Medicaid Home Care Chartbook

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Executive Summary

The **Research Institute for Home Care (the Institute)** is proud to release the Medicaid Home Care Chartbook, which represents the first comprehensive and detailed look at the role of home care services within the Medicaid program. For purposes of this report, we defined home care services as a subset of Medicaid home and community based services (HCBS) that focus on in-home services and supports and exclude center-based day services, residential care such as assisted living, and ancillary services such as case management and transportation.

The Chartbook covers a wide range of issues including participant eligibility, types of services delivered, inclusion in managed care arrangements, provider distribution, and projected impacts of 2025's HR1 Budget Reconciliation legislation on recipients of home care. **Key takeaways include:**

- **Approximately 3.3 million individuals** received Medicaid-funded home care services in 2023, 45% of whom were dually eligible for Medicare.
- Home care services were **delivered to 56% of the individuals** that the Centers for Medicare & Medicaid Services (CMS) identify as users of HCBS.
- Personal care was the most commonly utilized home care service, **representing 62.7% of the claims** in our dataset.
- **Nationally, 10% of all beneficiaries** who used home care services were enrolled in Medicaid through the Affordable Care Act expansion eligibility group.
- Across the country, **48% of all individuals,** and **49% of dual eligible participants,** who used home care services received at least a portion of those services from a managed care organization.
- **84% of home care recipients live in urban areas** of the country and **16% reside in rural areas.**
- The growth in enrollment of home care recipients outpaced providers, with the ratio of participants per provider **growing from 59:1 in 2019 to 65.65:1 in 2023.**
- By 2034, a **projected 311,879 fewer individuals (9.4% of baseline)** who receive home care services will be eligible for Medicaid due to HR1's changes.
- An **estimated 75,381 individuals (2.3%)** who receive home care services will be subject to the new mandatory cost sharing requirements established by HR1.

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Background

Part of a broader suite of public data products published annually by the Institute, the Medicaid Home Care Chartbook provides a detailed and comprehensive analysis of State-reported home care data contained within the Transformed Medicaid Statistical Information System (T-MSIS) system. This data includes information on the number of individuals who utilize home care services, expenditures, and provider density.

This chartbook identifies the number of home care users who are enrolled through the Affordable Care Act's Medicaid Expansion group. Chartbook information here is the most comprehensive look at this population made public to date, providing important context to the implications of some of the upcoming changes to the Medicaid program. Further analysis and materials will be developed from this data; state-level statistics are available to RIHC contributors.

In 2025, HR1 placed new conditions on eligibility and coverage for this group, including more frequent eligibility redeterminations, mandatory cost-sharing for certain services, and community engagement requirements for nonexempt populations. As policymakers across the country seek to implement these new statutory requirements, an understanding of the dynamics of individuals who receive home care services through the ACA expansion will be crucial to ensuring that individuals with significant health care needs and functional limitations are not inadvertently impacted.

Other notable publications, such as those by the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Centers for Medicare & Medicaid Services (CMS), provided important details and context about Home and Community-Based Services (HCBS). We do not seek to replicate the data already available and instead are publishing this chartbook to advance the understanding of a specific subset of HCBS: home care services. Other releases from CMS and MACPAC include a wide range of HCBS, including case management, respite, assisted living, group homes for individuals with intellectual and developmental disabilities, and other services that are not specifically 'home care' supports under our definition.

T-MSIS has well-documented limitations which readers and researchers should be aware of when referencing this chartbook. For example, we recognize that California's home care utilization and enrollment represent a drastic undercount as our process does not appear to capture enrollment in the In-Home Supportive Services (IHSS) program. Given that IHSS enrollment exceeded 900,000 individuals as of 2026, this is a significant undercount of the potential universe of home care utilizers. Other state data, such as Florida and Maryland, also appear to undercount the actual services provided in the state. We also recognize that data on expenditures, particularly in Managed Care arrangements, is underreported and overall expenditures are likely higher than the current data demonstrates.

Despite these limitations, we believe that this data is extremely valuable in understanding the dynamics of home care services across the country. Further, in publishing this information, we hope to provide a foundation for researchers to continue to analyze and expand the knowledge base of home care services within the broader HCBS universe.

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ACKNOWLEDGEMENTS

This report was authored by staff of the Research Institute for Home Care and the National Alliance for Care at Home on behalf of the Institute. Medicaid T-MSIS data and enrollment modeling utilized in this report was produced by Health Management Associates' (HMA) Washington DC Team. The Institute would like to thank our colleagues at the Alliance and the staff of HMA for all their work in the development of this Chartbook.

Authors for this report:

ALEX HARTZMAN, MPA, MPH

- VP Research & Analytics, National Alliance for Care at Home
- Head of Operations, Research Institute for Home Care

JENNIFER SCHILLER

- Director of Strategic Initiatives, National Alliance for Care at Home
- Director of Strategic Initiatives, Research Institute for Home Care

DAMON TERZAGHI, MSA

- VP of Medicaid & Home Care Policy, National Alliance for Care at Home

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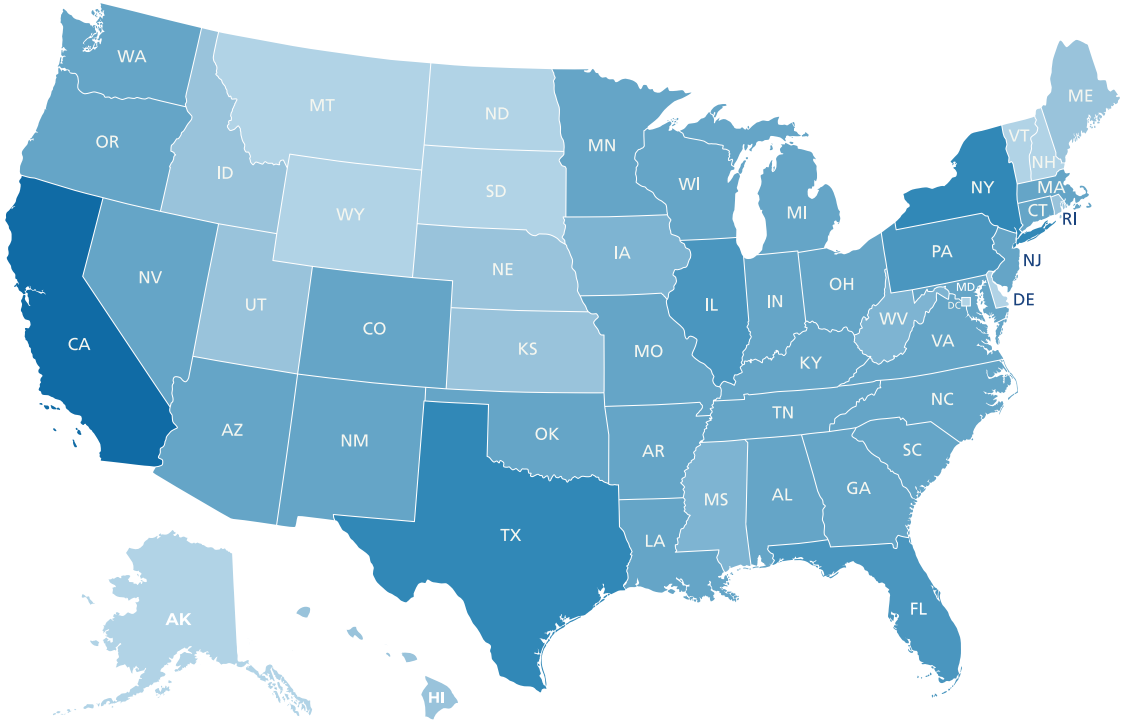
FIGURE 1: Total Medicaid Enrollment

As a baseline for our analysis, we identified the total number of unduplicated Medicaid enrollees at any point during the year for each state. As expected, Medicaid enrollment is largely correlated with the broader population of each state. California, at over 15 million individuals enrolled throughout 2023, has the largest Medicaid program as measured by enrollees followed by New York at nearly 9 million. In contrast, rural northern plains states such as Wyoming, North Dakota, and South Dakota, had the smallest programs. Each of those states had fewer than 200,000 enrollees across 2023.



100,000–399,000 | 400,000–699,000 | 700,000–999,000 | 1,000,000–3,999,000
4,000,000–6,999,000 | 7,000,000–9,999,000 | 10,000,000–12,999,000 | 13,000,000–15,999,000

STATE	TOTAL	STATE	TOTAL
AK	289,341	MT	360,705
AL	1,537,035	NC	3,228,192
AR	1,252,859	ND	156,270
AZ	2,723,956	NE	446,940
CA	15,063,064	NH	294,150
CO	1,965,202	NJ	2,442,098
CT	1,351,951	NM	1,046,960
DC	323,842	NV	1,068,490
DE	352,145	NY	8,909,237
FL	6,260,479	OH	3,742,521
GA	3,039,046	OK	1,503,756
HI	506,042	OR	1,673,542
IA	961,364	PA	4,076,452
ID	528,200	RI	422,555
IL	4,217,856	SC	1,695,308
IN	2,410,239	SD	182,857
KS	585,229	TN	2,077,146
KY	1,880,969	TX	7,326,794
LA	2,139,915	UT	588,064
MA	2,639,589	VA	2,363,108
MD	1,907,078	VT	219,612
ME	502,769	WA	2,517,153
MI	3,426,976	WI	1,687,749
MN	1,544,834	WV	741,402
MO	1,705,596	WY	102,845
MS	921,173		

