Institute for Disability Policy. https://heller.brandeis.edu/community-living-policy/clec/who-needs-ltss.html
3. *2022-2023 National Survey of Children's (NSCH) Health data query* (Data Set Indicator 1.10: One or more functional difficulties). (2023). Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). https://nschdata.org/browse/survey/results?q=11039&r=1
4. Centers for Medicare & Medicaid Services. (2026, March 10). *Home- and Community-Based Services*. CMS. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services
5. Carpenter, A., Stepanczuk, C., Murray, C., & Wysocki, A. (2025). *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 for Centers for Medicare and Medicaid (CMS). https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf
6. Burns, A., Wolk, A., & O'Malley Watts, M. (2025, November 20). *A look at waiting lists for Medicaid Home- and Community-Based Services from 2016 to 2025*. KFF. https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2025/
7. Larson, S., Neidorf, J., Pettingell, S., Nye-Lengerman, K., & Vegas, L. (2026). *Long-Term Supports and Services for individuals with intellectual or developmental disabilities: Status and trends through 2021*. University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. https://ici-s.umn.edu/files/aaQxdJjAit/risp_2021_final_acc?preferredLocale=en-US
8. Resendez, J., Cantor, K., Frank, L., Kueppers, G., Cothran, F. A., Choula, R. B., Caldera, S., Raimondi, A., Rainville, G. "Chuck," Guengerich, T., Lampkin, C. L., & Cuozzo, J. (2025). *Caregiving in the US: Research report*. AARP; National Alliance for Caregiving. https://www.caregivingintheus.org/wp-content/uploads/2026/03/caregiving-in-us-2025.doi_.10.26419-2fppi.00373.001.pdf
9. Houser, A., Caldera, S., Flinn, B., & Choula, R. (2026). *Valuing the invaluable 2026: Family caregivers' contribution reaches $1 trillion*. AARP Public Policy Institute. https://doi.org/10.26419/ppi.00402.001
10. Maniates, H. (2024). *Why did they do it that way? Home and Community-Based Services: Medicaid: The more you learn* [Research Brief]. National Association of Medicaid Directors. https://medicaiddirectors.org/wp-content/uploads/2024/04/NAMD-Understanding-HCBS-04-11-24.pdf
11. Kantoris, C., Murray, C., & Ross, J. (2025). *Money Follows the Person (MFP): Updated MFP grant recipient transitions as of December 31, 2023*. Mathematica for Centers for Medicare and Medicaid (CMS). https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-trantns-brief-2023.pdf

12. Coughlin, R., Ward, J., Denny-Brown, N., Hagen, B., Maurer, K., Morris, E., Smoot, J., Steiner, A., & Perez, B. (2017). Money Follows the Person demonstration: Overview of state grantee progress, January to December 2016. In *Mathematica Policy Research Published Reports*. Mathematica Policy Research.

13. Xing, J., Mancuso, D., & Felver, B. E. M. (2017). *Transitioning residents from nursing homes to community living: Impact of Washington state's Roads to Community Living (RCL) demonstration on Medicaid Long-Term Services and Supports costs*. Washington State Department of Social & Health Services. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-8-33.pdf

14. Robison, J., Porter, M., Shugrue, N., Kleppinger, A., & Lambert, D. (2015). Connecticut's 'Money Follows the Person' yields positive results for transitioning people out of institutions. *Health Affairs, 34*(10: Variety Issue), 1628–1636. https://doi.org/10.1377/hlthaff.2015.0244

15. Landers, G., Fuller, K., & Zhou, M. (2017). Medicaid savings continue in the year after end of participation in the program, Money Follows the Person. *Journal of the Georgia Public Health Association, 7*(1), 42–44. https://doi.org/10.21633/jgpha.7.107

16. Kaye, H. S. (2019). *Evidence for the impact of the Money Follows the Person program*. Community Living Policy Center, Brandeis University. https://doi.org/10.48617/rpt.358

17. Harrington, C., Ng, T., & Kitchener, M. (2011). Do Medicaid Home and Community Based Service waivers save money? *Home Health Care Services Quarterly, 30*(4), 198–213. https://doi.org/10.1080/01621424.2011.622249

18. Kaye, H. S., LaPlante, M. P., & Harrington, C. (2009). Do noninstitutional long-term care services reduce Medicaid spending? *Health Affairs, 28*(1), 262–272. https://doi.org/10.1377/hlthaff.28.1.262

19. Guo, J., Konetzka, R. T., & Manning, W. G. (2015). The causal effects of home care use on institutional long-term care utilization and expenditures. *Health Economics, 24*(S1), 4–17. https://doi.org/10.1002/hec.3155

20. Kaye, H. S. (2012). Gradual rebalancing of Medicaid Long-Term Services and Supports saves money and serves more people, statistical model shows. *Health Affairs, 31*(6), 1195–1203. https://doi.org/10.1377/hlthaff.2011.1237

21. McGarry, B. E., & Grabowski, D. C. (2023). Medicaid Home and Community-Based Services spending for older adults: Is there a "woodwork" effect? *Journal of the American Geriatrics Society, 71*(10), 3143–3151. https://doi.org/10.1111/jgs.18478

22. Jan, S., Steinway, C., Brensinger, C., Teng, O., Chen, J., Liu, Q., & Shults, J. (2026). State-based variations in risk of institutional placement among dually eligible non-elderly adults with intellectual / developmental disabilities. *Disability and Health Journal, 19*(2), 101973. https://doi.org/10.1016/j.dhjo.2025.101973

23. Grage, W.-F., & Walls, G. (2013). *State studies find Home and Community-Based Services to be cost-effective* (Spotlight No. 2). AARP Public Policy Institute. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf

24. *How could cuts to Medi-Cal Home and Community-Based Services impact California?* (2025). [Research Brief]. ATI Advisory. https://www.chcf.org/wp-content/uploads/2025/10/HowCutsMediCalHomeCommunityBasedServicesImpactCA.pdf

25. Biggar, A., & Hood, A. (Eds.). (2019). A primer on managed care: Multiple chronic conditions. *Generations*, (Spring 2019; Supplement 3), 1–88. https://nachw.org/wp-content/uploads/2020/07/NACDD/CDC215_A%20Primer%20on%20Managed%20Care-%20Multiple%20Chronic%20Conditions.pdf#page=13

26. Chong, N., Akobirshoev, I., Caldwell, J., Kaye, H. S., & Mitra, M. (2022). The relationship between unmet need for Home and Community-Based Services and health and community living outcomes. *Disability and Health Journal*, *15*(2), 101222. https://doi.org/10.1016/j.dhjo.2021.101222

27. Kim, S. (2025). A scoping review of Home and Community-Based Services and older adults' health outcomes. *Journal of Social Service Research*, *51*(1), 179–195. https://doi.org/10.1080/01488376.2024.2408618

28. Bixby, L. (2025, November). *Addressing the health consequences of structural ableism and racism: Disparities in chronic health conditions and social determinants of health at the intersection of disability and race/ethnicity*. American Public Health Association Annual Meeting.

29. Bixby, L. (2025, August). *Disparities in health, healthcare, and social determinants of health at the intersection of disability and race/ethnicity*. Annual Meeting of the American Sociological Association.

