HMA

The Value of Home-Based Personal Care Services



Hosted by Health Management Associates (HMA), in partnership with TEAM Services Group

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WELCOME

Today's Conversation

01

White Paper Highlights

A brief overview of new findings on the value of home-based personal care: the value proposition, key evidence signals, and six policy levers for high-value LTSS.

Boyd Brown, HMA · ~15 min

02

Moderated Expert Panel

The heart of today's session: value-based care experts discuss the current state of VBC, why it matters, and how home-based care can fit into and benefit from value-based models.

Full panel · ~35 min

03

Audience Q&A

Your questions for the panel. Submit questions at any time using the Q&A window; we will get to as many as time allows.

All speakers · ~10 min

Acknowledgements

This webinar and white paper was financially supported by TEAM Services Group.

TEAM Services Group is a home-based care services company that includes mission-driven brands working together to expand access to quality care. They have a range of options, including in-home caregiving, household employment solutions, and fiscal intermediary services, and employ thousands of individuals who provide care or other household services in meaningful ways. For more information, please visit their website.

HMA thanks TEAM Services Group for their support in this research. All insights provided on this webinar, research conducted, and findings published in the white paper reflect the expertise of HMA colleagues, and HMA retained full independent editorial control over the insights published and perspectives shared.



Why Home-Based Care, and Why Now

Demand for long-term services and supports is rising as budgets tighten and the direct care workforce remains strained. The question facing states, plans, and purchasers is no longer whether to invest in home-based care; it is how to make that investment produce measurable value.

8.4M

Medicaid beneficiaries received HCBS in 2023, compared with 1.5M receiving institutional services. [1]

63.8%

of Medicaid LTSS spending went to home- and community-based services in 2023. [2]

1.5M+

people self-directed HCBS in 2023 through programs funded primarily by Medicaid. [3]

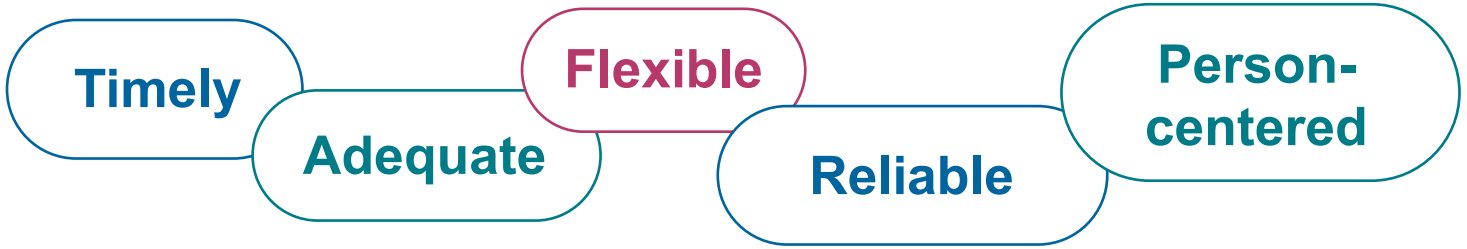
All 50

states and DC offer self-directed HCBS options, with program design varying by state. [3]

Sources: [1–2] CMS, 2023 LTSS users/expenditures and rebalancing briefs (2025). [3] MACPAC, Self-Directed Services (Dec. 2024).
Policy context: [4] KFF/HMA, Medicaid Budget Survey, FY 2025–2026 (Nov. 2025). Full citations in notes.

Personal Care Is Essential Home-Based Care Infrastructure

Personal care services, respite, and homemaker supports are more than a benefit category. They are the day-to-day infrastructure that makes community living possible, helping people with daily activities, sustaining family caregivers, and supporting people to remain safely at home.



Home-based services create the greatest value when support has these five qualities and is funded at a level that reflects real daily needs.

The opportunity is not simply to expand service volume; it is to increase access to high-quality support that produces measurable value.