Source: HMA analysis of T-MSIS data, 2023

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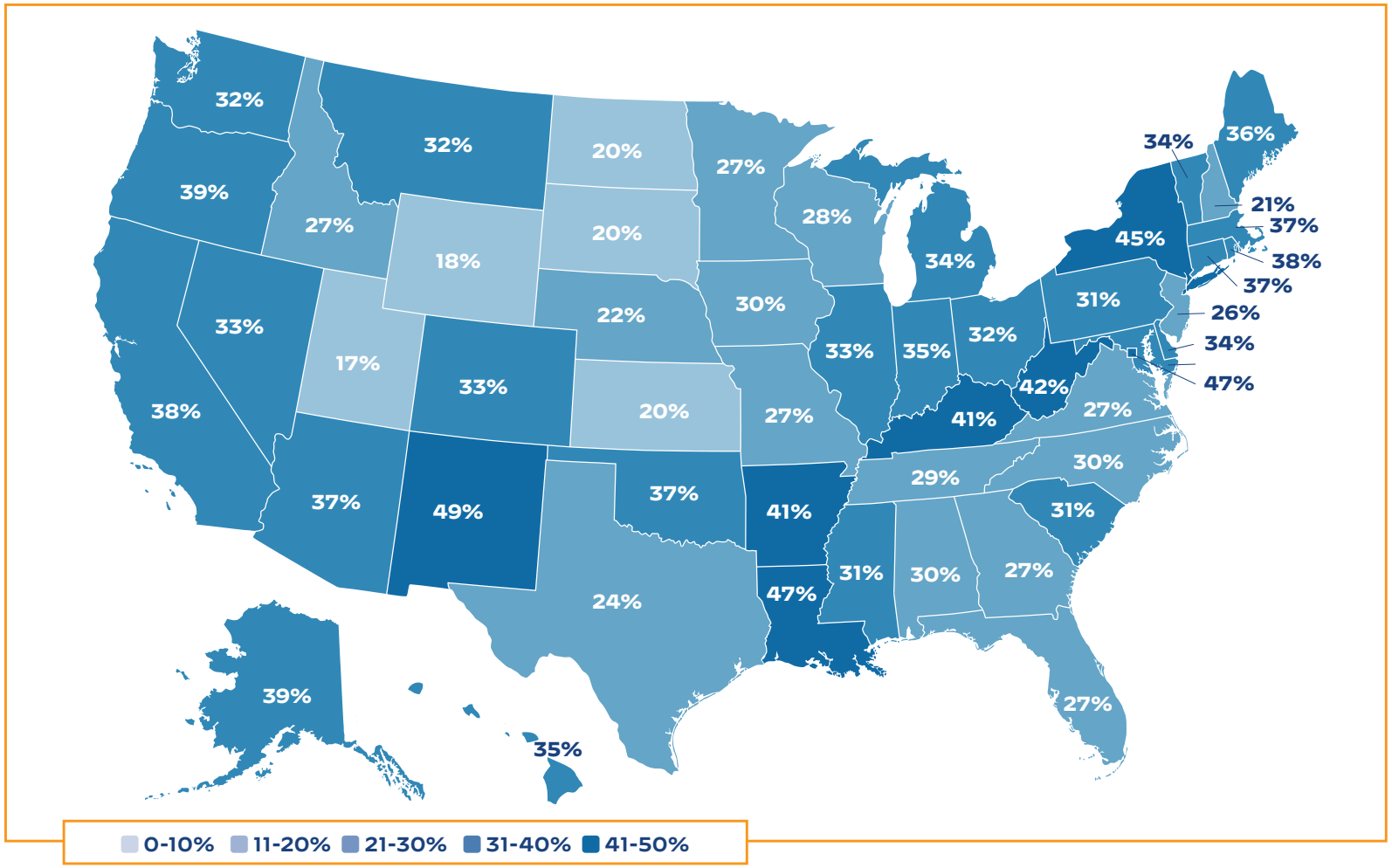
FIGURE 2: Proportion of State Population Ever Enrolled in Medicaid in 2023

Figure 2 shows state Medicaid enrollees as a proportion of the total state population.



Source: HMA analysis of T-MSIS data, 2023 and RIHC analysis of Census ACS data, 2023

FIGURE 3: Unique Users of HCBS

To provide a better understanding of home care as a subset of the broader HCBS universe, we compared the result of the Institute's inclusion criteria with the data developed by Mathematica for CMS' official HCBS publications. Our universe of home care recipients is approximately 3.3 million individuals, or slightly less than half (46%) of the individuals identified with the Mathematica methodology. Given the large cohorts of individuals receiving case management and rehabilitative services[1] in Mathematica's data,[2] it is unsurprising that the Institute's data includes a significantly smaller number of total individuals.

As discussed earlier, this Institute chartbook intentionally covers a narrower universe of services that are specific to the home care industry. For the purposes of this chartbook, we defined HCBS and home care services using two separate methods and combined the results into a single dataset with unduplicated counts of beneficiaries.

- All HCBS users: we replicated the cohort-selection logic defined by CMS and Mathematica® in 2024 to identify all users of HCBS across all settings of care and all HCBS services. We refer to this as the CMS/Mathematica method.
- Home care users: we used the CMS/Mathematica method as a benchmark to define a broader universe of HCBS. Within that universe, we more specifically identified 'home care' services as a subset of HCBS specifically delivered in the home setting. To accomplish this, **we added two additional selection criteria:**
  - First, we only included claims with a place-of-service code reported as Home.[3]
  - Second, we included only claims for HCBS services associated with the home setting. We defined these as claims that reported any of 15 taxonomy codes: community integration, private duty nursing, skilled nursing, home health aide, personal care, companion, home maker, chore, respite in-home, occupational therapy, physical therapy, speech/hearing/language therapy, respiratory therapy, cognitive rehabilitation therapy, other therapy.
  - In the absence of one of these taxonomy codes on claims, we further identified claims with procedure codes that appeared among the top five most frequent procedure codes associated with the 15 taxonomy codes. These claims were also required to list home as the place of service.
- Finally, to enumerate unique users, we deduplicated members so that individuals with multiple qualifying claims were counted once.

		% OF TOTAL	% OF ALL HCBS
Total Medicaid Enrollees ever enrolled 2023	108,910,655	100%	
Mathematica - All HCBS Users	7,125,646	6.5%	100%
Institute - Home Care Users	3,306,072	3.0%	46.4%

Source: HMA analysis of T-MSIS data, 2023

1 Our approach of using taxonomy codes and claims data should capture a subset of rehabilitative services, such as therapies, while excluding psychosocial rehabilitation services that are also frequently included via this option.

2 25.3 percent of Mathematica's reported cohort received state plan rehabilitative services and 22.9 percent received state plan case management services. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf

3 In TMSIS: POS_CD = 12

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FIGURE 4: Proportion of HCBS Users with a Home Care Claim

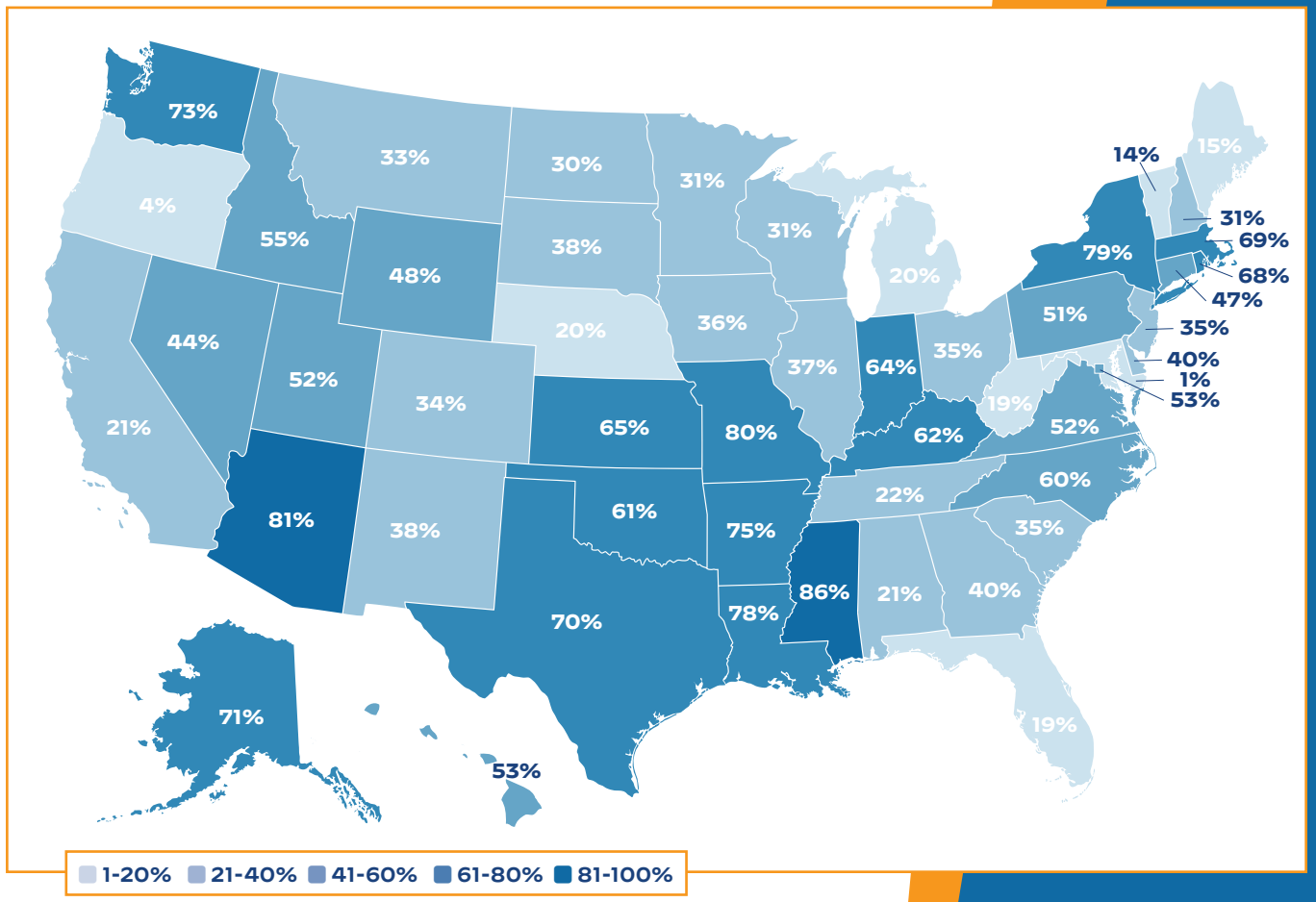
When examining the universe of HCBS, there are a wide range of services and supports that vary significantly across the country. Some of the HCBS that participants access include items such as:

- Assisted Living;
- Residential Group Homes;
- Adult Foster Care;
- Programs of All Inclusive Care for the Elderly (PACE);
- Adult Day Services, either health or social models;
- Day Habilitation for Individuals with Intellectual and Developmental Disabilities;
- Supported Employment;
- Transportation; and
- Home Care.

To better understand the way that home care services fit within each state's definition and delivery system, we identified the proportion of HCBS enrollees who utilized at least one home care service throughout the year. The denominator for this figure is all individuals who used any HCBS throughout the year (i.e. the Mathematica definition discussed in Figure 3) and the numerator for this figure is those that utilized a service that falls into the Institute's definition of home care.

States with higher percentages are likely to have more robust home care services, such as personal care, home health, private duty nursing, and other individualized supports that are generally provided in an individual's place of residence. In contrast, those with lower percentages are likely to have more HCBS provided through residential settings, such as Assisted Living or Group Homes, or via interventions such as Adult Day Services or Day Habilitation.

We also note some potential data quality issues in this measure, including Oregon, Maryland, Maine, and Florida, which appear to undercount specific programs, such as Attendant Care Services, those provided through managed care, and other home-based services.



