CHCF Issue Brief

OCTOBER 2025

ATI Advisory

How Could Cuts to Medi-Cal Home and Community-Based Services Impact California?

Executive Summary

As federal legislation and state budget shortfalls put pressure on California's Medi-Cal program, policymakers will face hard decisions on how to deploy existing resources. This brief explores how cuts to one part of the system could have the unintended consequence of raising other costs for the state.

Quick Numbers

Among Medi-Cal enrollees who meet a "nursing facility level of care" in 2025:

- 56,000 are nursing facility residents.[1]
- Nearly 500,000 are served in five key Medi-Cal home and community-based services (HCBS) programs (see text box).[2]

Key Takeaways

- Medi-Cal, California's Medicaid program, faces threats from federal legislation and state budget shortfalls. This puts optional Medicaid services — such as HCBS — at risk for cuts.
- HCBS help older adults and people with disabilities get the support they need with daily activities like bathing and using the toilet, enabling them to stay in their homes and communities instead of moving to nursing facilities. Most people prefer HCBS over nursing facility care. HCBS also cost much less per person than nursing facility care.
- CHCF engaged ATI Advisory to develop a model to analyze what might happen if California cuts Medi-Cal funding to five key HCBS programs. The analysis finds that a 10% cut to those programs for people who require a nursing facility level of care would likely result in:
  - **Higher net costs to the state** as more people would need to receive care in nursing facilities. The analysis shows that if such cuts were made and just 3% of HCBS recipients at a nursing facility level of care transitioned to nursing facilities, the state would see a net spending increase of $57 million in the first year.[3] The rate of financial impact of these cuts would increase over time. Because the costs of nursing facility services increase at a higher rate compared to HCBS, the state would see a total net spending increase of $1.17 billion over the subsequent five years.[4]
  - **Unmet care needs** if more than 3% of HCBS recipients need nursing facility care after HCBS cuts, as California would not have enough nursing facility beds to meet this potential higher demand. If nursing facility beds are filled, people who need this level of care could lose access to both HCBS and nursing facility care. Hospitals may face increased difficulty discharging patients who need rehabilitative or post-acute care services in a facility.[5]

The Five HCBS Programs in This Analysis

The HCBS programs included in this analysis are In-Home Supportive Services (IHSS), the Home and Community-Based Alternatives (HCBA) Waiver, Community-Based Adult Services (CBAS), the Assisted Living Waiver (ALW), and the Multipurpose Senior Services Program (MSSP).[6] Other essential HCBS programs, including those specifically focused on people with intellectual and or developmental disabilities, are not included in this analysis.

Why This Matters: Potential Impacts of HCBS Cuts

Medi-Cal's HCBS programs are an essential source of support for many people who might otherwise need to live in nursing facilities. But while states must provide nursing facility services for Medicaid enrollees who require them, HCBS programs are optional Medicaid benefits. States have more flexibility to make cuts to optional services when state budgets are tight. In light of anticipated reductions in federal Medicaid funding and ongoing state budget challenges, this analysis models what would happen if California were to cut Medi-Cal HCBS program slots or allowable hours in an effort to save state dollars.

What are HCBS and LTSS?

Home and community-based services (HCBS) are a subset of long-term services and supports (LTSS). LTSS help people with activities like bathing, dressing, and eating — referred to as "activities of daily living" — when they have difficulty caring for themselves due to aging, disability, or a health condition.[7] People may also receive help with more complex tasks (referred to as "instrumental activities of daily living") like managing medications, preparing meals, or making medical appointments. Many Californians rely on Medi-Cal funding for LTSS in institutions such as nursing facilities or, for those who receive HCBS, in homes and community settings. HCBS help people avoid or delay nursing facility care.

Some Medi-Cal HCBS programs exclusively serve people requiring "nursing facility level of care" (NFLOC), who generally need comprehensive and continuous nursing care and services to support daily activities.[8] Other HCBS programs also serve people with a lower intensity of needs.

The model assumes that if California makes cuts to Medi-Cal HCBS, some Medi-Cal enrollees who meet nursing facility level of care (NFLOC) would lose access to these services, and some HCBS recipients would transition into nursing facilities. The model finds that HCBS cuts aimed at achieving state savings will likely instead increase state spending and strain system capacity due to increased nursing facility occupancy — trends that can be expected to continue in subsequent years.

This model demonstrates that cuts to optional HCBS programs could:

Increase California's Medi-Cal LTSS costs. The model considers the following scenario: The state cuts five HCBS programs for NFLOC recipients by 10% and, as a result, 3% of NFLOC HCBS recipients transition to nursing facility care.[9] The model estimates that this scenario would result in a net increase in California's spending on Medi-Cal LTSS of $57M in the first year.[10] Thus, the model finds that even a modest increase in nursing facility use due to HCBS cuts and reduced HCBS access would increase the state's Medi-Cal spending.