WHEN SUPPORT IS RIGHT, HOME-BASED CARE CAN

- Improve outcomes and preserve independence
- Sustain family caregivers
- Strengthen satisfaction with care
- Support transitions after acute events
- Reduce reliance on higher-cost institutional, acute, and post-acute care

What the Evidence Says About Value

HOSPITAL USE

10–30% lower

Adequate or higher-intensity home support is associated with lower hospital use than minimal care.

ED USE

34% vs 52%

Emergency department use was higher when home-care needs were unmet versus fully met.

NURSING HOME PLACEMENT

25% vs 36%

Higher personal-care hours are linked to lower rates of facility placement.

COMMUNITY TENURE

~8 months longer

Earlier initiation of support helped participants remain at home longer.

COST SIGNAL

$15K–$57K lower

Per person per year in selected HCBS vs institutional-care comparisons.

SATISFACTION

62% → 92%

Satisfaction with living arrangement rose after facility-to-community transitions.

RESPITE

Meaningful dose

Substantial respite helps reduce caregiver strain.

Findings vary by population and program. Most evidence is observational.

How Home-Based Care Creates Value

Value is most credible when home support substitutes for high-cost settings or prevents acute and crisis utilization.

1 Prevent avoidable utilization

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

2 Extend days at home

Sufficient home- and community-based services can delay or prevent nursing home placement; earlier initiation extends community tenure.

3 Stabilize function and safety

Continuity, self-direction, and reliable caregiver assignments are associated with maintained daily functioning and fewer falls.

4 Sustain family caregivers

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

A Credible Savings Message

Home-based services can generate programmatic savings, but savings do not accrue from access alone.

Strongest cost case

Direct comparisons show lower per-person LTSS costs when home support substitutes for nursing facility care.

Target and measure

Focus on people at meaningful risk of hospitalization, ED use, post-acute care, or facility placement, and measure service delivery, outcomes and costs together.

Monitor offsets

Track whether new home-based care spending substitutes for higher-cost care, recognizing that savings may appear in a different budget than the one funding the service.

Do not overclaim

Expanding access to needed services may increase total spending when newly served people were not otherwise likely to use institutional care or crisis care in the near term.

A credible value case verifies delivery. Compare authorized, delivered, documented, and billed services, then assess outcomes and costs together.

The fiscal case is strongest when support starts early, is sufficient to meet daily needs, and is evaluated against avoided higher-cost care and participant experience.

Six Policy Levers for High-Value LTSS

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.

Stabilize the workforce

Use rates, wages, training, backup capacity, and continuity standards to support reliable delivery and stable aide relationships.

Measure outcomes, service delivery, and substitution

Reconcile authorized and delivered care. Track service timeliness, caregiver preparedness, readmissions/ED use, days at home, crises, facility use, costs across payers, and net episode costs.

Maintain flexible service delivery options

Preserve participant choice in models, including self-direction and paid family caregiver options, with oversight that ensures accountability.

Make respite meaningful

Treat respite as essential system capacity; support must be substantial enough to reduce caregiver strain.

Enable safe transitions and intervene before crises

Use shared discharge plans, prompt service start/resumption, caregiver preparation, and a named clinical escalation contact. Respond to declining function or caregiver strain before emergency or facility care becomes the default.

Together, these levers make home-based services accessible, adequate, reliable, person-centered, and accountable for results.

Across all six levers: verify delivery, bill accurately, protect program integrity, and preserve choice.

CALL TO ACTION

What Stakeholders Can Do

State Medicaid agencies & legislators

Set benefit and rate policy that supports adequate hours and workforce stability; compare authorized, delivered, and billed services, missed visits, and unmet need; prioritize populations at meaningful risk of facility use.

Health plans & MLTSS organizations

Identify unmet daily-living needs early; contract for continuity, backup coverage, and participant direction; tie value-based incentives to days at home, acute use, and member experience.