30. Caldwell, J., Daniels, E., & Stober, K. (2025). Unmet needs for Long-Term Services and Supports and associations with health outcomes. *Disability and Health Journal, Community Living Policy*, *18*(3, Supplement), 101678. https://doi.org/10.1016/j.dhjo.2024.101678

31. Keesee, E., Fabius, C. D., Kim, J., Stevenson, D., & Keohane, L. M. (2026). Medicaid Home and Community-Based Services initiation and acute services use. *JAMA Health Forum*, *7*(3), e260206. https://doi.org/10.1001/jamahealthforum.2026.0206

32. Segelman, M., Intrator, O., Li, Y., Mukamel, D., & Temkin-Greener, H. (2019). Variations in HCBS spending, use, and hospitalizations among Medicaid 1915(c) waiver enrollees. *World Medical & Health Policy*, *11*(3), 231–247. https://doi.org/10.1002/wmh3.315

33. Xu, H., Weiner, M., Paul, S., Thomas III, J., Craig, B., Rosenman, M., Carney Doebbeling, C., & Sands, L. P. (2010). Volume of Home- and Community-Based Medicaid waiver services and risk of hospital admissions. *Journal of the American Geriatrics Society*, *58*(1), 109–115. https://doi.org/10.1111/j.1532-5415.2009.02614.x

34. Wang, S., Temkin-Greener, H., Simning, A., Konetzka, R. T., & Cai, S. (2021). Medicaid Home- and Community-Based services and discharge from skilled nursing facilities. *Health Services Research*, *56*(6), 1156–1167. https://doi.org/10.1111/1475-6773.13690

35. *Person-Centered planning and practice: Final report*. (2020). National Quality Forum. https://www.n-a-q.org/assets/site/PersonCenteredness/pcpp_final_report%20.pdf

36. Bradley, V. J. (2024). *Person-Centered Planning: Choosing the approach that works for the person*. NCAPPS. https://ncapps.acl.gov/docs/Resources/NCAPPS%20Person-Centered%20Planning%20Choosing%20the%20Approach%20that%20Works%20for%20the%20Person%20Accessible.pdf

37. Caldwell, J., Stober, K., & Daniels, E. (2025). *Who receives Person-Centered Planning? Demographic predictors among service users with intellectual and developmental disabilities in the United States* [Manuscript submitted for publication]. Lurie Institute for Disability Policy, Brandeis University.

38. Chong, N., Caldwell, J., Kaye, H. S., & Mitra, M. (2024). Outcomes of Person-Centered Planning in Medicaid Home- and Community-Based Services. *The Gerontologist*, *64*(6), gnae017. https://doi.org/10.1093/geront/gnae017

39. Daniels, E., Caldwell, J., & Stober, K. (2025). *Association of Person-Centered Planning and service coordination with health outcomes of adults with intellectual disabilities* [Manuscript submitted for publication]. Lurie Institute for Disability Policy, Brandeis University.

40. Stober, K., Caldwell, J., & Daniels, E. (2025). *The impact of Person-Centered Planning on social inclusion for adults with intellectual and developmental disabilities* [Manuscript submitted for publication]. Lurie Institute for Disability Policy, Brandeis University.

41. *Evaluations of integrated care models for dually eligible beneficiaries: Key findings and research gaps.* (2020). [Research Brief]. Medicaid and CHIP Payment and Access Commission (MACPAC). https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf

42. Dobson, C., Mosey, A., Plasencia, R., Muster, C., Gibbs, S., & Smith, L. (2021). *Demonstrating the value of Medicaid MLTSS programs* [2021 Edition]. MLTSS Institute; ADvancing States; Center for Health Care Strategies (CHCS). https://www.advancingstates.org/sites/default/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf

43. Centers for Medicare & Medicaid Services. (n.d.). *Self-Directed Services*. Medicaid. Retrieved April 2, 2026, from https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services

44. Carlson, B. L., Foster, L., Dale, S. B., & Brown, R. (2007). Effects of Cash and Counseling on personal care and well-being. *Health Services Research*, *42*(1 Pt 2), 467–487. https://doi.org/10.1111/j.1475-6773.2006.00673.x

45. Brown, R., Lepidus Carlson, B., Dale, S., Foster, L., Phillips, B., & Schore, J. (2007). *Cash & Counseling: Improving the lives of Medicaid beneficiaries who need personal care or Home and Community-Based Services: Final report*. Mathematica Policy Research.

46. De Milto, L. (2015). *Cash & Counseling*. Robert Wood Johnson Foundation.

47. Caldwell, J., & Heller, T. (2007). Longitudinal outcomes of a Consumer-Directed program supporting adults with developmental disabilities and their families. *Intellectual and Developmental Disabilities*, *45*(3), 161–173. https://doi.org/10.1352/1934-9556(2007)45%255B161:LOOACP%255D2.0.CO;2

48. Sciegaj, M., Capitman, J. A., & Kyriacou, C. K. (2004). Consumer-Directed community care: Race/ethnicity and individual differences in preferences for control. *The Gerontologist*, *44*(4), 489–499. https://doi.org/10.1093/geront/44.4.489

49. Caldwell, J., Heyman, M., Atkins, M., & Ho, S. (2022). Experiences of individuals Self-Directing Medicaid Home and Community-Based Services during COVID-19. *Disability and Health Journal*, *15*(3), 101313. https://doi.org/10.1016/j.dhjo.2022.101313

50. Croft, B., & Parish, S. (2016). Participants' assessment of the impact of behavioral health Self-Direction on recovery. *Community Mental Health Journal*, *52*(7), 781–792. https://doi.org/10.1007/s10597-016-9999-0

51. Mahoney, E. K., Milliken, A., Mahoney, K. J., Edwards-Orr, M., & Willis, D. G. (2019). "It's changed everything": Voices of veterans in the Veteran-Directed Home and Community Based Services program. *Journal of Gerontological Social Work*, *62*(2), 129–148. https://doi.org/10.1080/01634372.2018.1458054

52. Matthias, R. E., & Benjamin, A. E. (2008). Paying friends, family members, or strangers to be home-based personal assistants: How satisfied are consumers? *Journal of Disability Policy Studies*, *18*(4), 205–218. https://doi.org/10.1177/1044207307311526

53. San Antonio, P. M., Simon-Rusinowitz, L., Loughlin, D., Eckert, J. K., & Mahoney, K. J. (2007). Case histories of six consumers and their families in Cash and Counseling. *Health Services Research, 42*(1 Pt 2), 533–549. https://doi.org/10.1111/j.1475-6773.2006.00674.x

54. Kueakomoldej, S., Dinelli, E., Beestrum, M., Sadler, T., Caldwell, J., McHugh, M., & Heinemann, A. W. (2024). Self-Directed Home- and Community-Based Services improve outcomes for family caregivers: A systematic review. *The Gerontologist, 64*(8), gnae068. https://doi.org/10.1093/geront/gnae068

55. San Antonio, P., Simon-Rusinowitz, L., Loughlin, D., Eckert, J. K., Mahoney, K. J., & Depretis Ruben, K. A. (2010). Lessons from the Arkansas Cash and Counseling program: How the experiences of diverse older consumers and their caregivers address family policy concerns. *Journal of Aging & Social Policy, 22*(1), 1–17. https://doi.org/10.1080/08959420903385544

56. Gomes, A.-M., Novack, V. J., The, K. J., Hu, L. A., Siegel, R., Rambharose, J.-L., Nguyen, T., & Caldwell, J. (2026). *Circles of care: Home and Community-Based Service Supports for people of color with disabilities leaving institutional settings* [Manuscript submitted for publication]. Brandeis University.

57. *Veteran-Directed Care Program.* (2025, March 13). ACL Administration for Community Living. http://acl.gov/programs/veteran-directed-home-and-community-based-services/veteran-directed-home-community-based

58. *Direct care workers in the United States: Key facts.* (2025). PHI.