Source: HMA analysis of T-MSIS data, 2023

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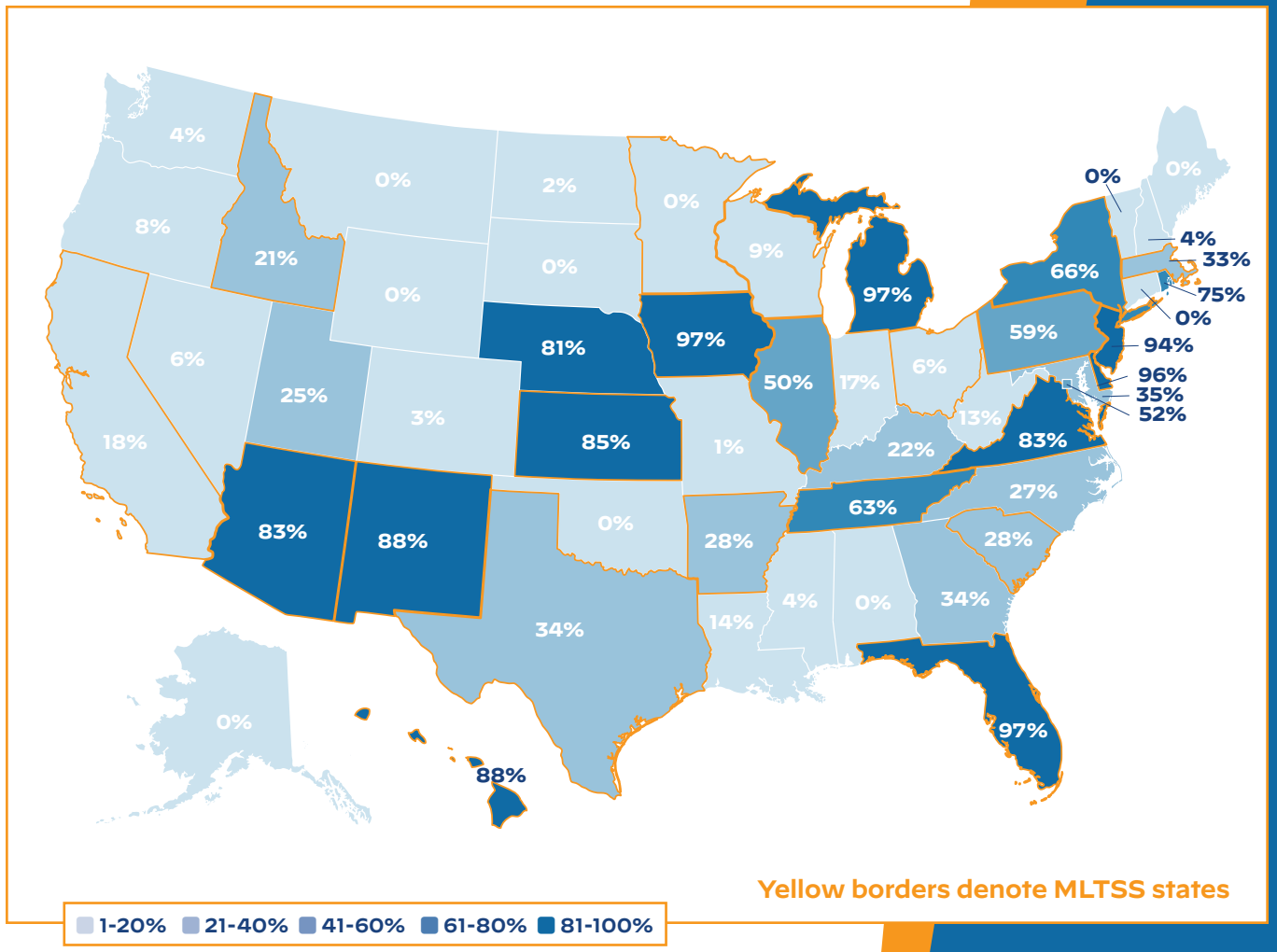
FIGURE 5: Proportion of Home Care Users Served through Managed Care

Over the past two decades, an increasing number of states have outsourced management of their long-term care programs, including HCBS, to private insurance companies (known as managed care organizations or MCOs) in arrangements frequently referred to as 'managed long-term services and supports' or MLTSS. According to MACPAC, this number grew from 8 states in 2004 to 24 in 2021. Yet despite discussion of these arrangements frequently treating states as having binary MLTSS or non-MLTSS Medicaid programs, there are many nuances to the populations, services, and parts of the state that are included in MLTSS.

Figure 5 provides a novel approach to assessing not just the presence of managed care for home care services but also the proportion of home care beneficiaries that are included within those managed care programs. In some states with MLTSS, a significant proportion of home care beneficiaries remain outside of contracts with managed care organizations. Conversely, some non-MLTSS states include a significant amount of post-acute home care within other managed care contracts even if their programs do not qualify as comprehensive MLTSS.

Across the country, 48% of individuals who used home care services received at least one such service from a MCO. Notably, Nebraska is identified as a non-MLTSS state yet the data records show 81% of individuals who receive home care services are enrolled in MCOs. In contrast, Wisconsin is identified as a MLTSS state yet the data only shows 9% of those who utilize home care as managed care enrollees.



Source: HMA analysis of T-MSIS data, 2023

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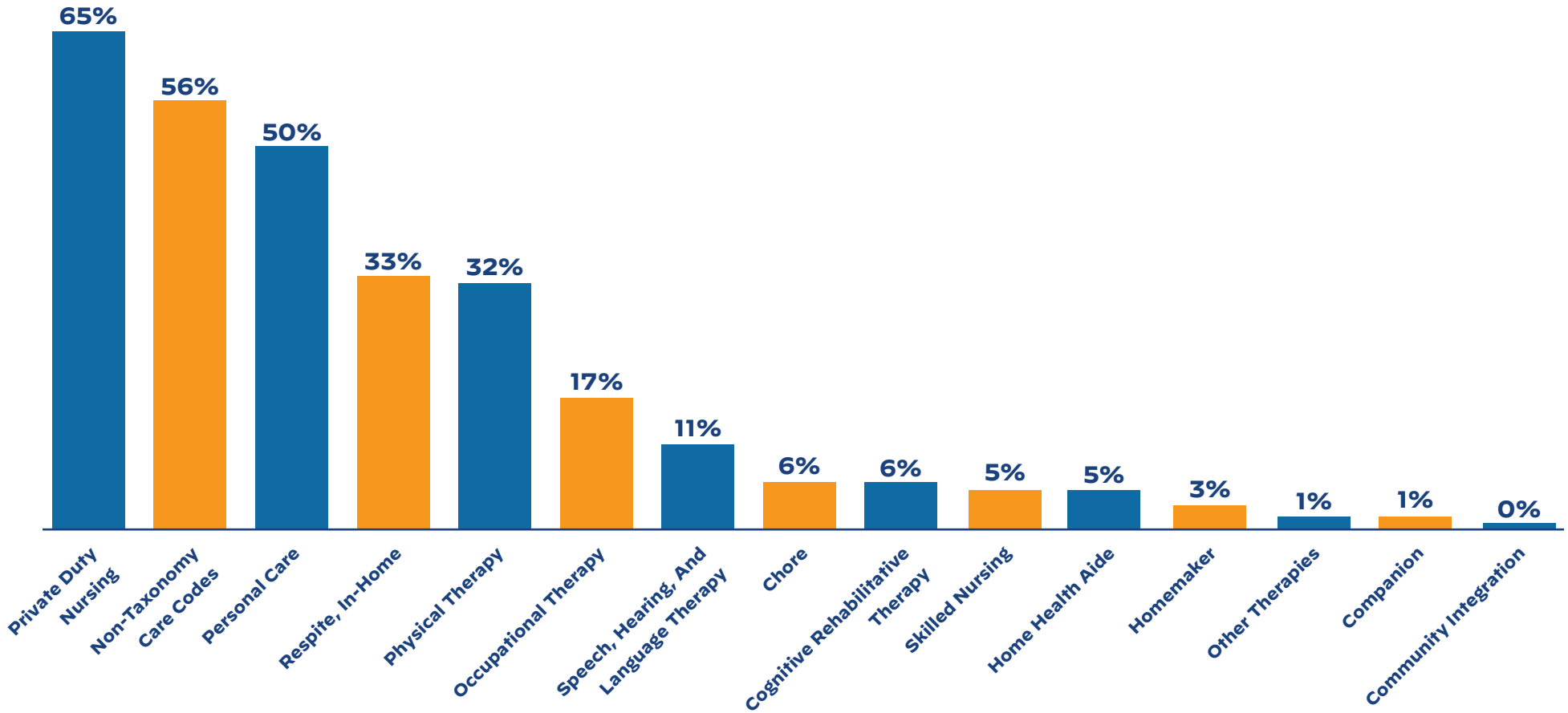
FIGURE 6: Percentage of Services Delivered by Managed Care

Within Medicaid managed care, different private health plans deliver different packages of home care services. Figure 6 shows the percentage of beneficiaries receiving services that are delivered through managed care models across the country. These range from Private Duty Nursing services, with 65% in managed care contracts, to community integration (0%), home maker (1%), and companion (1%), at or near zero.