Local aging, disability & community funders

Use flexible dollars for respite, homemaker support, caregiver navigation, and transition stabilization before families reach burnout or rely on emergency care.

Cross-payer & dual-eligible partnerships

Align Medicaid HCBS with Medicare acute and post-acute strategies, D-SNPs, PACE, and VA programs; share data and track offsets so value is not lost across budget silos.

PART TWO · MODERATED PANEL

Value-Based Care and the Future of Home-Based Services

A conversation on the current state of value-based care, why it matters, and how home-based care can fit into and benefit from the shift to value.

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INTRODUCTIONS

Today's Panel



MODERATOR

Boyd Brown

Associate Principal, HMA

Moderates today's discussion and presents highlights from the white paper on the value of home-based personal care services.



PANELIST

Amy Bassano

Managing Director, Medicare, HMA

Nationally recognized value-based care expert; former Deputy Director of the CMS Innovation Center (CMMI), where she oversaw Medicare and Medicaid value-based payment models.



PANELIST

Cara Henley

Regional Director, New York, HMA

New York Medicaid policy expert, with focus on policies delivery systems, behavioral health, LTSS, managed care, and value-based payment; former director of insurance and managed care for the Healthcare Association of New York State.



PANELIST

Don Novo

Regional Director, California, HMA

Expert in Medicaid, Medicare, and systems reform, including PACE and home-based services; former CMS Medicaid Program Branch Chief overseeing Region IX, including California.

The Value-Based Care Landscape in 2026

2030

THE FEDERAL GOAL

In 2021, CMS set a goal for 100% of Traditional Medicare beneficiaries, and most Medicaid beneficiaries, to be in accountable care relationships by 2030; roughly half of Traditional Medicare is there today.

Risk

THE BAR IS RISING

The CMS Innovation Center's 2025 strategy emphasizes prevention, patient empowerment, and protecting taxpayers, with a push towards greater financial risk.

Home

HOME IS IN FOCUS

The 10-year LEAD ACO model prioritizes high-needs, dually eligible, and homebound populations, and CMS's strategy names "days at home" as an outcome to measure.

States

STATES ARE TESTING

Half of states use managed LTSS. Some reward plans for keeping people at home, and some are paying home care providers for outcomes.

Even where states use managed care, personal care is still mostly paid by the hour or visit, not for results.

Sources: CMS ACO fact sheet (Jan. 2025); CMS Innovation Center 2025 Strategy; CMS LEAD overview; NASHP (Oct. 2025, 25 MLTSS states as of July 2025); state agencies: AHCCCS (AZ), PA DHS Community HealthChoices, WI DHS Family Care.

Where Home-Based Care Fits in Value-Based Care

WHAT VALUE-BASED MODELS NEED

- Fewer avoidable admissions, readmissions, and ED visits
- More days at home for frail and high-needs populations
- Better member and caregiver experience scores
- Lower total cost of care across payer boundaries
- Reliable data on function, risk, and daily life

WHAT HOME-BASED CARE DELIVERS

- Daily-life stability that prevents crises before they start
- The clearest pathway to institutional diversion and community tenure
- Person-centered, participant-directed care that helps families sustain caregiving
- Caregiver capacity that no other benefit sustains
- Eyes in the home, i.e. early detection of decline, risk, and unmet need
- Post-discharge stabilization: timely daily-living support, caregiver preparation, and coordination with the clinical team.

Home-based care is positioned to be a value driver inside accountable arrangements, if payment, measurement, and data connect it to the outcomes that matter.