59. *The state of America's direct support workforce crisis.* (2024). American Network of Community Options and Resources (ANCOR). https://www.ancor.org/wp-content/uploads/2024/12/The-State-of-Americas-Direct-Support-Workforce-Crisis-2024.pdf

60. *NCI state of the workforce for intellectual and developmental disabilities 2024 survey report.* (2025). National Core Indicators Intellectual and Developmental Disabilities. https://idd.nationalcoreindicators.org/wp-content/uploads/2025/12/2024-NCI-IDD-SoTW_Final-Tagged.pdf

61. *National Core Indicators Aging and Disabilities state of the workforce in 2023 survey report.* (2024). National Core Indicators Aging and Disabilities. https://nci-ad.org/upload/reports/2023_NCI-AD_SoTW_FINAL_4_14_25.pdf

62. *Strengthening the direct care workforce.* (2025, January 15). ACL Administration for Community Living. http://acl.gov/programs/direct-care-workforce

63. Friedman, C. (2021). The impact of direct support professional turnover on the health and safety of people with intellectual and developmental disabilities. *Inclusion, 9*(1), 63–73. https://doi.org/10.1352/2326-6988-9.1.63

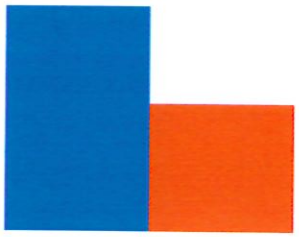
64. Tyler, D., Hunter, M., Porter, K., Horvath, M., & Suarez, G. (2024). *State efforts to improve direct care workforce wages: State case studies report.* RTI International. https://aspe.hhs.gov/sites/default/files/documents/ba806f15767b42593752744aab3e17ba/dcw-wages-state-case-studies.pdf

65. *Direct Care Workforce Strategies Center.* (2026, January 14). ACL Administration for Community Living. http://acl.gov/DCWcenter

66. Tyler, D., Khavjou, O., Hunter, M., Porter, K., Horvath, M., Suarez, G., Squillace, M., Dey, J., & Oliveira, I. (2024). *State efforts to improve direct care workforce wages: Final report.* RTI International; HHS Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/e88ca623469819d2444d07fe9564fb67/state-efforts-improve-dcw-wages-final.pdf

DIVISION OF VOCATIONAL SERVICES (DVR) *works* FOR WISCONSIN

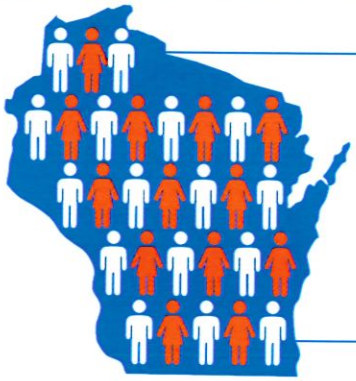
FED FISCAL YEAR 2025



DVR consumers whose cases were successfully closed earned an estimated $83.7 million through work, enriching the state's communities, economy, and workforce - exceeding the total cost of all DVR consumer services during the same period, at $60.8 million.

Earnings in millions ($83.7) Cost of DVR Services in millions $60.8)

20% increase in people served and highest case load in ten years.



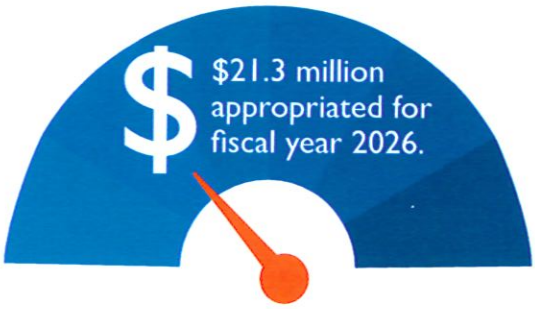
DVR successfully transitions Wisconsin residents with disabiities off federal and state programs.

This demonstrates a strong return on Wisconsin's continued investment in DVR programs.

In 2025, DVR served over 33,000 individuals and partnered with more than 3,200 employers to meet labor force needs.

DVR has implemented Order of Selection (OOS), a process also referred to as a waitlist, due to insuficient state budget funding.

Over the biennium, approximately 21,000 individuals may lack access to or experience significant delays in obtaining employment resources.



$21.3 million appropriated for fiscal year 2026.

$4.6 million shortfall in 2026
$2.4 million less than 2025 fiscal year

Why is this important?
DVR plays a key role in supporting and strengthening Wisconsin's economy!

DISABILITY SERVICE PROVIDER NETWORK

Medicaid cuts hurt unpaid caregivers.
More of them will leave Wisconsin's workforce.

Working unpaid caregivers are stretched to the limit, filling care gaps when there are no paid workers to hire, or no one shows up.

Statewide surveys show the paid care worker shortage is impacting Wisconsin families and workforce now. Medicaid cuts will make it worse. Medicaid pays for most long-term care and the salaries of paid care workers.

Full-time caregiving is a main reason why adults aren't working

IMPACT ON WORKERS

53 million
US adults care for a spouse, elderly parent or relative, or special-needs child ...

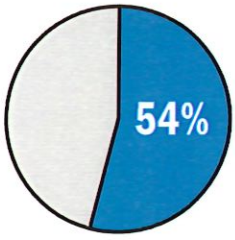
that's 20% of adults in the US

34 M working unpaid caregivers

U.S. Labor Force 171 M

Annually, employees who leave jobs lose up to
$3 trillion
in wages and benefits

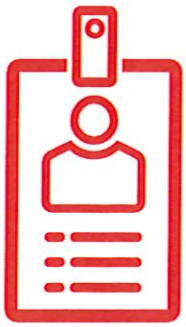
COST TO EMPLOYERS



More than half the workforce will be an unpaid caregiver during their career.

Annually, employers lose
$17-33 billion
to absence and turnover.

When caregiving employees drop out of the workforce, it can cost 6-9 months' worth of salary to recruit and train a replacement worker.



To provide care, many unpaid caregivers already leave the workforce, reduce hours, and pass on promotions.

When unpaid caregivers leave jobs to provide care, Wisconsin loses tax revenue.

Employers and communities lose expertise and service capacity.	**Unpaid caregivers lose income and retirement security.**

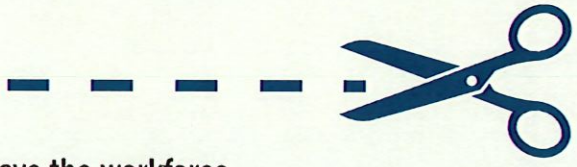
Current unpaid family caregivers:

80%
spend most of their time providing care, coordinating care, or filling in for missing care workers.

66%
say family finances are negatively impacted

50%
leave their jobs or reduce hours to provide care because there are no care workers to hire.

Medicaid cuts will mean



- Less money for states to provide care.
- Any less help means more Wisconsin caregivers leave the workforce.
- When unpaid caregivers leave jobs it means less family income, less retirement savings, more expenses, and impacts health insurance.

What does it mean for unpaid caregivers when they leave the workforce?

- **$432,000** in lost income over 10 years
- **$56,000** in lost contributions in Social Security over 10 years
- **$74,000** increased out of pocket expenses over 10 years
- **Total impact on one individual is $563,000**

55 year old employee with average income ($43K per year) leaving the workforce and providing care for 10 years loses.

LEADERSHIP

The Business Benefits Of Hiring People With Disabilities

By Our Place, Brand Contributor.
for Forbes EQ, BRANDVOICE | Paid Program

Published Jul 08, 2025, 09:36am EDT, Updated Aug 05, 2025, 11:25am EDT

Written by Dr. Katie Arnold, Executive Director, Our Place

In today's competitive economy, companies are constantly seeking new ways to innovate, increase productivity and build strong, resilient teams. One of the most powerful yet often overlooked strategies to achieve these goals is disability inclusion in the workplace. Hiring people with disabilities isn't just the right thing to do; it's smart business.