Source: HMA analysis of T-MSIS data, 2023

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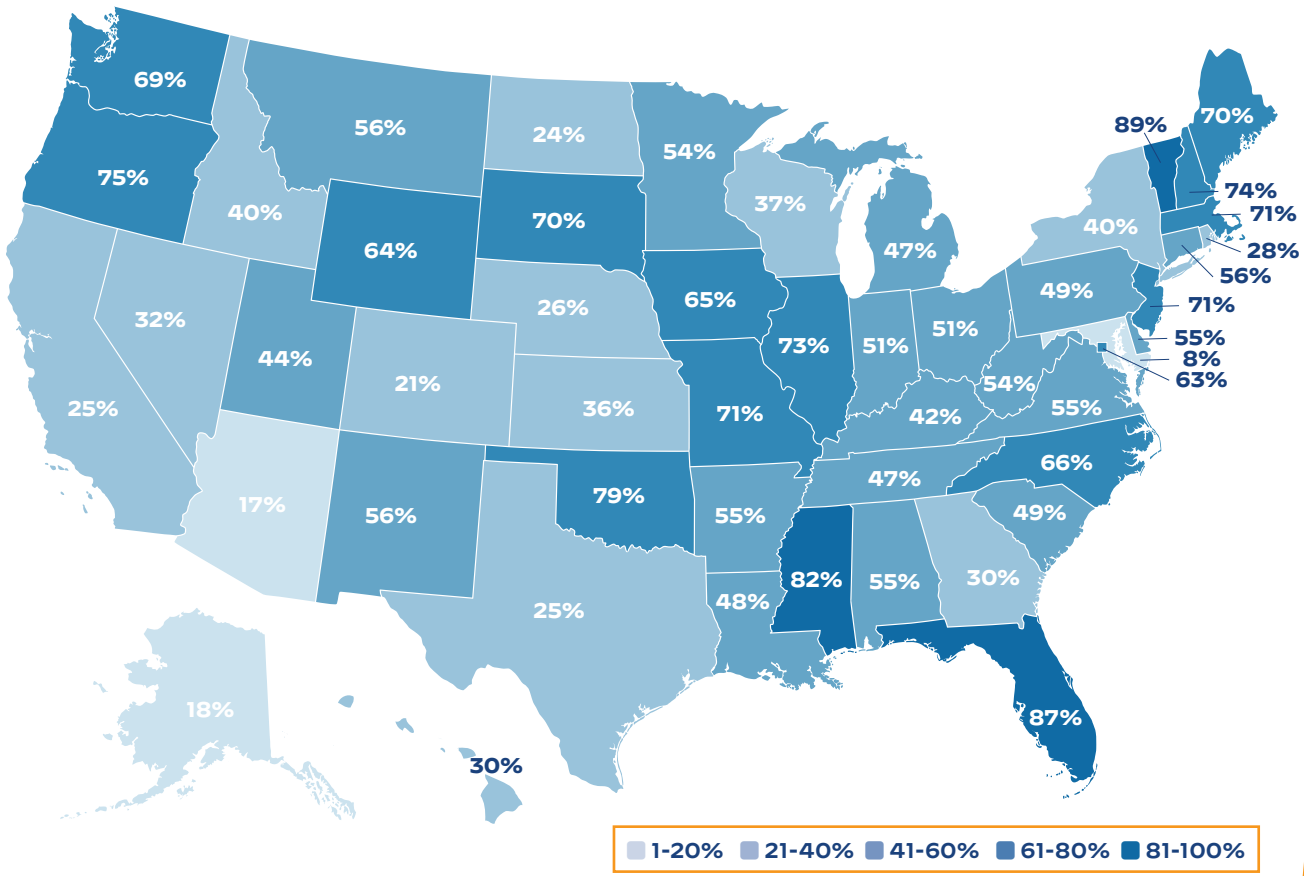
FIGURE 7: Proportion of HCBS Home Care users Dual Enrollees

Individuals enrolled in both Medicare and Medicaid simultaneously are called 'dual eligible' participants. Dual eligibility can reflect a number of different things about a state and its program, from the demographic makeup, the economic conditions, the generosity of its Medicaid eligibility criteria, or the types of home care services provided to the broader cohort of Medicaid enrollees. According to MACPAC, there were 13.6 million individuals dually eligible during at least one month of 2022 (the most recent data available under their data book). MACPAC's data book further found that 16% of these dually eligible individuals used HCBS through the state plan and 20% used a HCBS waiver.

To complement the MACPAC data, we examined the proportion of individuals who utilized home care services who were also dual eligible individuals. In aggregate, 45% of individuals who used at least one home care service during 2023 were a dual eligible individual across the country. The proportion varied significantly across the country, from a maximum of 89% in Vermont to a minimum of 8% in Maryland. Recognizing some of the data quality issues in MD, the next smallest proportion is 17% in Arizona.



Source: HMA analysis of T-MSIS data, 2023

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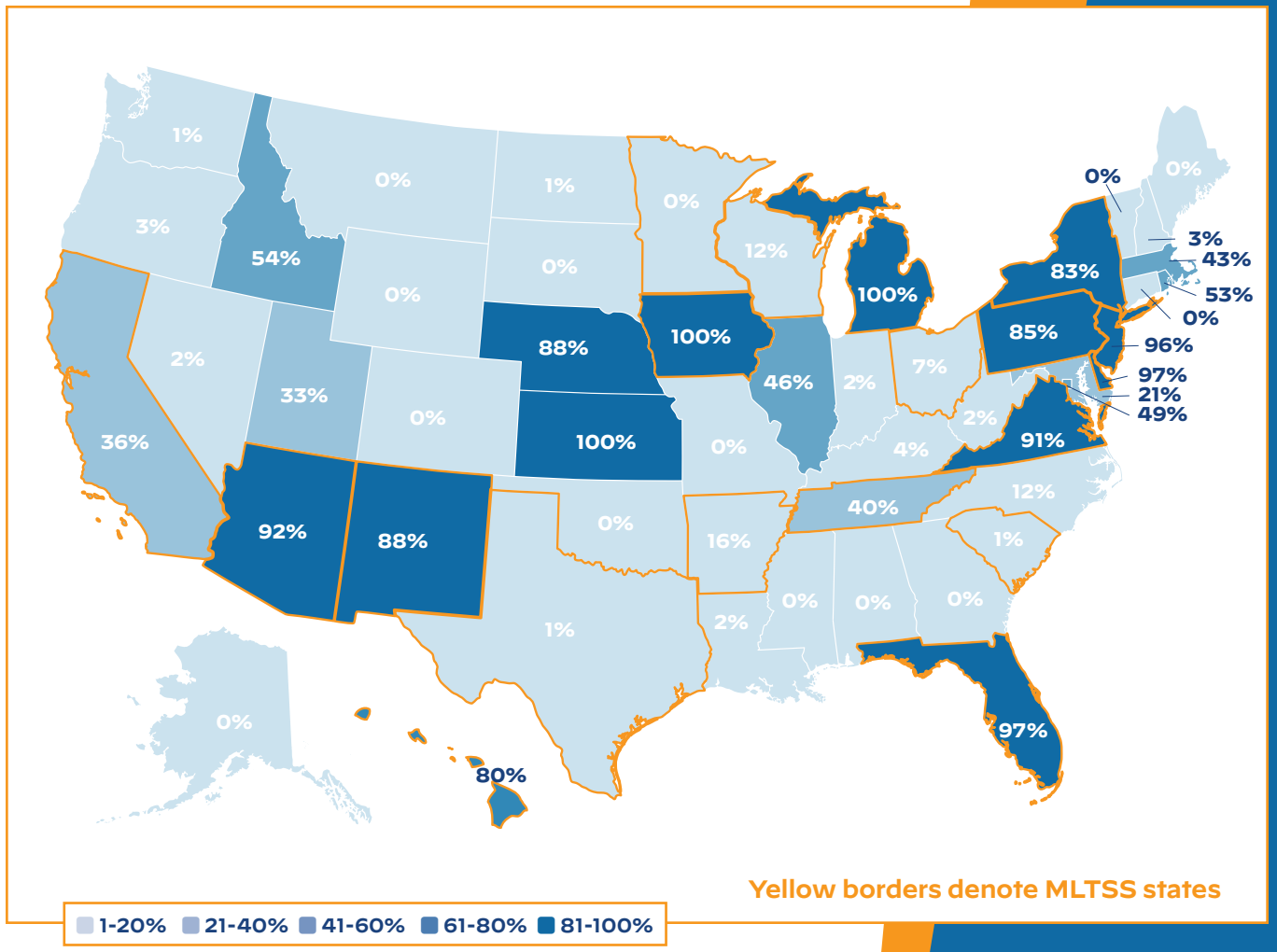
FIGURE 8: Proportion of Dual HCBS Home Care users MCO

This section of the data identifies the proportion of home care users who were dually eligible for Medicaid and Medicare and who were enrolled in a managed care plan. States and CMS have spent the past 15 years aggressively seeking ways to better integrate care between Medicare and Medicaid services to overcome some of the fractured and disjointed authorizations, eligibility, and care delivery that exists for dual eligible individuals. A significant portion of that effort has involved contracting with MCOs through the "Financial Alignment Initiative" and subsequent efforts to transition that program to the broader dual-eligible Special Needs Plans (D-SNPs), a specialized type of Medicare Advantage plans.

Unlike the proportion of home care users broadly, which reflected a wide range of managed care utilization regardless of MLTSS or non-MLTSS state, the data for dual eligible home care utilizers tracks closely with those identified as MLTSS. Nine of the top ten states with Managed Care enrollment of dual eligible home care users are MLTSS states. Only Nebraska, discussed earlier as an outlier in the space, is a non-MLTSS state from the top ten. In aggregate, 49% of dual eligible home care recipients received at least a portion of their home care from a MCO.



Source: HMA analysis of T-MSIS data, 2023

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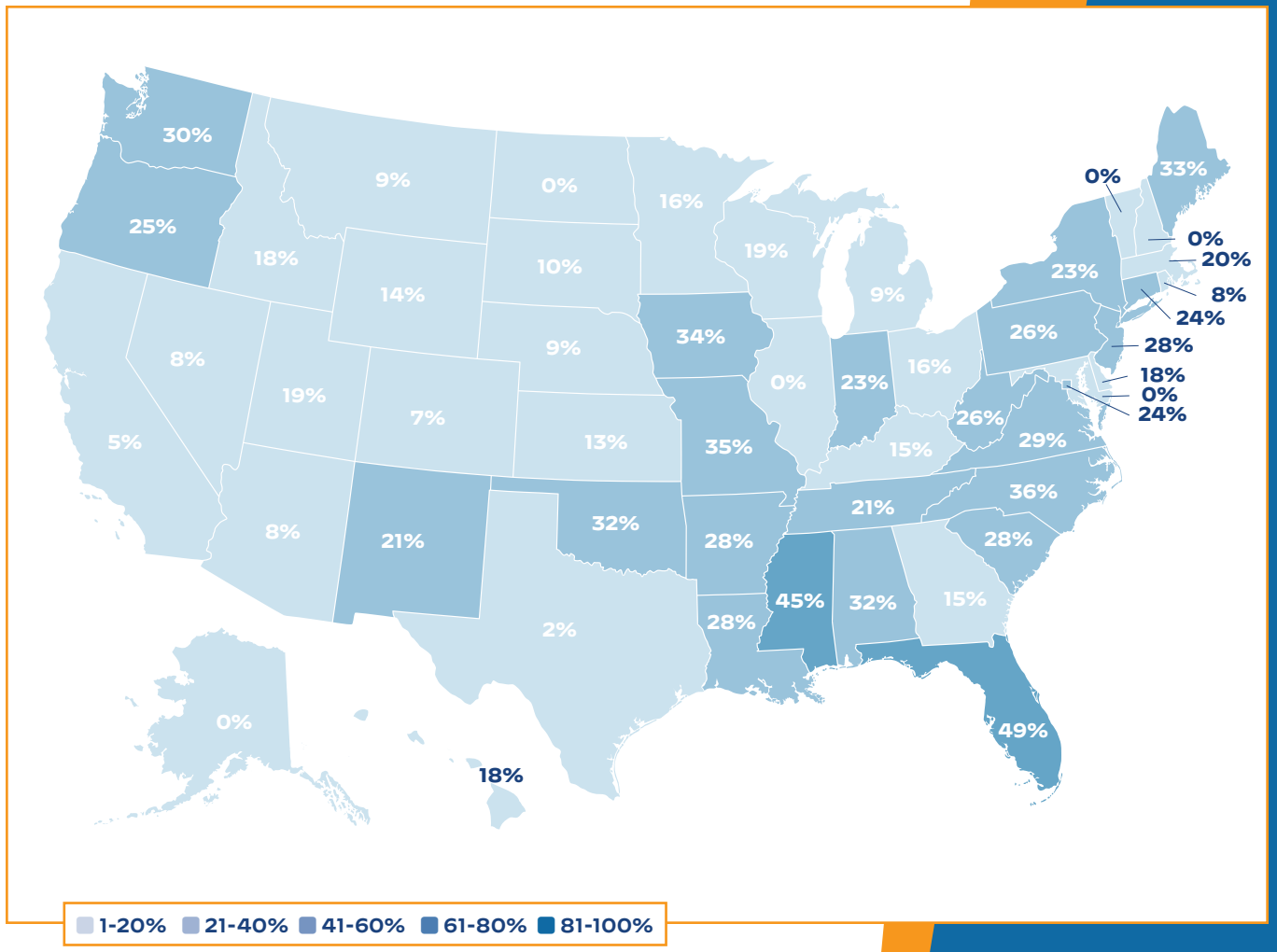
FIGURE 9: Proportion of HCBS Home Care SNP-enrolled, 2023