Fill all nursing facility beds. Reduced access to HCBS may require some older adults and people with disabilities who prefer to remain in their homes to enter nursing facility settings to receive the care they need, increasing statewide nursing facility demand. California's nursing facility supply is already constrained, and the number of beds is declining while the state's aging population grows.[11] As of 2024, estimates show there are only 16,123 unfilled nursing facility beds statewide (about 3 per 100 NFLOC HCBS recipients).[12] This analysis finds that shifting just 3% of the NFLOC HCBS population to nursing facilities would overwhelm nursing facility capacity, filling all currently unfilled beds.

As a result, reduced access to both HCBS and nursing facility care could also increase the risk of hospital discharge delays and the number of people experiencing accelerated functional decline.[13] Nursing facilities are a crucial part of post-hospital care, and the modest transition of 3% of Medi-Cal NFLOC HCBS recipients to nursing facilities could complicate hospital discharges not only for Medi-Cal enrollees, but for people with all

types of insurance coverage who need rehabilitative or post-acute nursing facility care.[14] Limited nursing facility availability and reductions in HCBS will likely also increase reliance on family caregivers, which could exacerbate caregiver burnout and impact caregivers' abilities to work outside the home. And with new federal work requirements for certain Medi-Cal enrollees, caregivers' future access to Medi-Cal coverage may be hindered.

Drive downstream impacts on HCBS recipients' quality of life. Beyond increasing Medi-Cal LTSS spending, cuts to California's HCBS programs could negatively impact the quality of life of people and caregivers who depend on these services. A 2021 AARP survey found that 77% of adults age 50 and older prefer to remain in their homes as they age, and HCBS honors those strong preferences.[15] Numerous other reports show that HCBS can enhance well-being, reduce depression, and improve self-reported health status among recipients.[16]

Increase Medi-Cal LTSS costs for California over time. The model indicates that state budget burdens would continue to amass for many years following the initial policy decision to reduce HCBS access. If California were to sustain a 10% cut to the five HCBS programs included in the model between 2026–2030, the state's Medi-Cal LTSS costs would increase by an estimated $1.17 billion. That's because nursing facility costs have a faster projected growth rate than those of HCBS. This model only reflects the cost of people transitioning to nursing facilities up to the available amount of beds; it does not account for additional likely impacts of hypothetical HCBS cuts, which may include unmet HCBS needs, increased risk of longer hospital stays, and other LTSS costs under Medi-Cal. The model also does not factor in the possibility that the supply of nursing facility beds may grow to meet increased demand.

While the model focuses on the NFLOC population, cuts could also impact HCBS recipients with lower levels of care need. For them, HCBS cuts could make it harder to live independently, consequently accelerating their functional decline. As a result, this cohort would be more likely to require nursing facility care sooner, leading to higher state spending in the longer term.

Shining a Light on Potential Cuts: Policy Context and Modeling Approach

States are expected to face increased budgetary pressures for their Medicaid programs following the federal passage of H.R. 1 in July 2025.[17] In California, Medi-Cal accounts for approximately 15% of all General Fund spending.[18] With federal funding cuts, policymakers may explore ways to reduce Medi-Cal spending. Among Medi-Cal LTSS — which are jointly funded through federal, state, and, in some cases, county funds — nursing facility services are mandatory per federal requirements, but most HCBS are optional services that states can elect to provide. In addition, states have discretion to expand income eligibility for people who require LTSS. Given budgetary pressures, states might reduce available HCBS or cut optional eligibility categories for LTSS recipients. This has been done during previous budget downturns: Following the Great Recession, every state cut eligibility or service spending in one or more of its HCBS programs between 2010 and 2012.[19]

With this context in mind, the model considers how reduced HCBS might impact the NFLOC population — whose members have the greatest care needs and are most likely to immediately enter nursing facility care in the absence of HCBS — and estimates the resulting cost implications for California. The analysis conservatively assumes that only a small percentage of NFLOC HCBS recipients would transition to nursing facility care after HCBS cuts. Some HCBS recipients who lose access to care may instead increasingly rely on informal supports, such as unpaid family caregivers, or forgo needed supports altogether.

Specifically, the model:

- Examines changes in net state spending following a 10% reduction in hours for In-Home Supportive Services (IHSS) recipients and a 10% reduction in available slots for the other four featured HCBS programs
- Analyzes changes in net spending on the NFLOC population across the five analyzed HCBS programs
- Demonstrates the likely financial implications of 3% of all NFLOC HCBS recipients transitioning to nursing facility care after the above described HCBS cuts
- Accounts for the state's nursing facility capacity, which in 2025 constituted 16,123 unfilled nursing facility beds.[20] The model estimates net state spending based on the state reaching full occupancy of all nursing facility beds due to 3% of NFLOC HCBS recipients transitioning to nursing facility care in response to HCBS cuts.