GETTY

A Largely Untapped Talent Pool

There are over 60 million adults in the United States living with some form of disability. Despite this, the employment rate for people with disabilities remains significantly lower than for those without disabilities. According to the U.S. Bureau of Labor Statistics, the employment-population ratio for persons with a disability was only 21.3% in 2022, compared to 65.4% for those without a disability. Yet employers who have taken proactive steps to hire people with disabilities consistently report benefits ranging from improved workplace morale to stronger business outcomes.

Individuals with disabilities bring a wide range of skills, experiences, and perspectives to the workplace. From problem-solving and adaptability to loyalty and resilience, many of the qualities employers seek are abundant in this population. Companies that recognize and embrace this potential are often rewarded with committed employees and a more dynamic workforce.

Proven Business Benefits

The data backs it up: hiring people with disabilities is good for the bottom line. A 2023 study by Accenture, in partnership with Disability:IN and the American Association of People with Disabilities (AAPD), found that companies that actively employ and support people with disabilities outperform their peers. These companies experienced 1.6 times more revenue, 2 times more economic profit, and 2.6 times more net income compared to those with less inclusive practices. Also, compared to their industry peers, these companies are 25% more productive—measured by revenue per employee.

Inclusive companies benefit from higher employee retention, stronger morale, and enhanced brand reputation. They are also more likely to foster innovation, as diverse teams, particularly those that include individuals who have had to navigate the world in unique ways, tend to challenge assumptions and generate creative solutions.

Real-World Examples of Impact

The true stories of employers show the real impact. For example, Dell Technologies demonstrates how inclusive hiring and support practices can drive business success. By integrating neurodiversity career coaches into its onboarding process, partnering with disability service organizations, and providing personalized support for both employees and managers, Dell ensures that neurodiverse talent can thrive. Additionally, in 2021, an accessibility project was developed called LEAD, a Dell Research, Development, and Innovation Center with the purpose of creating innovative solutions in areas such as wearable devices, AI, language processing, and more.

Another example is Bitty & Beau's Coffee, a coffee shop that employs people with intellectual and developmental disabilities. Their model has gained national attention not due to its mission and for the outstanding customer service that make it a standout experience for patrons. The brand has expanded to multiple cities, showing that inclusive employment isn't just sustainable, it's scalable.

Busting the Myths: Capability and Cost

One of the most persistent myths about hiring people with disabilities is that they are less capable or that workplace accommodations are prohibitively expensive. In fact, research shows the opposite. Research from the Job Accommodation Network shows that more than half (56%) of accommodations cost absolutely nothing to implement, while the rest

typically average around $300. That's a small price to pay for inclusive hiring that can expand talent pools, boost innovation, and reflect the diversity of customers served.

Another misconception is that employees with disabilities are less productive or more prone to absenteeism. The truth could not be more different. People with disabilities tend to be more loyal, consistent, and reliable employees. Walgreens, for example, integrated a significant number of workers with disabilities into its distribution centers. The company found that these employees had lower turnover rates, better safety records, and equal or higher productivity compared to employees without disabilities. These aren't feel-good statistics, they're bottom-line results.

The Role of Disability:IN

Leading the way in inclusive hiring is Disability:IN, a nonprofit that works to empower businesses to achieve disability inclusion and equality. Through its network of over 500 corporations, Disability:IN provides tools, training, and benchmarking systems that help companies build more inclusive workplaces. Disability:IN also supports employee resource groups (ERGs), leadership development for people with disabilities, and corporate partnerships that foster accountability and innovation. Their work has transformed how companies view disability not as a compliance issue, but as a strategic advantage.

Why It's a Win-Win

Hiring people with disabilities is smart business. Here's why:

Talent Advantage: There are over 61 million adults with disabilities in the U.S. alone—a vast, largely untapped talent pool.

Innovation and Problem-Solving: Employees with disabilities often bring unique perspectives and creative solutions developed through navigating a world that wasn't designed for them.

Customer Connection: Companies that prioritize accessibility and inclusion reflect the diversity of their customers and communities, building brand loyalty and trust.

Workplace Culture: Inclusive teams are more collaborative, empathetic, and engaged.

And finally, let's not forget: disability can affect any of us at any time, whether through injury, illness, or aging. Building inclusive workplaces is about creating environments where everyone can thrive, now and in the future.

Moving Forward

Forward-thinking companies recognize that hiring people with disabilities is not about charity—it's about opportunity. It's about building teams that reflect the world we live in and tapping into the full range of human potential. By actively recruiting, hiring, and supporting people with disabilities, businesses not only do good—they do well.

Unlocking talent begins with challenging outdated assumptions and embracing the reality that disability is part of the human experience. When employers open their doors to people with disabilities, they gain dedicated employees, strengthen their culture, and build a more innovative and successful future.

This is a content marketing post from a Forbes EQ participant. Forbes brand contributors' opinions are their own.

OUR PLACE

By Our Place, BRANDVOICE | Paid Program. Our Place's vision is a world where people with intellectual and developmental disabilities live with purpose and are valued members of their communities. We focus on our mission by supporting people with intellectual and...

Read More

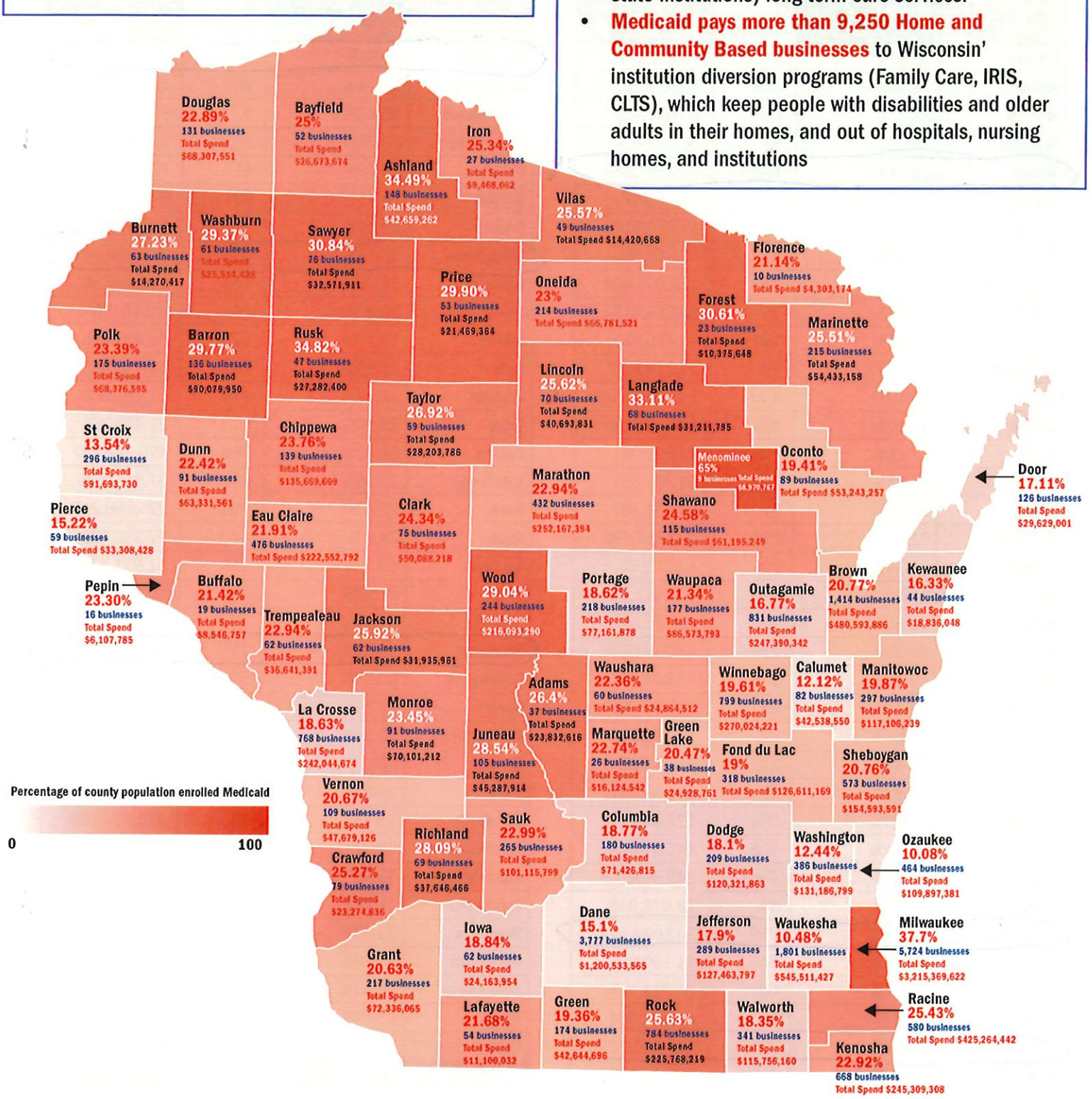
Find Our Place on LinkedIn. Visit Our's website.