There are several different types of Special Needs Plans in the Medicare program, including those for institutional services (I-SNPs), Chronic Condition SNPs (C-SNPs), and those for Dual Eligibles (D-SNPs). Of the 6.6 million SNP enrollees in 2024, most were in D-SNPS (88%); followed by 10% in C-SNPs; and 2% in I-SNPs according to data from the Kaiser Family Foundation. Within D-SNPs, there are different levels of integration between Medicare and Medicaid, ranging from fully integrated to coordination-only plans. As discussed earlier, Federal policy has prioritized D-SNPs as the primary strategy for coordinating services across Medicare and Medicaid and enrollment in these programs continues to grow with the end of the Financial Alignment Initiative.

As of 2023, there were fewer users of home care enrolled in D-SNPs than those in broader managed care through Medicaid. This intuitively makes sense because not all home care users are dual eligible and not all MLTSS Plans have a companion D-SNP. Enrollment among home care users ranged from a high of 49% in Florida to several states, including Vermont, New Hampshire, and North Dakota, with no individuals with home care services in D-SNP plans.



Source: HMA analysis of T-MSIS data, 2023

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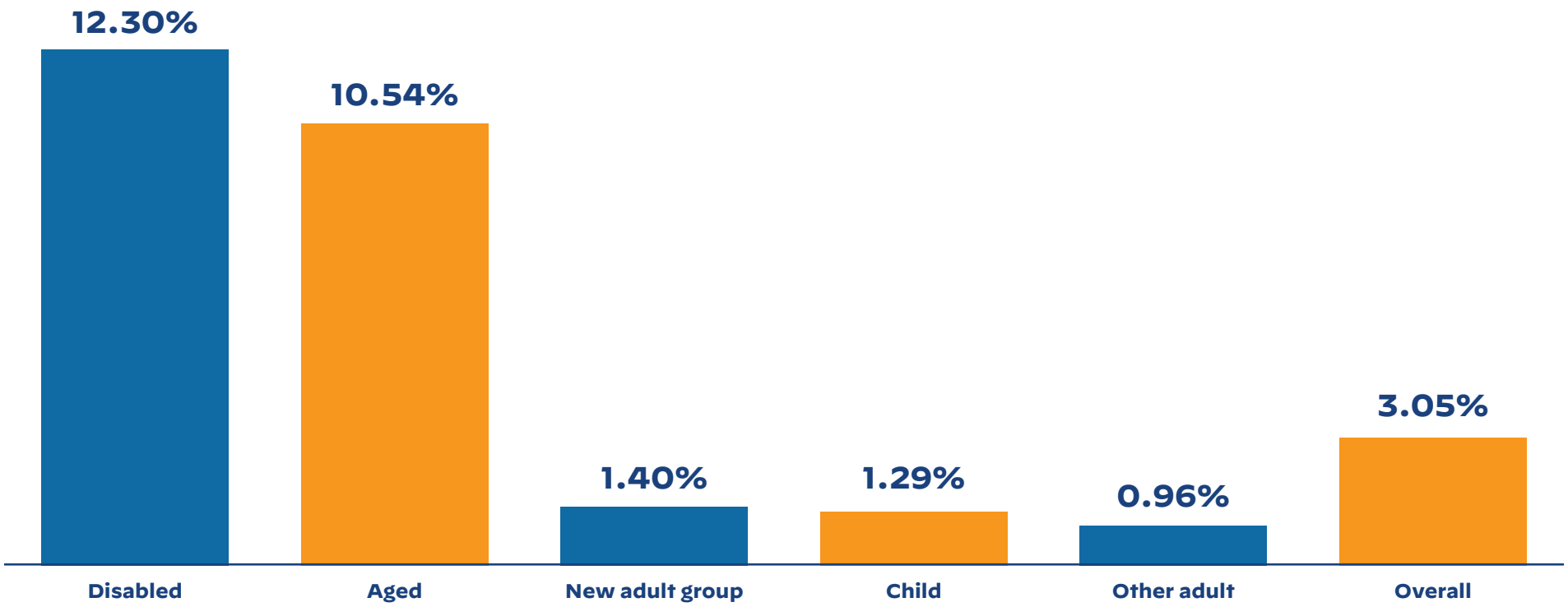
FIGURE 10: Proportion of Each Medicaid Eligibility Category using HCBS Home Care

To understand the dynamics of eligibility category and home care utilization, we examined the proportion of individuals in each category who received home care services. Overall, approximately 3% of all Medicaid enrollees used any home care service in 2023. Unsurprisingly, aging and disability were the categories with largest percentage of individuals who received home care at 10.5% and 12.3% respectively. Though only a small percentage of ACA expansion enrollees (1.4%) received home care services, this is still higher than many policy makers may realize as it is often characterized as a "non-disabled childless adult" enrollment category.



Source: HMA analysis of T-MSIS data, 2023

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FIGURE 11: Urban / Rural Residence of Home Care Recipients

To better understand the dynamics regarding rural home care delivery, we identified the Rural-Urban Commuting Area (RUCA) Codes for the zip codes associated with participant records in the T-MSIS data. Using definitions commonly accepted in health care policy analysis,[4] we classified participants as urban and rural based upon their RUCA code. Under this framework, RUCA codes 1-3 are considered urban and codes 4-10 are categorized into rural.

Overall, the trends largely matched the general population of the USA, with 84% of home care recipients living in urban areas of the country and 16% in rural areas. Using the same urban-rural definition for the broader population, as of 2020, 83% of the general population lived in urban areas and 17% resided in a rural region.

A discrete breakout of the 10 different RUCA codes shows similar consistency across the country. The largest discrepancy is a higher density of home care recipients than the general USA population living in regions classified as RUCA code 1: "core Metropolitan" areas which generally include urban downtown and inner-ring neighborhoods. In contrast, fewer home care recipients live in RUCA code 2 regions, which are "high commuting" areas that are largely comprised of suburban neighborhoods and regions near urban areas.

PRIMARY RUCA CODE	HOME CARE USERS	USA POPULATION
1 Metropolitan core	77.0%	71.9%
2 Metropolitan high commuting	5.8%	10.3%
3 Metropolitan low commuting	0.8%	1.2%
4 Micropolitan core	6.7%	5.4%
5 Micropolitan high commuting	1.3%	2.3%
6 Micropolitan low commuting	0.4%	0.7%
7 Small town core	2.0%	1.6%
8 Small town high commuting	0.4%	0.6%
9 Small town low commuting	0.2%	0.3%
10 Rural	4.8%	5.7%

Source: HMA analysis of T-MSIS data, 2023

4 See: https://pmc.ncbi.nlm.nih.gov/articles/PMC12614380/

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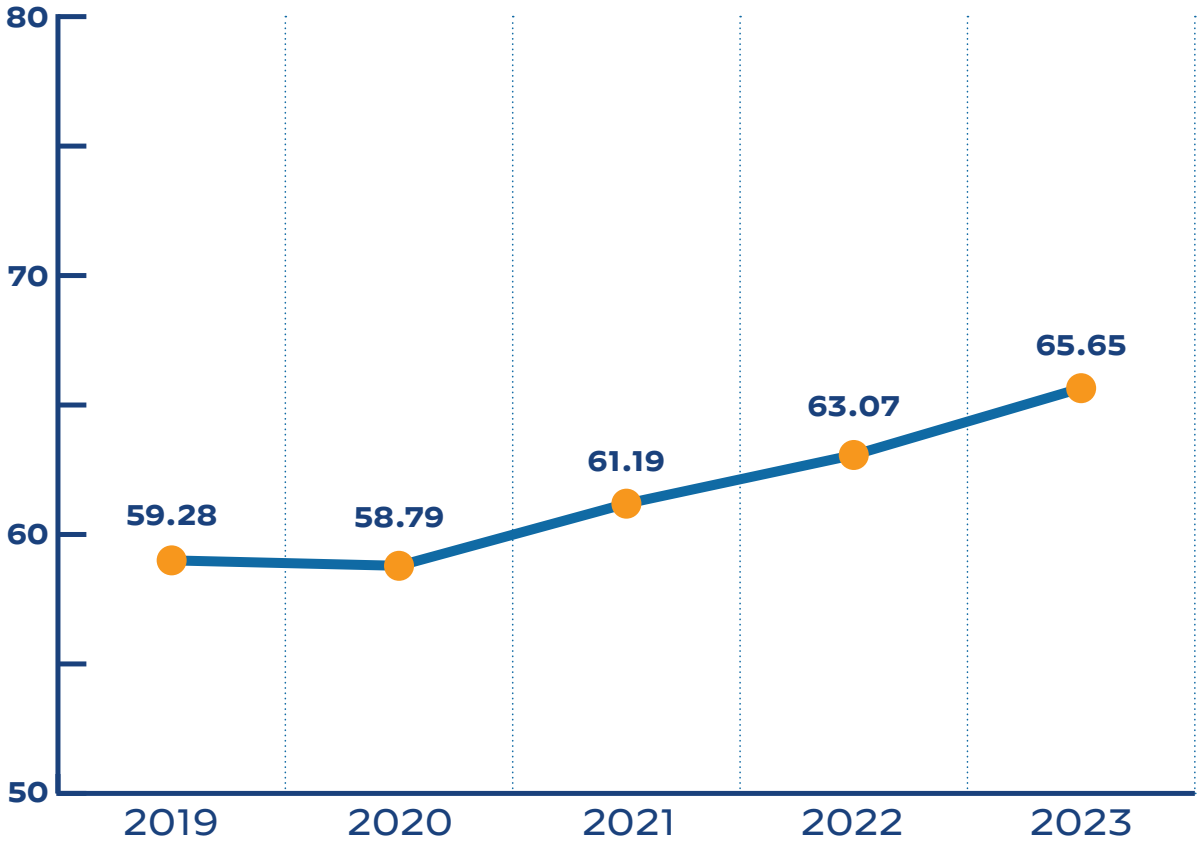
FIGURE 12: Ratio of Participants per HCBS Home Care Billing Providers

T-MSIS data shows steady growth in the number of providers that submitted a claim for home care services from 2019-2021, followed by largely flat growth between 2021-2023. Despite the initial growth in billing providers during the 2019-2021 period, the number of beneficiaries per provider increased every year throughout the data. In other words, even though the total number of billing providers grew, it did not grow fast enough to keep pace with the growth in beneficiaries. Growth in participants outpacing growth in providers, coupled with the well-documented worker recruitment and retention challenges that providers are experiencing, are further exacerbating access concerns in Medicaid-funded homecare.