Figure 1. HCBS Program Recipients Meeting NFLOC Requirements, Estimated Per Day, 2025

Notes: *ALW* is Assisted Living Waiver; *CBAS* is Community-Based Adult Services; *HCBA* is Home and Community-Based Alternatives Waiver; *HCBS* is home and community-based services; *IHSS* is In-Home Supportive Services; *MSSP* is Multipurpose Senior Services Program; *NFLOC* is nursing facility level of care. Waiver recipients (ALW, HCBS, and MSSP) were approximated by the number of available waiver slots in 2025.

Sources: "In-Home Supportive Services (IHSS) Program Data: Monthly IHSS Program Data," California Department of Social Services, May 2025; "CA Assisted Living Waiver (0431.R04.00)," US Centers for Medicare & Medicaid Services (CMS), February 16, 2024; "CA Home and Community Based Alternatives Waiver (0139.R06.00)," CMS, March 25, 2025; "CA Multipurpose Senior Services Program Waiver (0141.R07.00)," CMS, September 26, 2024.

The analysis of 2025 net spending across five HCBS programs and nursing facility care incorporates a set of assumptions, including the number of program recipients per month (and the potential for growth over time), the percentage of the population meeting NFLOC requirements, the propensity of that population to enter nursing facility care, the average number of service hours used monthly per recipient, average hourly service costs, and California's share of total program costs. Future projections (2026–2030) account for projected price growth for each HCBS program and for nursing facility rates.

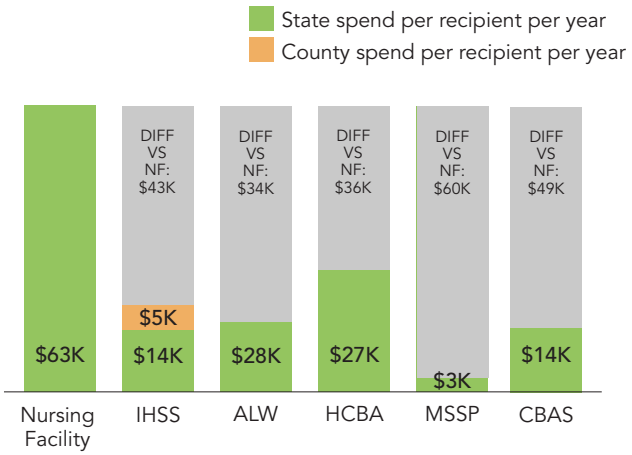
Please refer to the **Technical Appendix**, available on the CHCF website, for more comprehensive information on the assumptions built into the financial model.

Deep Dive: Comparing Nursing Facility Use and Costs with Five California HCBS Programs

The five analyzed HCBS programs serve nearly 500,000 Californians meeting NFLOC requirements. The IHSS program has the largest NFLOC enrollment by a considerable margin: Its NFLOC recipients make up 89% (443,000) of the five modeled HCBS programs' combined recipient populations (see **Figure 1**, left). Both the state and counties contribute to California's share of IHSS funding, and any potential funding cuts would have an outsized influence on state spending.

The financial model focuses on the costs of services to California. Nursing facility care costs California between $34,000–$60,000 more per recipient per year than HCBS for NFLOC users, based on estimated average costs in 2025 (see **Figure 2**, next page). Those estimates do not include federal spending. Combined, state and federal Medi-Cal nursing facility care costs are $62,000–$113,000 more per recipient per year than HCBS for NFLOC recipients.

Figure 2. California Spending on HCBS vs. Nursing Facility Care for NFLOC Recipients, Estimated Per Recipient Per Year, 2025



Notes: *ALW* is Assisted Living Waiver; *CBAS* is Community-Based Adult Services; *HCBA* is Home and Community-Based Alternatives Waiver; *HCBS* is home and community-based services; IHSS is In-Home Supportive Services; *MSSP* is Multipurpose Senior Services Program; *NF* is nursing facility; *NFLOC* is nursing facility level of care. Estimates exclude federal Medi-Cal contributions. As counties only contribute financially to the IHSS program, county spending is shown separately from state spending.

