GUBMENT POLICY WHITEPAPER NO. 7 · SERIES GBMT-7 · FILED 2026-08-03

Elder care: does workforce or funding actually cap home care?

A feasibility assessment of long-term services and supports for older Americans — the workforce-vs-funding test this inquiry was built to settle, a federal staffing rule killed twice, and the one architecture in the whole candidate set with a real trial behind it.

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ABSTRACT

This inquiry set out to test whether direct-care workforce capacity, not Medicaid funding, is the binding constraint on home- and community-based care — the same shape of finding our childcare and housing reports reached in their own domains. The best available natural experiment, a 2021 funding surge routed mostly to the direct-care workforce, produced a pattern consistent with that theory but equally explained by economy-wide post-pandemic wage inflation; we could not tell the two apart, and report the hypothesis INDETERMINATE rather than confirmed. That evidence base is also mostly not about older people — a majority of the Medicaid home-care users and waiting-list entrants it rests on are under 65 — a scope we should have stated when we filed and did not. Separately, the federal nursing-home minimum-staffing rule finalized in 2024 was vacated by two courts and mooted by a congressional moratorium running to September 30, 2034 — dead, not merely contested. Of nine candidate policy architectures scored against cost, quality, workforce, caregiver relief, and autonomy, only one is anchored in a genuine randomized controlled trial: Cash and Counseling, a self-direction program that lets Medicaid beneficiaries pay family members directly. It does not win under every objective weighting once its own documented cost increase is scored honestly — a correction we made to our own first-pass scorecard on independent re-score, and report rather than smooth over. A second, structurally blinded re-score then moved 25 of the scorecard's 40 cells and forced us to withdraw the finding we had stated most confidently: our scoring scale marked instruments down for being under-researched, and the architecture we declared a clear loser turned out to have almost no evidence behind it in either direction. Corrected, most of the board sits at neutral. A subsequent steelman pass, run against the three claims this filing makes loudest, withdrew two of them: that the best-evidenced fix is one nobody is proposing — it has been federal law

since 2005, carries a six-point federal match bonus, and about 1.5 million people already use it — and that our headline verdict, "Medicare mostly doesn't pay for this," holds as stated. It holds for custodial care, which is a statutory exclusion; it does not hold for paid elder care, where Medicare is the largest single payer of home health in the country. That pass also found that the statute we cite for killing the staffing rule contains a partial enactment of the very architecture we scored as untried. We conclude the domain's conventional wisdom is less settled than either political party assumes — that our own scorecard was more confident than its evidence, and that we read our own sources in one direction — and stamp all three uncertainties in the text.

PART 1

The baseline: Medicaid pays for this, not Medicare — and only after the savings are gone

56%
WILL NEED SEVERE LTSS

$415B
TOTAL US LTSS SPENDING

61%
MEDICAID'S SHARE

$209M
OAA TITLE III-E CAREGIVER PROGRAM

More than half of Americans turning 65 will develop a severe long-term-care need before death — 56% under HHS's current microsimulation model. The 70% figure still in circulation is also HHS's, from an older survey-based study with a different definition; cite the 56% and say which model it came from. Medicare covers acute and narrow post-acute care; it is not the long-term-care payer

most people assume. Medicaid, reached only after a household spends down its assets, covers 61% of the $415B this country spends annually on long-term care; within Medicaid specifically, home- and community-based spending overtook institutional spending in 2013. That 61% is KFF's *long-term services and supports* construct, which excludes Medicare post-acute care by definition — and we should have said so, because the other standard construct answers differently. In CMS's National Health Expenditure Accounts for 2024, Medicare is the **largest single payer of home health care in the country** ($55.7B of $169.4B, 32.9%, ahead of Medicaid's 22.6%) and the third-largest payer of nursing-facility care ($47.3B of $219.9B, 21.5%). Across both settings Medicare pays 26.5 cents of every dollar to Medicaid's 30.1. No single canonical "LTSS spending" figure exists — federal accounting categories mix short-stay Medicare rehab with long-stay Medicaid custodial care, and we previously named that problem only in the direction that understates Medicaid, never the one that understates Medicare.

ASPE 2022 (DYNASIM4) · KFF, 10 Things About LTSS · CMS National Health Expenditure Accounts

> PLAIN TALK
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> Most people think Medicare pays for someone to help them wash and dress at home indefinitely. It doesn't — the law bars it (42 U.S.C. §1395y(a)(9) excludes "custodial care"), and Medicaid picks that up only after a family has spent down its savings. But Medicare pays for a great deal of the short-term nursing-home and home-health care around it — more of the nation's home-health bill than any other payer. Two different things; we ran them together.

PART 2

The worker problem: wages rose, vacancies didn't fall, and nobody's proven which caused what

INDETERMINATE

$37.1B
ARPA HCBS FUNDING, 2021

71%
TO RECRUITMENT & RETENTION

710K+
ON HCBS WAITLISTS, 2024

36.5%
HOME HEALTH AIDES FOREIGN-BORN

The best natural experiment available is a 2021 funding surge — $37.1B in state and federal money that states *planned* to spend, 71% of it on workforce recruitment and retention: provider rate increases, wage add-ons and hiring bonuses, not wages alone. Wages moved substantially where states spent it that way — Colorado's direct-care wage rose from $12.41 to roughly $18/hour — but vacancy and turnover did not improve to match, and the national HCBS waiting

list did not fall: it has sat at roughly 0.7 million in most years since 2016, and stood above 710,000 in 2024.

