

WHITE PAPER

The Value of Home-Based Personal Care Services

Evidence, Value Pathways, and Six Policy Levers for High-Value LTSS

For state and local funders, health plans, providers, and policymakers

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INTRODUCTION

Home-based personal care, personal assistance, homemaker supports, and respite are the practical infrastructure that allows older adults and people with disabilities to remain safely in their homes and communities. These services create value when they do more than provide access on paper. They must deliver enough help, at the right time, with enough reliability and flexibility to prevent unmet daily needs from leading to avoidable emergency department (ED) visits, hospital stays, caregiver burnout, or nursing facility use. The value of these services is particularly evident during periods of transition, such as returning home after a hospital or post-acute stay, when timely initiation or resumption of daily-living assistance, effective caregiver support, and coordination with clinical providers can help prevent complications and avoid unnecessary readmissions.

The evidence supports a practical policy message: High-value home-based care depends on matching service intensity to assessed need, intervening before a crisis occurs, maintaining workforce continuity, supporting participant direction, and funding respite at a dose that can sustain family caregivers. The cost case is strongest when home-based services substitute for institutional care or prevent acute and crisis utilization. Because much of the research is observational or program-specific, decisionmakers should treat the findings as evidence-informed signals—not universal savings estimates—and validate them with local service, utilization, experience, and cost data. A credible value case also depends on balanced program integrity, confirming that support is appropriate to assessed needs, authorized correctly, delivered as intended, documented and billed accurately, and monitored for missed care or unmet need without limiting participant choice or flexibility.

WHY HOME-BASED CARE, AND WHY NOW

Demand for long-term services and supports (LTSS) is rising as budgets tighten, and the direct care workforce remains strained. Personal care, respite, and homemaker supports are the day-to-day infrastructure that makes community living possible. They help people with daily activities, sustain family caregivers, support transitions after acute events, and reduce reliance on higher-cost institutional, acute, and post-acute care.

Thus, the question is no longer simply whether to expand home-based care, but how to make that investment timely, adequate, reliable, flexible, person-centered, and accountable for services delivered and measurable value. Accountability means knowing whether authorized services reached participants, whether documentation and payment accurately reflect delivery, and whether missed care or unmet needs have contributed to avoidable crises.

Bottom Line

The opportunity is not simply to expand service volume, but rather to increase access to high-quality support that produces measurable value. Home-based care is most effective when services are timely, adequate, reliable, flexible, and person-centered, and when verified delivery, accurate payment, and measurement connect those services to outcomes that matter.

EVIDENCE SIGNALS AT A GLANCE

The evidence points in a consistent direction: Home-based care delivers the greatest value when support is timely, adequate, reliable, flexible, person-centered, targeted to real needs, and measured against outcomes. Findings vary by population, program design, service intensity, and local delivery conditions and should be tested against local utilization, experience, and cost data.

10–30% Lower hospital use with adequate or higher-intensity support ¹	52% vs. 34% ED use when home care needs are unmet vs. fully met ²	25% vs. 36% nursing home placement with higher versus lower care hours ^{3,4}
\$15K–\$57K lower per person-year in selected home and community-based services (HCBS) vs. institutional care comparisons ^{5,6,7,8}	62% to 92% satisfaction after transition from facility to community ⁹	Meaningful Dose Respite must be substantial enough to reduce caregiver strain ^{10,11}

THE VALUE PROPOSITION

Personal care services, respite, and homemaker supports are more than benefit categories. They are essential home-based care infrastructure. When support is well matched to need, these services can preserve independence, sustain family caregivers, strengthen satisfaction, support transitions after acute events, and reduce reliance on higher-cost care.

Timely	Adequate	Flexible	Reliable	Person-Centered
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FOUR PATHWAYS TO VALUE

Home-based care creates the most credible value when it prevents avoidable utilization, extends days at home, stabilizes function and safety, and sustains family caregivers. These pathways also explain where home-based care fits in with value-based care. Accountable models need fewer avoidable admissions and emergency visits, more days at home, better participant and caregiver experience, lower total cost across payer boundaries, and reliable information about function and daily life. Each pathway depends on reliable information about services authorized, delivered, documented, and billed. Without that foundation, changes in outcomes or costs cannot be attributed confidently to home-based care.

1. Prevent avoidable utilization

Adequate service intensity and coordination can reduce hospital and ED use when unmet need would otherwise drive crises.