STATE ACTIVITY

Where Value Reaches Home Care

	STATE → PLAN *(Value-based purchasing)*	PLAN → PROVIDER *(Value-based arrangements)*	HOME CARE RESULT
AZ ALTCS	Capitation with tiered profit/loss reconciliation	Required DAP rate increases for qualifying HCBS providers	**Higher rates for meeting DAP criteria**
PA CHC	$100M P4P pool: NH transitions, self-direction	Personal assistance agencies: pay for fewer preventable admissions	**Paid for fewer hospital admissions**
WI Family Care + Partnership	P4P, 2018–2023: satisfaction, employment, assisted living, community connections	State-directed rate & workforce funding reaches home care *P4P remains at plan level*	Indirect relationship: no direct home-care P4P payment confirmed

States create the incentive. Few plans pass it to home care providers.

BEYOND HOME CARE: HCBS value-based models in other services

TN ECF CHOICES
Employment payments tied to outcomes

TX STAR+PLUS
50% of plan payments in APMs

IN PathWays
Facility incentives for transitions to HCBS

LA I/DD waivers
Approved incentives for staff retention
Fee-for-service

Sources: AHCCCS ACOM 301 & DAP CYE 2027, PA DHS, WI DHS WLTCAC (Sept. 2023), TennCare, TX HHSC, Anthem PathWays outcome-based programs, LA OCDD memo OCDD-P-25-019 (Oct. 1, 2025).

Questions for Our Panel

1 State of play

Where is VBC in LTSS today and what has driven the shift to value?

2 Reaction to the findings

Which evidence signals and policy levers resonate most from your state vantage point, and where are the gaps?

3 Getting value to home care

Where does VBC stand in HCBS, and what makes home care an opportunity? Are there state examples that show the possibilities for VBC in HCBS?

4 Making it work

What would it take, data, measures, contracting, risk capacity, for home-based care providers to succeed in value-based arrangements?

5 The next 24 months

What should states, plans, providers, and community partners do now to move home-based care into value?

Key Takeaways on Value and Home-Based Care

- Timely, adequate home-based support can preserve independence, sustain family caregivers, and create value for people receiving care and health care funders.
- Reliable delivery is essential: sufficient hours, a stable workforce, meaningful respite, and participant choice help translate access into better outcomes.
- Savings depend on replacing higher-cost care or preventing avoidable crises. Expanding access alone does not guarantee lower total spending.
- Value-based payment must reach home care providers. Connect incentives to verified service delivery, days at home, participant experience, and costs across payers.

AUDIENCE Q&A

Questions & Discussion

Submit your questions using the Q&A window. We'll get to as many as time allows.

CONTINUE THE CONVERSATION

- The white paper, The Value of Home-Based Personal Care Services, will be shared with all registrants following the webinar.
- Explore HMA's value-based care insights, webinar replays, and the Vital Viewpoints podcast at healthmanagement.com/insights.
- A brief post-webinar survey will follow - your feedback shapes future sessions.

Thank you for joining us. | Hosted by Health Management Associates (HMA), in partnership with TEAM Services Group

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KEEP EXPLORING

HMA on Value-Based Care: Public Resources

Today's discussion draws on HMA's ongoing public work on value-based care. All resources are freely available at healthmanagement.com/insights.

WEBINAR REPLAY

The VBC Landscape: Analysis into Action

HMA and Wakely experts review the nation's progress on value-based payment and what's next for the CMMI model portfolio and risk-bearing entities. (Nov 2025)

WEBINAR REPLAY

Operationalizing New CMMI Models

How safety net providers, health systems, and community-based organizations can seize opportunities under CMS's newest value-based models. (May 2026)

ANALYSIS

CMS's New Innovation Agenda & the LEAD Model

HMA's read on the Innovation Center's refreshed strategy including downside risk, prevention, consumer empowerment, and the 10-year LEAD ACO model focused on duals and homebound populations.

PODCAST

Vital Viewpoints: The Next Era of Medicare Innovation

Featuring today's panelist Amy Bassano on why value-based care is complex, why scaling models is hard, and where Medicare innovation is headed.

REPORT

2026 Duals Integration Environmental Inventory

How states are using Medicaid policy levers, including enrollment, procurement, and contracting, to drive Medicare-Medicaid alignment for dually eligible populations.



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