Sources: Juwan Trotter, "The 2025-26 Budget: In-Home Supportive Services," Legislative Analyst's Office, March 6, 2025; "CA Assisted Living Waiver (0431.R04.00)," US Centers for Medicare & Medicaid Services (CMS), February 16, 2024; "CA Home and Community Based Alternatives Waiver (0139.R06.00)," CMS, March 25, 2025; "CA Multipurpose Senior Services Program Waiver (0141.R07.00)," CMS, September 26, 2024; *CBAS: Billing Codes and Reimbursement Rates*, California Department of Health Care Services (DHCS), last updated February 2023; and "Freestanding Nursing Facility Level-B (FS/NF-B) Rates on File for Dates of Service January 1, 2025–December 31, 2025," downloadable Excel file, DHCS, accessed July 25, 2025.

Conclusion

Rather than saving the state money, cuts to the five Medi-Cal HCBS programs included in this model could pose state budgetary risks and threaten statewide care availability. California should carefully consider the unintended consequences of HCBS program cuts, which may include increased costs to the state, negative impacts on Medi-Cal enrollees' quality of life, and nursing facility bed shortages.

About the Author

ATI Advisory is a health care research and advisory firm dedicated to system reform that improves health outcomes and makes care better for everyone. ATI guides public and private leaders in solving the most complex problems in health care through objective research and deep expertise and bringing ideas to action.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. Projected estimates of Medi-Cal nursing facility residents used the compound annual growth rate projection formula and a 2021 state-reported daily census count of Medi-Cal nursing facility residents.
2. The 2025 count of Medi-Cal recipients across five of the state's HCBS programs was calculated using the sum of May 2025 reported In-Home Supportive Services (IHSS) enrollment count, a May 2025 reported Community-Based Adult Services (CBAS) enrollment count multiplied by the percentage of program enrollees with Medi-Cal, and the maximum number of 2025 waiver participants for the Assisted Living Waiver (ALW), the Multi-Purpose Senior Services Program (MSSP), and the Home and Community-Based Alternatives (HCBA) Waiver.
3. The modeled 10% cut to HCBS spending for individuals with a nursing facility level of care (NFLOC) would represent a cut of $2.1 billion in total Medicaid spending and $951 million in non-federal Medicaid spending. The number of NFLOC HCBS recipients modeled as entering nursing facilities is 16,123, which is approximately 3% of this population.
4. Under the model, the first year reflects 2025 prices, and the next five years project 2026–2030 price growth for nursing facility care and each modeled HCBS program.
5. ATI's financial model reflects spending implications associated solely with the transition of NFLOC HCBS recipients into nursing facilities due to HCBS cuts.
6. Other Medi-Cal HCBS programs include California Community Transitions (CCT), the Self-Determination Program (SDP) for Developmentally Disabled, and HCBS for the Developmentally Disabled.
7. "Long-Term Services and Supports," Medicaid and CHIP Payment and Access Commission (MACPAC), January 12, 2021.
8. 22 California Code of Regulations (CFR) § 51124.
9. Cuts to HCBS may occur in the form of cutting hours provided in In Home Supportive Services (IHSS) by 10%, reducing days in Community-Based Adult Services (CBAS) by 10%, and reducing slots in the remaining three waiver programs MSSP, HCBA, and ALW by 10%.
10. Based on analysis of public data from California state agencies, governor's budget projections, waiver projections, and MACPAC NF average spending data. Model results represent first-order impacts, focus on spending on the NFLOC HCBS population, and assume that 3% of NFLOC HCBS recipients who leave HCBS convert into NF residents. Under the model, the first year reflects 2025 prices, and the next five years projects 2026-2030 price growth for nursing facility care and each modeled HCBS program.
11. *Long-Term Care in California – 2024 Edition*, CHCF, December 2024.
12. *Long-Term Care Facilities Annual Utilization Data*, California Health and Human Services Agency (CalHHS), May 5, 2025.
13. *Recommendations of the Joint Task Force on Hospital Discharge Challenges* (PDF), Oregon Joint Taskforce on Hospital Discharge Challenges, November 12, 2024.
14. Antonio Rojas-Garcia, "Impact and Experiences of Delayed Discharge: A Mixed-Studies Systematic Review," *Health Expectations* 21, no. 1 (Aug. 2017): 41-56.
15. "Where We Live, Where We Age," AARP, November 18, 2021.
16. Xuanru Lyu et al., "The Impact of Home- and Community-Based Services on the Health of Older Adults: A Meta-Analysis," *Sage Open Journal* 14, no. 3 (July 2024).
17. The One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025).
18. *The 2025-26 Budget: Medi-Cal in the May Revision* (PDF), California Legislative Analyst's Office, May 19, 2025.
19. Jessica Schubel et al., "History Repeats? Faced With Medicaid Cuts, States Reduced Support for Older Adults and Disabled People," Health Affairs Forefront, April 16, 2025.
20. *Long-Term Care Facilities Annual Utilization Database*, CalHHS.