2. Extend days at home

Sufficient support can delay or prevent nursing home placement; earlier initiation can extend community tenure.

3. Stabilize function and safety

Continuity, participant direction, and reliable assignments support maintained daily functioning and safer care.

4. Sustain family caregivers

Formal support and meaningful respite preserve unpaid caregiving capacity; very low-dose respite may have limited impact.

SIX POLICY LEVERS FOR HIGH-VALUE HOME-BASED LTSS

These six levers translate the evidence into action. They help states, plans, providers, and community partners strengthen access while connecting payment and accountability to fewer avoidable crises, more days at home, stable function and safety, sustainable caregiving, and a better care experience.

1. Fund cost-effective services Provide enough hours at the right rates to meet actual daily living needs, the foundation for preventing missed care and avoidable downstream use.^{12,13,14}	2. Stabilize the workforce Treat rates, wages, training, and continuity standards as quality strategies. Stable aide relationships support safer, more reliable care.¹⁸
3. Measure outcomes, service delivery, and substitution Track whether services increase days at home, prevent crises, delay facility use, improve participant and caregiver experience, and create value across payer boundaries.^{22,23} As a core program integrity function, reconcile authorized, delivered, documented, and billed services; monitor missed visits, unresolved exceptions, and unmet need; and interpret these findings alongside outcomes and costs.	4. Maintain flexible service delivery options Preserve participant choice across service models, including self-direction and paid family caregiver options, with the infrastructure to make flexibility work: Financial Management Services (FMS), backup coverage, flexible scheduling, clear documentation, and oversight that supports accurate payment without reducing participant authority or choice.^{24,25}
5. Make respite meaningful Fund respite as real system capacity. Token amounts rarely reduce burden; meaningful doses help families keep care sustainable at home.^{26,27}	6. Enable safe transitions and intervene before crises Move support upstream after discharge, when function declines, or when caregiver strain appears. For hospital- and post-acute-to-home transitions, arrange timely service start or resumption, reassess daily-living needs and caregiver capacity, and establish clear handoffs and a clinical escalation contact before emergency or facility care becomes the default.^{28,29}

Public Financing Takeaway

Public dollars should buy care that is appropriate to need, delivered as intended, documented and paid accurately, and capable of improving outcomes through adequate hours, timely support, workforce continuity, participant choice, caregiver sustainability, and measurable reductions in avoidable, high-cost care. Expansion alone should not be treated as proof of savings.

APPLYING THE LEVERS ACROSS PROGRAMS AND PLANS

Each stakeholder has a different role, but the policy direction is consistent: finance and contract for supports that are adequate, timely, stable, person-directed, and accountable for results. Roles differ, but each organization should be able to show whether intended services reached participants, payment reflected actual delivery, and oversight protected access and participant choice. These actions also create the foundation for home-based care to participate more effectively in value-based arrangements.

State Medicaid Agencies and Legislators	• Set benefit and rate policy that supports adequate hours and workforce stability, not just enrollment growth • Use waiver and managed long-term supports and services (MLTSS) oversight to monitor authorized, delivered, documented, and billed services, missed visits, unmet need, and intensity dilution • Require timely review of recurring delivery, documentation, and payment discrepancies and use findings to correct provider, plan, authorization, workforce, or system-level problems • Prioritize populations at meaningful risk of facility use or crisis utilization when expanding access
Health Plans and MLTSS Organizations	• Use assessments and utilization data to identify unmet activities of daily living and instrumental activities of daily living (ADL/IADL) needs early and link members to timely home support • Contract for continuity, backup coverage, participant direction, rapid in-home response after acute events and reliable service delivery documentation • Reconcile authorized, delivered, documented, and billed services; review missed visits and recurring verification exceptions; and take timely corrective action without interrupting necessary care • Tie value-based incentives to days at home, ED and hospital use, nursing home entry, member experience, and equity

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Local Aging, Disability, and Community Funders	• Use flexible dollars to close gaps that Medicaid or plans may not fill quickly, including respite, homemaker support, caregiver navigation, home safety, and transition stabilization • Fund practical supports before families reach burnout or rely on emergency care • Use proportionate reporting and contract oversight to confirm that funded supports reached intended participants without creating unnecessary administrative burden • Connect community organizations with health plans, Area Agencies on Aging, FMS entities, and self-direction support
Cross-Payer and Dual-Eligible Partnerships	• Align Medicaid HCBS, Medicare acute and post-acute care, dual special needs programs (D-SNP), Program of All-inclusive Care for the Elderly (PACE), and Veterans Affairs (VA) strategies so value is not lost across budget silos • Share data to track institutional offsets, Medicare-side acute and post-acute use, caregiver sustainability, and equity • Where data-sharing arrangements permit, use cross-payer information to identify missing, conflicting, overlapping, or duplicate services and payment records • Use joint pilots or contracting models when one payer funds home support and another payer captures avoided acute care