Medicaid Matters to Wisconsin Business

On average, more than **23%** of people living in every Wisconsin county rely on Medicaid for health or long-term care, with some counties having as much as **65%** of their population in a Medicaid program.

In 2023, **Medicaid reimbursements infused $11Billion dollars** into local economies and worker paychecks.

- More than **30,000 Wisconsin businesses were paid** for providing health and institutional (nursing home, state institutions) long term care services.
- **Medicaid pays more than 9,250 Home and Community Based businesses** to Wisconsin' institution diversion programs (Family Care, IRIS, CLTS), which keep people with disabilities and older adults in their homes, and out of hospitals, nursing homes, and institutions



How many people, how many businesses, how much Medicaid dollars flow into the county?

Billing Provider County	Percentage of County population enrolled in Medicaid	Number of businesses	Total Spend ($)
Adams	26.40%	37	23,832,616
Ashland	34.49%	148	42,659,262
Barron	29.77%	136	90,079,950
Bayfield	25%	52	26,673,674
Brown	20.77%	1,414	480,593,886
Buffalo	21.42%	19	8,546,757
Burnett	27.23%	63	14,270,417
Calumet	12.12%	82	42,538,550
Chippewa	23.76%	139	135,669,609
Clark	24.34%	75	50,088,218
Columbia	18.77%	180	71,426,815
Crawford	25.27%	79	23,274,836
Dane	15.10%	3,777	1,200,533,565
Dodge	18.10%	209	120,321,863
Door	17.11%	126	29,629,001
Douglas	22.89%	131	68,307,551
Dunn	22.42%	91	63,331,561
Eau Claire	21.91%	476	222,552,792
Florence	21.14%	10	4,303,174
Fond du Lac	19%	318	126,611,169
Forest	30.61%	23	10,375,648
Grant	20.63%	217	72,336,065
Green	19.36%	174	42,644,696
Green Lake	20.47%	68	24,928,761
Iowa	18.84%	62	24,163,954
Iron	25.34%	27	9,468,062
Jackson	25.92%	62	31,935,961
Jefferson	17.90%	289	127,463,797
Juneau	28.54%	105	45,287,914
Kenosha	22.92%	668	245,309,308
Kewaunee	16.33%	44	18,836,048
La Crosse	18.63%	768	242,044,674
Lafayette	21.68%	54	11,100,032
Langlade	33.11%	68	31,211,795
Lincoln	25.62%	70	40,693,831
Manitowoc	19.87%	297	117,106,239
Marathon	22.94%	432	252,167,394
Marinette	25.51%	215	54,433,158
Marquette	22.74%	26	16,124,542
Menominee	65.00%	9	8,970,767
Milwaukee	37.70%	5,724	3,215,369,622
Monroe	23.45%	91	70,101,212
Oconto	19.41%	89	53,243,257
Oneida	23.00%	214	66,781,521
Outagamie	16.77%	831	247,390,342
Ozaukee	10.08%	464	109,897,381
Pepin	23.30%	16	6,107,785
Pierce	15.22%	59	33,308,428
Polk	23.39%	175	68,376,595
Portage	18.62%	218	77,161,878
Price	29.90%	53	21,469,364
Racine	25.43%	580	425,264,442
Richland	28.09%	69	37,646,466
Rock	25.63%	784	225,768,219
Rusk	34.82%	47	27,282,400
St. Croix	13.54%	296	91,693,730
Sauk	22.99%	265	101,115,799
Sawyer	30.84%	76	32,571,911
Shawano	24.58%	115	61,195,249
Sheboygan	20.76%	573	154,593,591
Taylor	26.92%	59	28,203,786
Trempealeau	22.94%	62	36,641,391
Vernon	20.67%	109	47,679,126
Vilas	25.57%	49	14,420,668
Walworth	18.35%	341	115,756,160
Washburn	29.37%	61	25,514,428
Washington	12.44%	386	131,186,799
Waukesha	10.48%	1,801	545,511,427
Waupaca	21.34%	177	86,573,793
Waushara	22.36%	60	24,864,512
Winnebago	19.61%	799	270,024,221
Wood	29.04%	244	216,093,290
Other		4,236	414,001,451
Total	23.27%	30,363	11,354,658,156

The Purpose and Importance of Day Services

Day Services for people with disabilities are non-residential programs that provide structured activities and support to help individuals improve their socialization, self-help, and adaptive skills, fostering independence and community engagement.

Benefits of Day Services include:

- **Skill Development**: Enhancing self-care, daily living skills, communication, and adaptive skills.
- **Sense of Belonging**: Opportunities to interact with others, fostering social skills, building relationships, and reducing feelings of isolation. Individuals are connected to and contributing to their community.
- **Well-Rounded Lifestyle:** Leisure activities, art & music, field trips, sports, and fitness promote physical health, expression and mental well-being.
- **Stability**: A consistent schedule helps develop a sense of stability.

For families, day services offer peace of mind knowing their loved one is in a safe and supportive setting with personalized care plans to help them reach their goals. Additionally, it allows caregivers to pursue careers, contributing to the economy and their own sense of worth, while reducing the chance of caregiver burnout.

"Our adult children fill their days with purpose and meaning. Each activity is tailored to their interests and life goals, allowing them to live the life they want to live. Because our children are so well cared for at Aspiro, we as parents can also live our way!"

- Amy Bushman, parent of Hannah and Eli

Summer 202

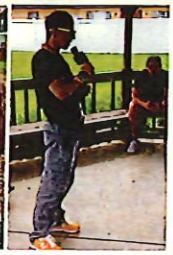
ASSISTED DAY SERVICES

"Your life does not get better by chance, it gets better by change." ~Jim Rohn

We say goodbye to our longtime home with gratitude for the memories made within its walls, and we look forward with excitement to the day we can return.

But before we left...

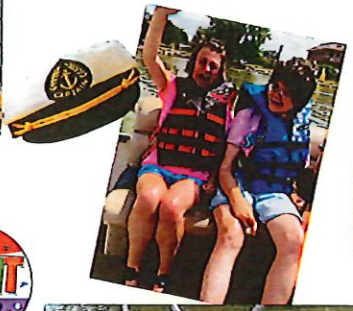
We played a game of whack-a-mole involving "whacking" the staff.



And enjoyed some outside karaoke in the gazebo.

Regardless of where our programming takes place, soaking up the summer air is our top priority. Baseball and boat rides were a great way to spend our days.