Source: HMA analysis of T-MSIS data, 2019-2023

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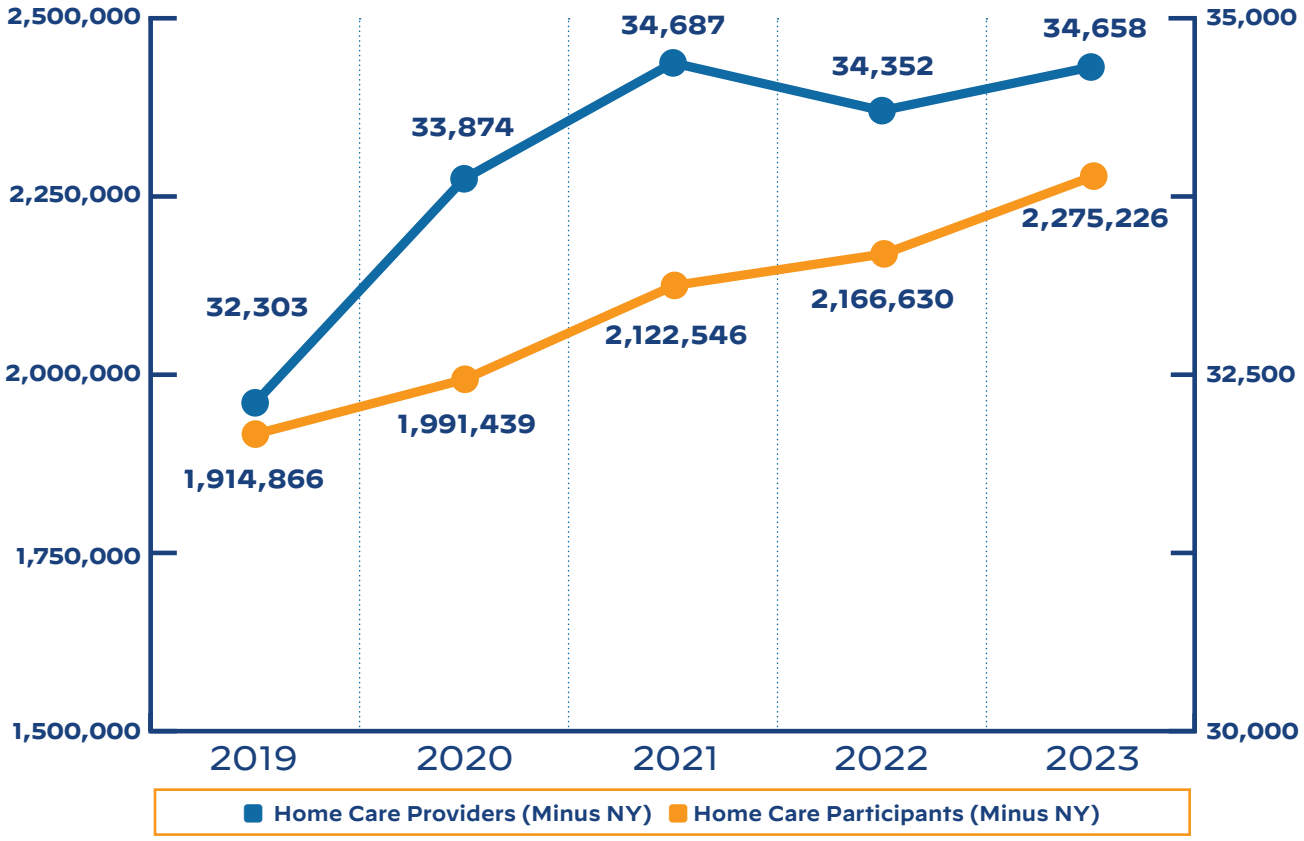
FIGURE 13: HCBS Home Care Participants vs. Providers

Notably, there are data quality issues associated with this measure that should be recognized. First, states enroll providers in different ways which may lead to differentiated provider counts. For example, some states will enroll all individual providers, including those delivering services in a self-direction model, as the billing provider of record whereas others will have a third party, such as a fiscal intermediary, submit claims on behalf of those individual providers. Second, New York's data had some inconsistencies from year to year in the number of enrolled and billing providers. We therefore chose to exclude New York providers from the data. To maintain comparability with beneficiary data, we also excluded NY home care participants from the comparison with total providers.



Source: HMA analysis of T-MSIS data, 2019-2023

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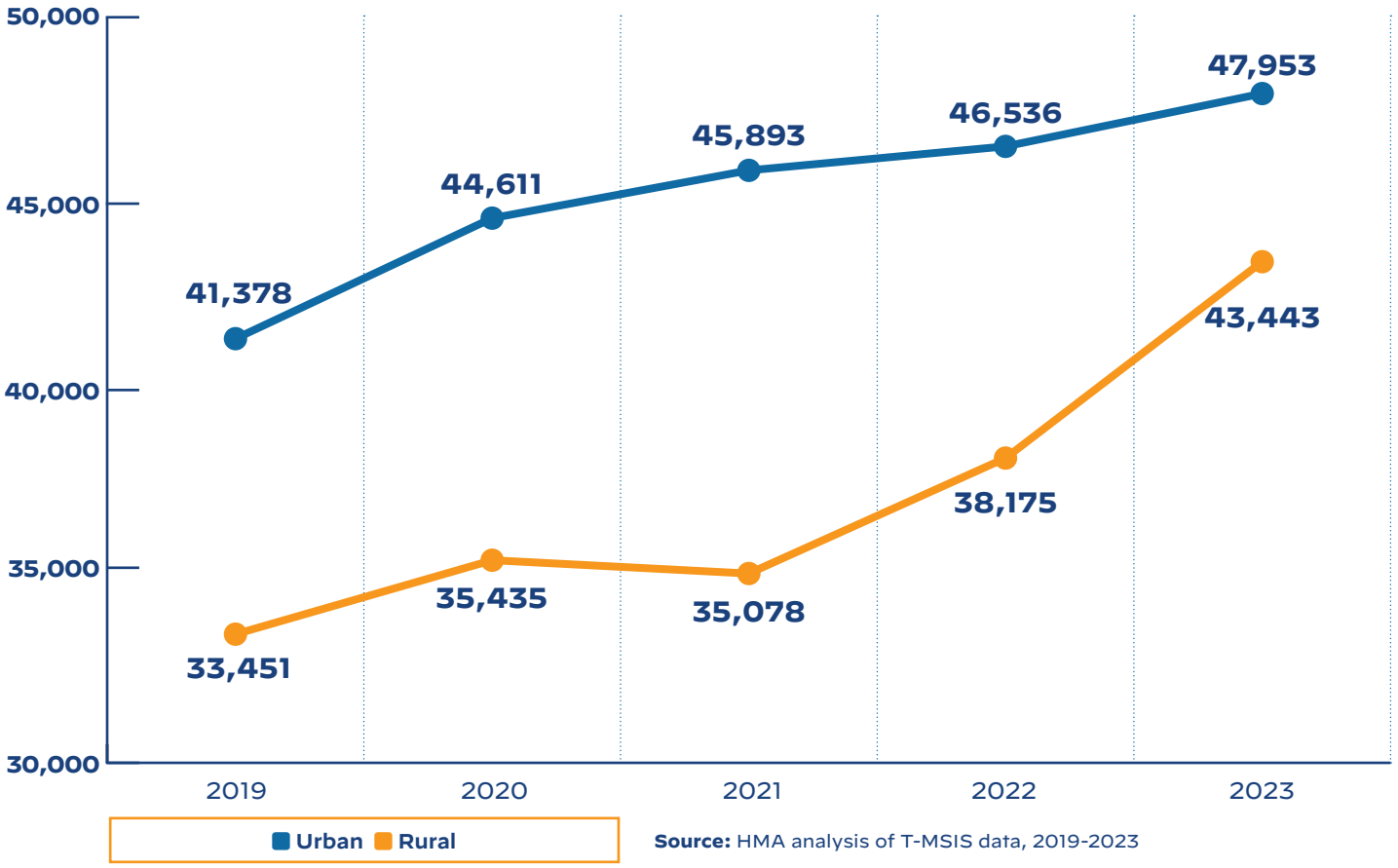
FIGURE 14: National Frequency of providers by RUCA category, 2019 and 2023

The T-MSIS data also allows us to examine the distribution of providers by RUCA code, similar to our analysis of participant RUCA status. Unsurprisingly, most providers are located in urban areas across the country. However, it is notable that a greater proportion of home care providers in rural areas (48% in 2023) than the percentage of home care recipients (16%). Rather than viewing this as an indication of greater access in rural areas, we believe it is instead a reflection of the dynamics of service delivery. Due to the large land area rural services must cover coupled with smaller populations, providers in these areas often serve significantly fewer beneficiaries and have fewer employees delivering home care to participants. As a result, urban providers served an average of 38.16 clients in 2023 whereas rural providers served an average of 10.69.