A Credible Public Message

Home-based care is essential LTSS infrastructure and can be a value driver within accountable arrangements. That value depends on sufficient support, reliable delivery, accurate payment, and data that show whether authorized services reached participants and contributed to outcomes that matter.

ACCOUNTABILITY FOR BUDGETS AND CONTRACTS

Access is not the same as impact. Budgets, contracts, and value-based arrangements should reward services that are targeted, timely, and sufficient to prevent avoidable crises, increase days at home, sustain caregivers, and substitute for higher-cost institutional, acute, and post-acute care. Balanced program integrity examines both sides of accountability: 1) whether payment is accurate, and 2) whether participants receive the services necessary to meet assessed needs. Oversight should address improper payment and under-delivery without creating avoidable barriers to care or participant direction.

Policy Goal	What to Measure	Why It Matters
Adequate support	Authorized vs. delivered hours, missed visits, unmet need, time from assessment to service start.	Shows whether access translates into enough help to prevent use of crisis services.
Program integrity: reliable delivery and accurate payment	Authorized, delivered, documented, and billed services; missed or shortened visits; unresolved verification exceptions; duplicate or overlapping claims; services outside authorization; recurring discrepancies; and corrective action trends. ³²	Shows whether participants received intended support, whether payment accurately reflects delivery, and whether discrepancies require participant, provider, plan, or system-level correction.
Acute use prevention	ED visits, hospital stays, potentially preventable admissions, post-discharge days at home.	Connects home support to avoidable high-cost utilization.
Institutional diversion	Nursing home entry, long-stay admissions, transition success, days at home.	Captures the clearest LTSS cost-effectiveness pathway.