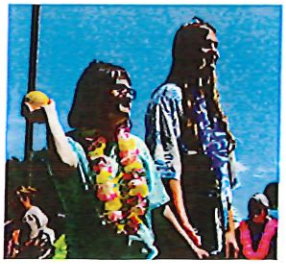
Life at Tank Elementary has been nothing short of an adventure! We're learning, exploring, and having a blast as we shape the next chapter for Aspiro.



Celebrating Spirit Days!

June
Aspiro's Birthday

July
Patriotic Day



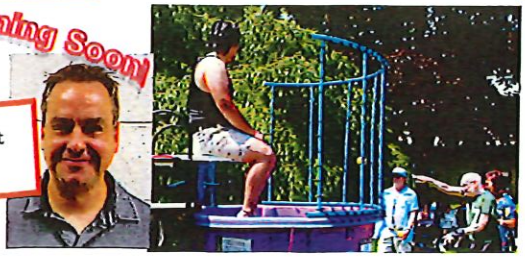
The Aspiro summer picnic and the Brown County Fair kept us busy and very entertained.

August
Tie Dye Day

We also said "see you later" to Program Specialist Maisie-She will be missed!

Participate in future Aspiro Spirit Days:
Oct 1st Crazy Hair Day
Nov 3rd Pajama Day
Dec 1st Ugly Tie Day

Coming Soon!



Program Specialist
Rob Waters

Medicaid HCBS

Support at Home, Life in Community for nearly 5 million Americans

What are Home and Community-Based Services (HCBS)?

HCBS is a **suite of Medicaid benefits** that include different types of services that support individuals with significant disabilities and chronic health conditions with everyday tasks to experience good lives in their chosen communities, instead of in a nursing home or other institutional setting. States deliver HCBS to people with disabilities and older adults at an average cost of $17,298 per user compared to institutional care at a $54,462 average per person cost.*

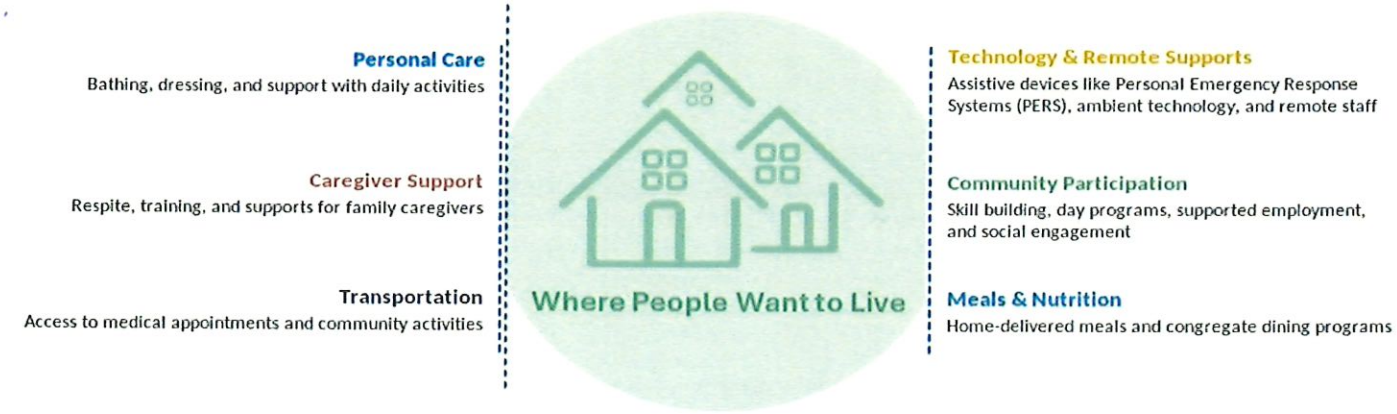
HCBS is a **key element of the nation's healthcare ecosystem** and can play a pivotal role in Making America Healthy Again (MAHA), keeping families together and in the workforce, and delaying costly medical and institutional care.

A core tenet of HCBS is **person-centered care planning**, which enables an individually tailored service array based on a **formalized assessment of need**.

Quality and accountability are essential to the success of HCBS. Numerous tools are available to states to ensure program integrity, like electronic visit verification, fraud referral hotlines, and service authorization audits.

HCBS Services

HCBS provides a range of services and supports, including those described below, to support independence, dignity, and community engagement for people with disabilities and older adults.



HCBS Providers

HCBS are delivered by a mix of **private for-profit organizations**; **nonprofit agencies**; and **government entities**. Many are small agencies, often founded by family members. They operate with lean staffing and slim margins, resulting **in less capacity to make investments** compared to large health systems and corporations.

Residential Supports
include community-based group homes, supported living services, or assisted living

In-home Services
include homemaker/personal care services, in-home habilitation, and respite

Community-based Supports
include day and employment services or community integration

NASDDDS
National Association of State Directors of Developmental Disabilities Services

NAMD
National Association of Medicaid Directors

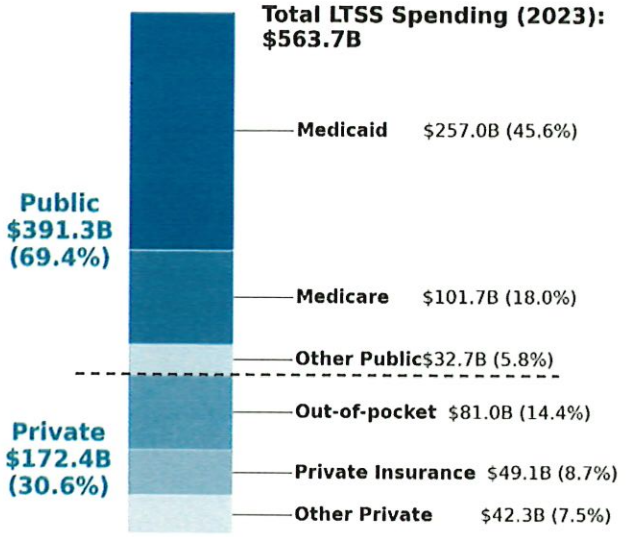
ADVANCING STATES

Why is HCBS Growing?

Medicaid is the **single largest payer for long-term care** (inclusive of HCBS and institutional settings) **in the United States.** Medicare's footprint is extremely small and **limited to post-acute services**.

Demand for HCBS is growing as the U.S. population ages. All baby boomers will be 65 or older by 2030, and **the 80+ cohort is the fastest-growing.** It is estimated that 1 in 4 people aging or with disabilities **do not have family caregivers**.

Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2023 (in billions)



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2024.
Notes: Analysis includes Medicare post-acute care spending in an expanded definition of LTSS spending. Percentages may not sum to 100% due to rounding.

Figure 2.