Source: HMA analysis of T-MSIS data, 2019-2023

FIGURE 15: Providers by RUCA code

PRIMARY RUCA CODE	2019	2020	2021	2022	2023
1 Metropolitan core	26,227	28,322	29,221	29,253	29,485
2 Metropolitan high commuting	11,955	12,855	13,282	13,302	13,793
3 Metropolitan low commuting	3,196	3,434	3,390	3,981	4,675
4 Micropolitan core	9,719	10,348	10,639	10,774	11,533
5 Micropolitan high commuting	3,897	4,095	4,025	4,584	5,424
6 Micropolitan low commuting	2,083	2,247	2,138	2,699	3,443
7 Small town core	5,205	5,587	5,516	5,936	6,598
8 Small town high commuting	1,877	2,019	1,810	2,511	3,278
9 Small town low commuting	1,126	1,230	1,133	1,671	2,394
10 Rural	9,544	9,909	9,817	10,000	10,773
No Zip Code / RUCA Data	3647	2974	2897	3333	3922

Source: HMA analysis of T-MSIS data, 2019-2023

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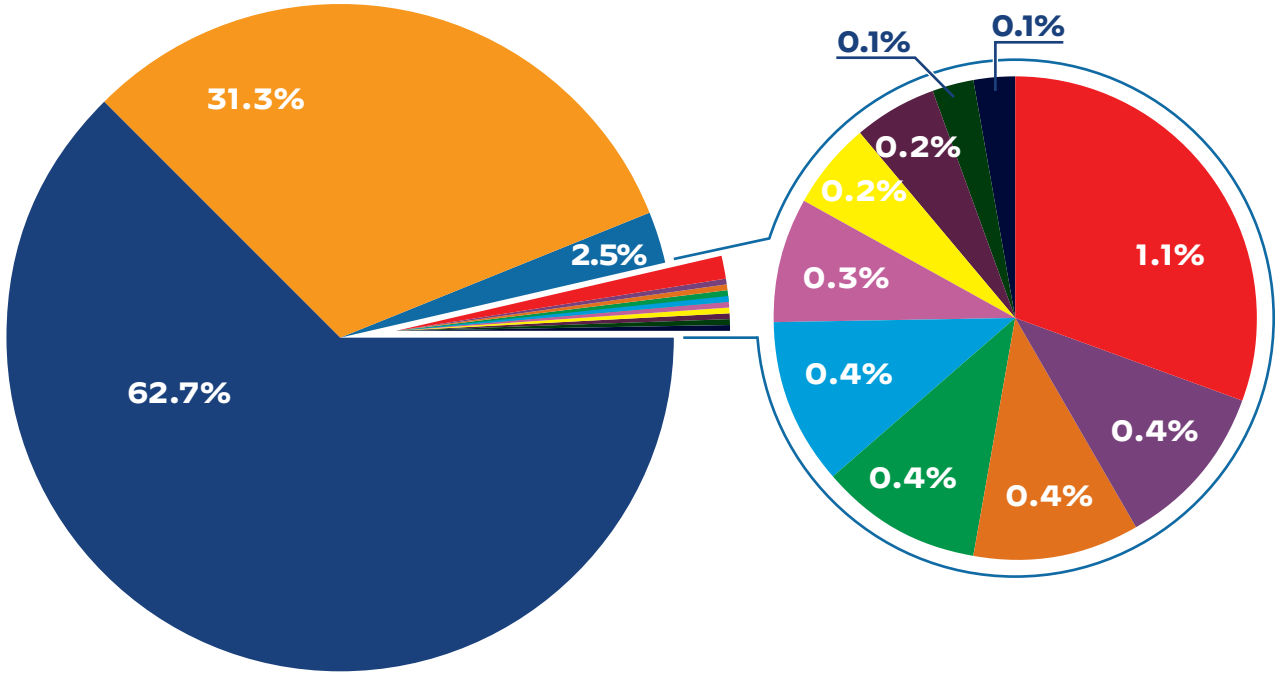
FIGURE 16: Home Care Claims by Service Category

The vast majority (62.7%) of all home care claims are for personal care services in the dataset. This is unsurprising for several reasons. First of all, personal care is the most provided HCBS across the country and our definition of home care is a subset of HCBS that includes personal care. Second, personal care represents a flexible, person-centered service that addresses a wide range of functional limitations for individuals who require LTSS. The nature of personal care makes it an extremely valuable service for participants who qualify to receive HCBS in the Medicaid program.

Following personal care, the second most common service in our dataset is derived from claims and procedure codes as opposed to the home care taxonomies we utilized to develop our home care analysis. These "non-taxonomy care codes" are 31.3% of the claims. The remaining 6% of the services are spread widely across a wide range of services, including therapies, private duty nursing, home health aide, companion, and homemaker services. Due to the way that we constructed the data for this project, it is highly likely that the 31% of claims categorized as "non-taxonomy" include many of the same medical and nonmedical in-home supports. Future research and analysis can be focused on better identification and categorization of the non-taxonomy codes to improve understanding of the types of non-personal care supports delivered to individuals in the home.

Personal Care	62.7%
Non-Taxonomy Care Codes	31.3%
Homemaker	2.5%
Respite, In-Home	1.1%
Skilled Nursing	0.4%
Companion	0.4%
Community-Integration	0.4%
Other Therapies	0.4%
Home Health Aide	0.3%
Occupational Therapy	0.2%
Physical Therapy	0.2%
Private Duty Nursing	0.1%
Speech, Hearing, And Language Therapy	0.1%
Cognitive Rehabilitative Therapy	0.0%
Chore	0.0%



Source: HMA analysis of T-MSIS data, 2023

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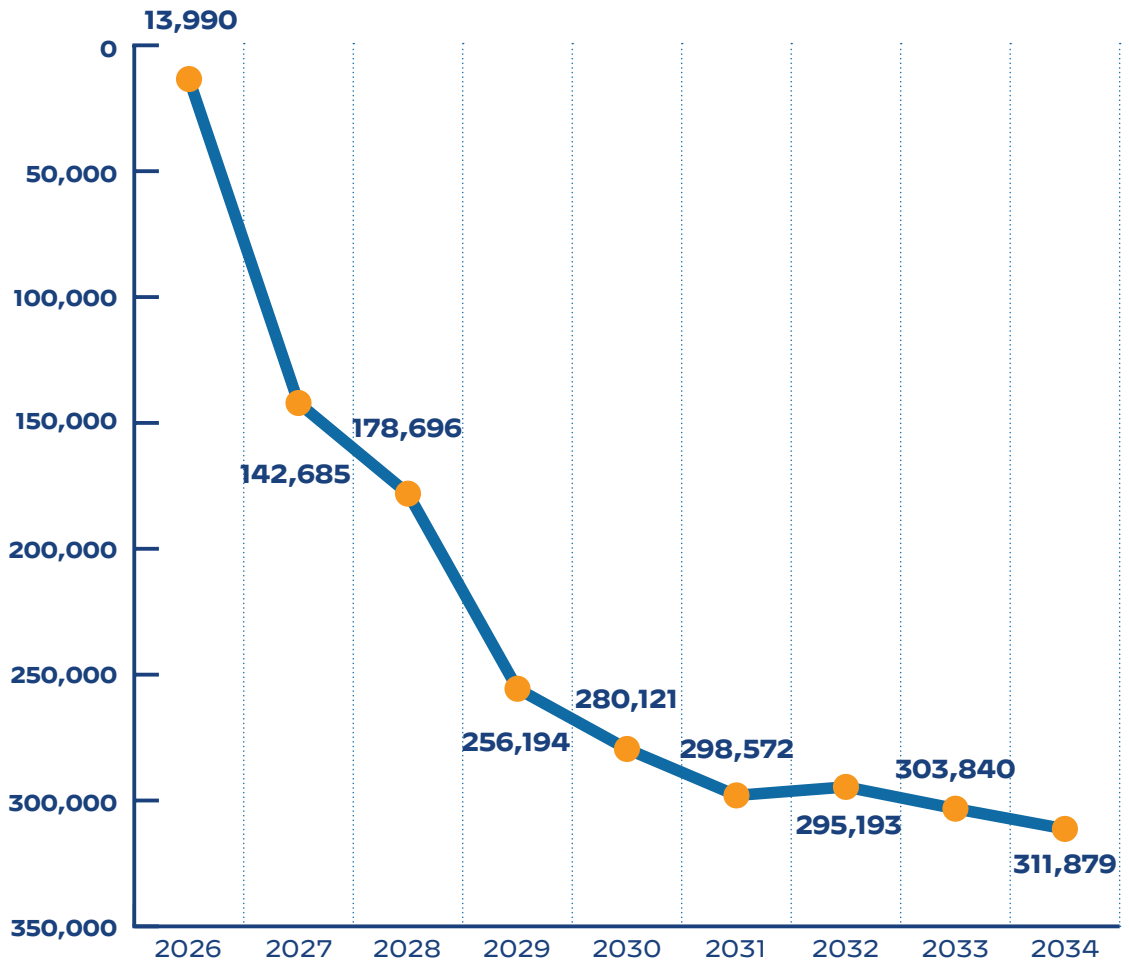
FIGURES 17: Expected loss in enrollment of home care utilizers by 2034

As discussed previously, the 2025 HR1 Reconciliation legislation made substantial changes to Medicaid eligibility rules and to funding for state governments. The bulk of these changes are targeted to the ACA expansion group, though some of the changes apply more broadly. Some of the new policies that may impact eligibility include:

- More frequent eligibility redeterminations;
- Restrictions on retroactive Medicaid eligibility criteria;
- Limits on allowed home equity; and
- Community Engagement Mandates (also known as "Work Requirements").

Using methodology developed by HMA, we estimated the changes to Medicaid, including eligibility and financing restrictions, and projected the resulting impacts to the number of individuals who would otherwise receive home care services. The estimates compare the number of individuals who would otherwise be enrolled in Medicaid and receive home care without HR1 to the expected number of individuals who will receive home care services under the new law. By 2034, we project that there will be 311,879 fewer individuals enrolled in Medicaid who receive home care services due to HR1's changes, a substantial 9.4% reduction.