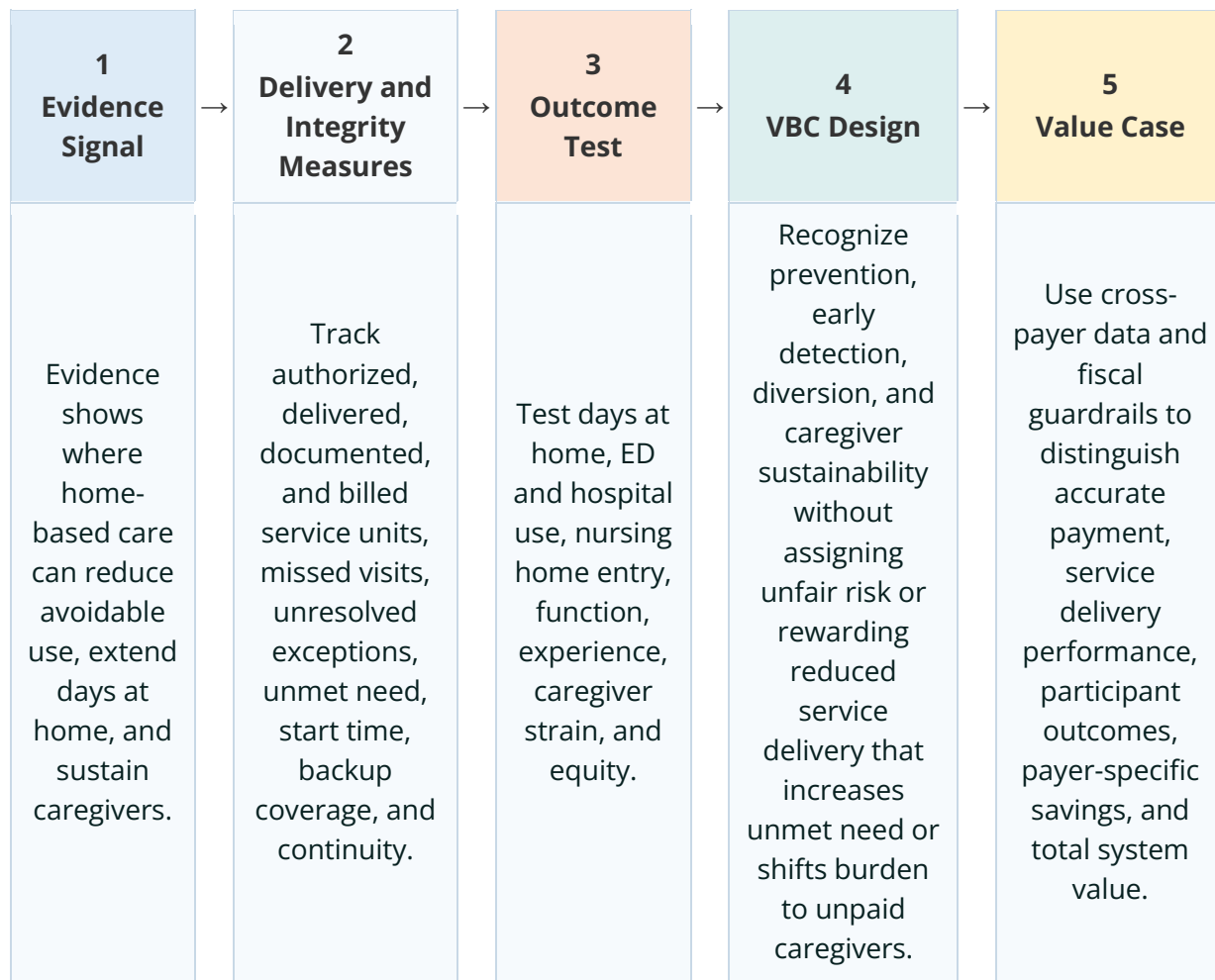
Policy Goal	What to Measure	Why It Matters
Workforce stability	Continuity of aide relationships, turnover, vacancies, wage/rate adequacy, training.	Stability is tied to function, safety, access, and quality.
Caregiver sustainability	Respite dose and uptake, caregiver strain, backup coverage, caregiver ability to continue care.	Family caregivers are essential LTSS capacity; respite must be meaningful.
Equity and access	Aggregate access and outcome patterns across populations and service areas; delayed starts; inappropriate denials; rural and language-access barriers; and administrative burden.	Ensures that accountability controls improve outcomes without creating avoidable access barriers or disproportionate burden.

A Disciplined Savings Message

Home-based services can generate programmatic savings, but savings should not be assumed from access alone. The fiscal case is strongest when support substitutes for nursing facility care or prevents acute and crisis utilization, reaches people at meaningful risk, starts early, is sufficient to meet daily needs, and is evaluated against avoided higher-cost care and participant experience. Program integrity improvements, including verified delivery, corrected billing, recoveries, and avoided improper payment, strengthen fiscal stewardship but should be reported separately from savings attributable to reduced acute, crisis, or institutional care.

FROM EVIDENCE TO VALUE-BASED CARE

Moving from evidence to value-based care (VBC) requires a staged approach, starting with what the evidence shows; establishing dependable information about what was authorized, delivered, documented, and billed; testing whether outcomes change; aligning payment with the provider contribution; and then evaluating value across payer boundaries. Providers should not assume significant outcome risk until service delivery data, attribution, and the outcomes they can reasonably influence are sufficiently reliable.



ABOUT THE EVIDENCE

This white paper draws from a Health Management Associates (HMA) and TEAM Services Group evidence baseline review of more than 100 peer-reviewed studies, government evaluations, and policy reports on Medicaid-funded personal care, personal assistance, homemaker services, participant direction, and respite. Most studies are observational or quasi-experimental, and many examine bundled HCBS rather than a single service. Findings are therefore presented as associations unless stronger study designs support causal conclusions. Cost evidence is strongest for HCBS compared with institutional care and more indirect when the comparator is no or inadequate formal care.

The program integrity recommendations also draw from policy and operational guidance on service verification, payment accuracy, and oversight. Electronic visit verification and related tools can support delivery and payment oversight, but they do not by themselves establish service quality, adequacy, participant experience, or program value. Service verification data should be interpreted alongside participant-reported experience, missed care information, unmet need, and access measures.

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This paper translates existing evidence into public policy and payer design considerations. It is not a substitute for state-specific actuarial analysis, rate development, or program evaluation.

ABOUT HMA

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With multidisciplinary consultants coast to coast, HMA's expertise, services, and team are always within client reach.

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