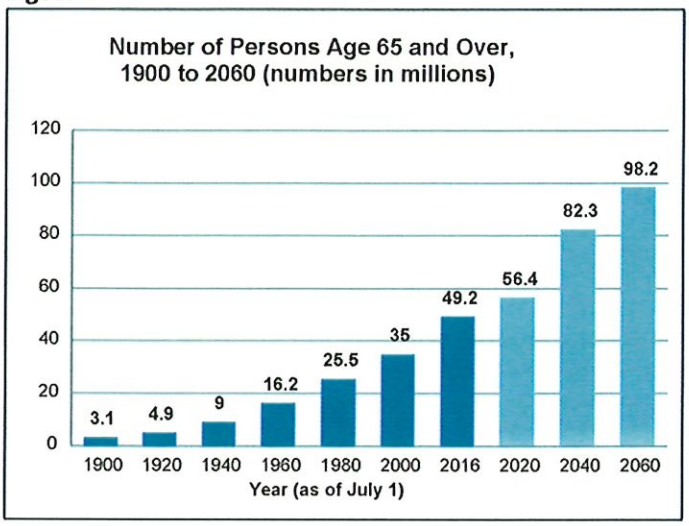
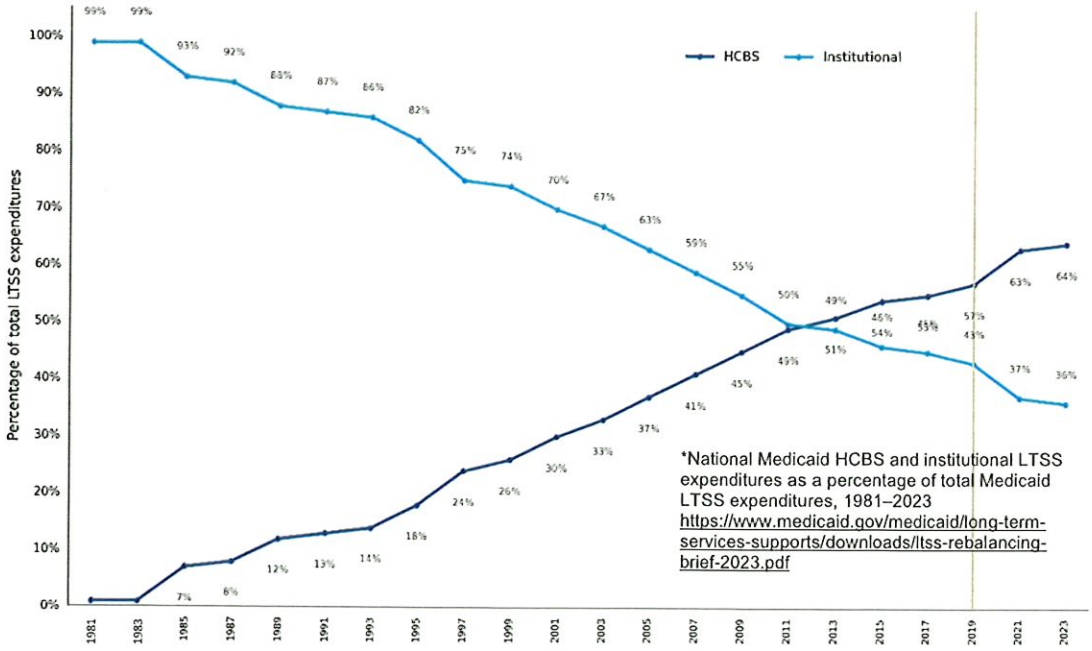


Figure 2 - this chart shows the large increases in the older population from 3.1 million people in 1900 to 49.2 million in 2016 and projected to 98.2 million in 2060.

Data compiled by Administration of Community Living, *2017 Profile of Older Americans*
Note: Increments in years are uneven.
Source: U.S. Census Bureau, Population Estimates and Projections

Figure 3. National Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, 1981–2023*



*National Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, 1981–2023
https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf

Long-standing joint Federal/state policy has focused on **reduced reliance on institutional services** and **increased reliance on HCBS. HCBS is less expensive than institutions** and deliver supports where people want to live – their homes.

As states and the federal government invest in HCBS as a cost-effective alternative to institutional care, **states stand ready to partner with CMS** to enhance the array of existing levers to prevent and address fraud, waste, and abuse.

NASDDDS National Association of State Directors of Developmental Disabilities Services
NAMD National Association of Medicaid Directors
ADVANCING STATES

Unfounded Fraud Allegations Threaten Vital Medicaid Home And Community-Based Services

March 16, 202610.1377/forefront.20260312.6067

This article is the latest in the Health Affairs Forefront *featured topic, "Health Policy at a Crossroads," produced with the support of the Commonwealth Fund. Articles in this topic offer timely analysis of regulatory, legislative, and judicial developments in health policy under the Trump-Vance Administration and the 119th Congress.*

The Centers for Medicare & Medicaid Services (CMS) has just announced a major crackdown on Medicaid fraud, including the deferral of more than $250 million in federal Medicaid funds owed to Minnesota as well as an intent to withhold future funds exceeding $500 million per quarter. CMS has opened investigations into several other states' Medicaid programs, citing potential fraud in Home and Community-Based Services (HCBS), the services that help people with disabilities and older adults live in their own homes and communities instead of in nursing homes or other institutions. Just days before the CMS announcement, a policy commentary coauthored by the former White House health policy lead in the first Trump Administration characterized HCBS as particularly vulnerable to fraud, citing rapid spending growth and arguing that services delivered in individuals' homes present heightened oversight challenges compared to services delivered in institutional settings.

Everyone would agree that, just as is true for all public and private health insurance programs, fraud prevention is essential in Medicaid, which finances care for more than 80 million Americans and accounts for nearly one-third of total state expenditures. Safeguarding public funds is an important shared federal-state obligation. But the tools to fight fraud must be effective and precise, especially when applied to HCBS, which is critical to the safety and independence of disabled people and older adults—the very populations CMS claims to be focused on protecting. CMS's framing of HCBS as inherently suspect suggests that in-home care lacks effective guardrails. This completely overlooks the fact that furnishing care in home and community settings has been a Medicaid program feature for decades.

Indeed, withdrawing support for HCBS and pursuing sweeping structural changes without clear evidence of systemic fraud jeopardizes services that have become foundational to our country's modern long-term care system. It would undo more than 40 years of bipartisan federal policy designed to rebalance that system away from institutional care

toward less restrictive care provided in the homes and communities where disabled people and older adults want—and have a civil right—to live.

Fraud is a serious issue, and it cuts across all health care programs and all types of services. The real issue is whether current federal actions represent a reasonable response to the problem. A look back at the history of HCBS demonstrates that its growth is not, in fact, evidence of massive undetected fraud, but rather is based on decades of federal policy response to major demographic change, guided by national civil rights priorities and implemented with strict fiscal guardrails.

HCBS Growth Reflects Bipartisan Federal Policy And Demographic Changes

The 1981 introduction of HCBS into Medicaid has long been hailed as an historic advance in health policy. Furthermore, since the Supreme Court's landmark 1999 decision in *Olmstead v. L.C.*, which held that unnecessary institutionalization of people with disabilities constitutes discrimination under the Americans with Disabilities Act (ADA), federal and state policymakers alike have sought to use HCBS to meet the ADA's integration mandate by directing care away from institutions and into home and community settings.

Both Republican and Democratic Administrations have reinforced that direction. The Deficit Reduction Act of 2005 created a state plan HCBS option (Section 1915(i)) and the Money Follows the Person Program to help people transition from institutions to the community. The Affordable Care Act established the Community First Choice option (Section 1915(k)) and the Balancing Incentive Program, and the Obama administration emphasized community integration through Medicaid policy and enforcement of disability rights law. The Trump administration released the 2020 Rebalancing Toolkit encouraging states to accelerate HCBS expansion. Under the Biden administration, the American Rescue Plan Act of 2021 temporarily increased the federal Medicaid matching rate for HCBS to support COVID-19 pandemic recovery. Even the recently passed H.R. 1, which makes major cuts to Medicaid spending, included a new HCBS authority.

The results of these actions are measurable. By 2023, 64 percent of national Medicaid spending on long-term services and supports (LTSS) was directed to HCBS, compared to just 27 percent in 1995. This shift reflects deliberate policy decisions, not regulatory drift. The growth in HCBS also reflects demographic inevitability. The US Census Bureau estimates that 10,000 Americans turn age 65 each day, with the 85-and-older population projected to more than double by 2040; the majority of these older adults will need LTSS. The population of disabled people is also growing, in part because individuals

with intellectual and developmental disabilities are now living decades longer than in previous generations.

Access Is A Major Challenge Facing HCBS

At the same time these demographic trends are playing out, unmet need remains substantial. As of 2025, more than 600,000 individuals nationwide were on waiting lists for HCBS programs. Many states have reported substantial yearly increases in the number of people on their waiting lists.