Source: HMA analysis of T-MSIS data, 2023 and *HR1* policy impact projections

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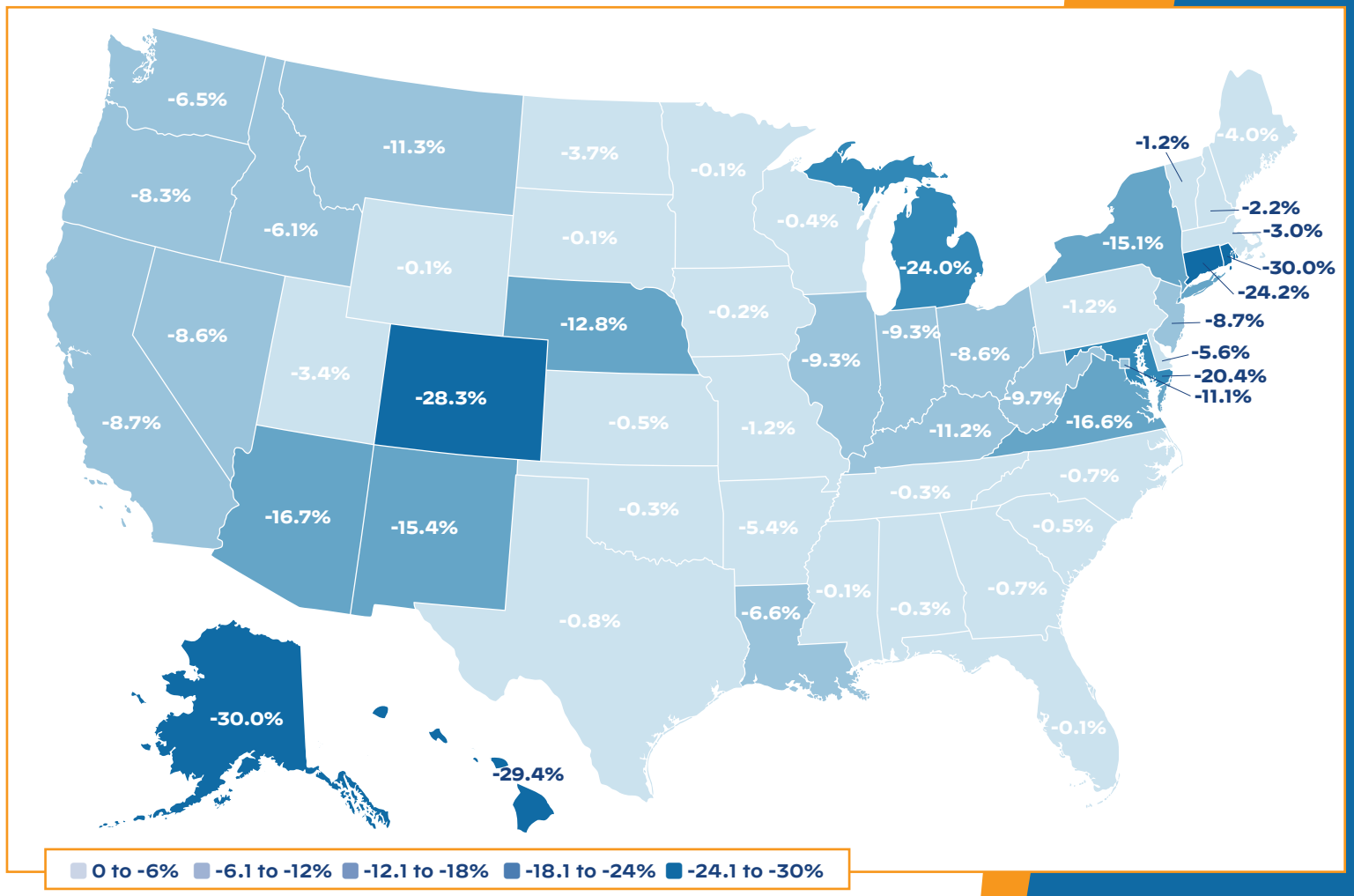
FIGURES 18: Expected change in enrollment of home care utilizers by 2034

As figure 18 shows, the distribution of enrollment changes are not uniform across the country. Impacts range from a high of 30% of individuals who utilize home care services in Alaska and Rhode Island to a low of 0.1% in Florida, Minnesota, Mississippi, South Dakota, and Wyoming.

In general, states that adopted the ACA expansion, and especially those states with higher proportions of ACA expansion enrollees who utilize home care services, are expected to experience greater impacts than nonexpansion states. However, some states, including Minnesota and South Dakota, show very low projected losses despite having ACA expansions in place.

Conversely, we project that non-ACA expansion states will also see some decline in enrollment of individuals who use home care services. This projection is due to some of the restrictions on eligibility that are not solely applied to the ACA expansion, such as home equity limits, as well as anticipated state responses to limits on federal funding through provider taxes and other related policies.



Source: HMA analysis of T-MSIS data, 2023 and *HR1* policy impact projections

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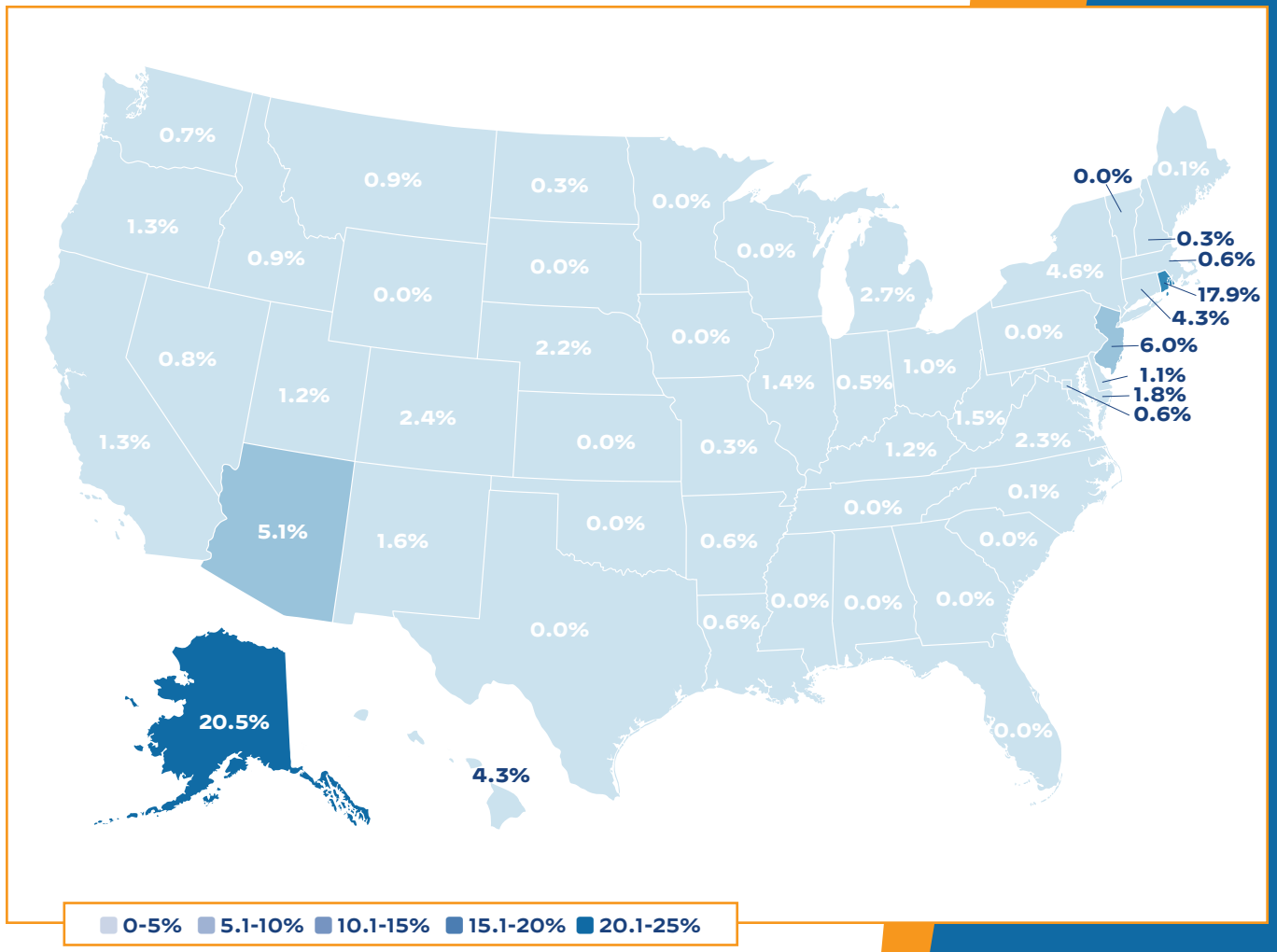
FIGURE 19: Proportion of Home Care users expected to become newly eligible for cost sharing in 2028

In addition to eligibility changes, HR1 also established mandatory cost sharing for Medicaid services that applies to individuals enrolled in the ACA expansion group. Though cost sharing has been an option for many years, this is the first time that Medicaid agencies are required to apply cost sharing to subsets of individuals in the program. The law exempted certain primary care services from mandatory cost sharing, and hospice services were already exempt from any cost sharing in Medicaid[5] prior to the enactment HR1, but it did not exclude home care or other HCBS on a blanket basis.

It is unclear how CMS will interpret the requirements created by HR1 and whether the mandatory cost sharing will be applied to all services, including HCBS. To inform the discussion, we utilized HMA's methodology for identifying participants subject to mandatory cost sharing with the data of home care users enrolled in the ACA group. Overall, we estimate that slightly more than 75,000 individuals who receive home care services will be subject to the new cost sharing requirements. The proportion of home care recipients subject to cost sharing ranges from a high of 20% in Alaska and a low of 0% in 14 states across the country.



Source: HMA analysis of T-MSIS data, 2023 and *HR1* policy impact projections

5 Though hospice is exempt from service-based cost-sharing, individuals receiving hospice who are subject to Medicaid's post-eligibility treatment of income (PETI) requirements may have out of pocket costs associated with the PETI. This is distinct from copayments and cost-sharing.

APPENDIX: Note on Data Quality

Payment data: This project examined utilization by providers as well as expenditures. Certain data – including all cost analyses – were held back due to overwhelming concern with the usability and interpretability of the underlying T-MSIS data. While T-MSIS claims typically include payment information for fee-for-service claims, they are not available for managed care claims. This project did not impute managed care payments amounts and so we found total state payment levels to be implausibly low (as they apply only for FFS claims) relative to expected outlays.

Other known issues in T-MSIS quality: These issues are commonly faced in analysis of T-MSIS data. While the accuracy of this data source has improved significantly over time, it also makes time trends difficult to trust and individual states have many data quirks. Medicaid issues a Data Quality Atlas to help data users understand the specific limitations of this data.

Suggested improvements to T-MSIS: CMS can continue to improve the quality of Medicaid data made available for researcher use. While the T-MSIS data is the cleanest and most usable it has ever been, there is room for improvement in every facet of the data. 1) states and managed care organizations should be required to submit relevant data fields, including provider identifiers and minimum billing information, 2) CMS should collect complete payment information regardless of payor, 3) CMS should address systemic known issues in the beneficiary ID and MSIS ID generation and encryption system, 4) states must reconcile localized billing and coding schemas, or at very least publish machine-readable charge masters to interpret the data.

Data notes for each figure are available on request. Contact info@researchinstituteforhomecare.org for more information.

Citation information: Research Institute for Home Care's Medicaid Home Care Chartbook. April 2026. (Citing and analyzing from T-MSIS claims 2019 -2023)

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