Workforce shortages compound access challenges. Unpaid family caregivers, estimated at 63 million Americans, provide the majority of long-term support—a 50 percent increase over the last decade due to these demographic shifts and longer waiting lists. States' HCBS programs often provide limited paid assistance to enable families to sustain caregiving and delay institutional placement. Thus, a primary challenge facing HCBS is insufficient access rather than unchecked growth in service delivery.

HCBS Is Grounded In Federal Statutes That Incorporate Both Program Integrity Requirements And Civil Rights Law

As we seek ways to address the access challenges facing HCBS, it is important to understand that this is not an informal or weakly regulated benefit category—it is authorized under specific statutory authorities, most prominently Section 1915(c) HCBS waivers. Section 1915(c) of the Social Security Act, enacted in 1981, allows states to provide HCBS as an alternative to institutional care for individuals who would otherwise require a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or a hospital level of care (LOC). These HCBS waiver participants must therefore meet an institutional LOC standard.

Equally important, Section 1915(c) waivers must demonstrate cost neutrality: On average, the cost of serving individuals in the community cannot exceed what Medicaid would have spent on institutional care for the same population. States must submit actuarial projections and obtain federal approval demonstrating that waiver services will be cost-neutral relative to institutional alternatives.

Building off the 1915(i) State Plan HCBS authority Congress passed over 20 years ago, Congress recently expanded the Section 1915(c) framework. Beginning July 1, 2028, H.R. 1 creates an additional Section 1915(c) waiver option, allowing states to provide HCBS to individuals who do not meet the traditional institutional LOC threshold. This will permit states to offer earlier, preventive supports to individuals who need assistance to remain safely at home but who may not yet qualify for institutional care, while still tightly managing access. The policy logic is preventive in nature: Providing support before deterioration

occurs may avert institutionalization. Importantly, this expansion remains subject to federal approval and program integrity requirements.

Clearly, HCBS is not an open-ended entitlement. It is, by design, an institutional substitute and now a structured preventive support option embedded within Medicaid's financing and program integrity rules.

The civil rights framework for HCBS reinforces this statutory design. Medicaid HCBS is the principal financing mechanism through which states comply with their obligations under the ADA and *Olmstead* to provide services in "the most integrated setting appropriate to an individuals' needs"—people's own homes and communities instead of institutions.

Portraying HCBS as inherently high-risk for fraud overlooks the fact that HCBS operates at the intersection of fiscal guardrails and civil rights obligations. It has generally been limited to individuals who meet institutional LOC criteria, is subject to federal cost-neutrality requirements, and has evolved through defined statutory authority, while also serving as a central mechanism for states' compliance with federal disability law.

HCBS Is More Cost-Effective Than Institutional Care

The assumption that HCBS is prone to wasteful spending is contrary to the evidence that consistently has demonstrated its cost effectiveness. CMS data show that institutional LTSS users broadly have substantially higher average expenditures than HCBS users. In fact, a Mathematica analysis estimated that average 2022 Medicaid spending per person was $47,000 for institutional LTSS users compared to $16,600 for people receiving HCBS.

difference of $30,400

Plentiful peer-reviewed research supports the fiscal logic of rebalancing. The Money Follows the Person (MFP) demonstration has shown that transitioning individuals from institutions to community settings reduces Medicaid expenditures over time while improving quality-of-life outcomes. State-level comparisons further reinforce this pattern, showing that positive impacts of rebalancing are consistent nationwide. If HCBS is retrenched under the banner of fraud prevention, the likely fiscal outcome is increased institutional spending—something which would cost far more than any purported savings from new efforts to reduce fraud.

Strong Safeguards Against HCBS Fraud And Targeted Enforcement Already Exist

Before considering new options for addressing HCBS fraud, it is important to understand the strong safeguards already in place to prevent such fraud through targeted enforcement. Electronic Visit Verification (EVV), mandated under the 21st Century Cures Act, requires verification of time and location before payment for personal care and home

health services. Provider enrollment screening includes background checks and periodic revalidation of credentials, and managed care contracts require compliance programs and referrals to state authorities. In fact, states' Medicaid Fraud Control Units reported over 1,100 convictions and $1.4 billion in recoveries in fiscal year 2024. States also use predictive analytics, recovery audit contractors, utilization management standards, and corrective action plans.

These mechanisms allow states and the federal government to identify and address specific vulnerabilities without disrupting lawful—and critical—services. By contrast, broad funding deferrals or categorical moratoria substitute financial shock and service disruptions for targeted oversight, placing legitimate providers and vulnerable beneficiaries at risk before any finding of wrongdoing.

Improper Payments Are Different From Fraud

CMS's fraud initiative is based on an assumption that all types of payment errors are fraud, which incorrectly conflates intentional wrongdoing with administrative and paperwork errors. CMS's Payment Error Rate Measurement (PERM) program makes clear that improper payments are not measures of fraud. A recent KFF analysis further explains that PERM estimates are measures of compliance error, not indicators of intentional wrongdoing, and outlines methodological complexities that make a direct fraud inference inappropriate.

Improper payments often reflect documentation deficiencies, eligibility-processing issues, or other administrative compliance problems, not intentional deception. Collapsing improper payments, abuse, and fraud into a single category inflates perceptions of criminal misconduct and risks misdirected policy action. Administrative compliance issues certainly warrant administrative remedies, but not larger structural retrenchment.

Blunt Financial Tools Risk Collateral Damage

Even if withholding federal Medicaid funds may be legally authorized, it is a blunt instrument that is likely to be ineffective over the long term. Such actions do not directly pinpoint fraudulent actors. Instead, they introduce fiscal instability into programs serving populations who rely on Medicaid for their safety and independence.

Recent reporting from Minnesota illustrates risks from abrupt enforcement actions, including delayed payments to legitimate providers and service disruptions for disabled and aging beneficiaries. When payroll stalls or providers close, the consequences fall on individuals with significant disabilities of all ages and their families. Again, empirical analysis indicates that cutbacks in HCBS just shift care into more costly institutional settings, harming the very beneficiaries federal policy aims to protect.

History shows that when Medicaid funding is reduced, states often cut HCBS for older adults and people with disabilities first. This is particularly problematic when demographic pressures driving demand for HCBS will not reverse. When enforcement tools destabilize essential services rather than isolate wrongdoing, they cease to be instruments of integrity and instead become catalysts for harm.

Conclusion

Maintaining program integrity in Medicaid is essential. Fraudulent actors must be identified and prosecuted. Enforcement must be proportionate to the fraud, evidence-based, and structured to avoid collateral damage.

HCBS is the principal means by which older adults and people with disabilities avoid unnecessary and more expensive institutional care; it is the legal framework for state compliance with federal civil rights law. Growth in HCBS spending does not reflect evidence of systemic corruption but rather bipartisan federal policy choices, demographic change, and structured statutory evolution.

Federal law embeds strong fiscal guardrails in HCBS: institutional LOC standards, cost-neutrality requirements, waiver approval processes, electronic verification systems, and layered program integrity mechanisms. Where vulnerabilities exist, they should be addressed through targeted analytics and corrective action plans, not broad funding leverage or rhetoric that casts suspicion on an entire program. Oversight strengthens public programs when it is precise and collaborative. When it is blunt, it risks destabilizing programs such as HCBS—the very system that bipartisan federal policy has spent decades building—and harming disabled and aging people whose lives depend on HCBS. The goal should not be to characterize the entirety of HCBS as prone to fraud, but to ensure that HCBS continues to function as Congress designed it: fiscally disciplined, legally grounded, and centered on enabling people to live safely in their homes and communities.