MACPAC, Implementation of ARPA §9817 (2026) · KFF 50-state HCBS surveys

That pattern fits the workforce theory. It equally fits economy-wide, sector-agnostic wage inflation touching nearly every low-wage service job in 2021–2024 — a confound nobody has ruled out. The program carried no evaluation requirement, and the federal assessment that could settle this is still pending. The honest verdict is open, not proven.

Two things we should have said the first time. Only 5% of that money ($1.7B) was aimed at waiting lists at all, so a flat waiting list is weaker evidence against the funding theory than we made it sound. And this is Medicaid home-care data, which is mostly not elder-care data: 63% of Medicaid home-care users are under 65, and most people on these waiting lists have intellectual or developmental disabilities. Both facts are in our own sources; neither was on this page.

> PLAIN TALK
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> More than a third of home health aides are foreign-born — roughly twice the rate for the workforce overall, on 2019 census data — and real 2025–2026 immigration-enforcement changes have hit this sector already, but so far that's fear-driven absenteeism reported locally, not a measured national decline. Two different claims; don't merge them.

PART 3

Money and insurance: the last federal program died before it opened; the new one has no track record yet

The CLASS Act, a federal long-term-care insurance program enacted in 2010, collapsed in 2013 without ever enrolling a person, opening a claim, or collecting a premium — HHS's own 19-month review found voluntary signup let only the sickest people buy in, and no benefit design could price around it. Washington State's WA Cares removes exactly that channel with a mandatory 0.58% payroll tax, but its $36,500 lifetime cap versus CLASS's proposed open-ended benefit means the two programs are not a clean contrast — a design that fails on adverse selection and one that fails on an inadequate benefit could look identical from outside. WA Cares benefits first became payable on July 1, 2026, weeks before this report; there is no outcome data yet.

HHS actuarial review of CLASS (2010–11) · American Taxpayer Relief Act of 2012 · Washington ESD, WA Cares Fund

CONFOUNDED NATURAL EXPERIMENT

A softer fix was tried and didn't pencil out: Washington modeled a state reinsurance backstop for private insurers instead of a public benefit, and its 2015 feasibility study found "little potential to generate savings" — suggestive evidence against that specific design, from one state, reported

secondhand, not a verdict on every possible reinsurance mechanism. The standalone individual LTC insurance market has shrunk from 125 carriers (2000) to roughly 7–10 today.

> PLAIN TALK
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> The last federal long-term-care insurance program collapsed because only sick people signed up. Washington's mandatory tax fixes that specific problem — but its benefit is also smaller and capped, so we don't yet know if it actually works or just fails differently.

PART 4

Who's waiting, and why: nursing homes are a legal right, home care is a waiting list

Nursing home care is a mandatory Medicaid entitlement; home- and community-based care runs through optional, capped waivers with waiting lists in most states — backwards from the "home care is cheaper, so of course it's prioritized" intuition. The national waitlist was undersold in this project's own starting assumptions: roughly 710,000 people by 2024, about 40% above the seeded prior. Indiana matches the theory: a waitlist that grew from 12,800 to over 17,000 in nineteen months, atop a spending mix sending two-thirds to three-quarters of Medicaid long-term-care dollars to institutional care. But it is one state, and the state most commonly cited for this argument — Texas — is the one state where the relevant spending data is unknowable, excluded from the two national trackers that would answer the question.

KFF, Waiting Lists for Medicaid HCBS 2016–2024 · Indiana FSSA/DDARS · AARP LTSS State Scorecard

CONSISTENT, NOT CONFIRMED

Two things we left out, and the second one is ours to own. First, the cap has a reason: Congress made home care available by waiver on the statutory condition that it cost no more per person than the institutional care it replaces (42 U.S.C. §1396n(c)(2)(D)). Limiting enrollment is one of the two levers a state has to meet that test — so a waiting list is partly what a budget-neutral optional benefit looks like, not only what a preference for institutions looks like. Second, **Congress has already partly removed the cap, in the very statute we cite two sections up for killing the staffing rule.** Pub. L. 119-21 §71121 — in a subchapter titled "Expanding Access to Care" — lets the Secretary approve, from July 1, 2028, standalone waivers covering home care for people who *do not* meet the institutional level-of-care test, on state-set needs-based criteria, with $150 million appropriated to build the systems. We scored HCBS de-capping as though it were untried policy. It isn't. The enacted version also keeps the cost cap (the state must attest per-person spending won't exceed institutional per-person spending), requires that the new waiver not materially lengthen the wait for people already in the queue — Congress wrote queue competition into the law — and bars the money from paying for direct-care workers' health insurance or training where Medicaid is that class of practitioners' primary source of revenue.

PLAIN TALK

Money isn't obviously the problem — how it's structured might be. But that's one state's evidence, the state everyone actually argues about is the one where the numbers can't be checked, and the cap we called backwards is the price Congress attached to the benefit in the first place — a price it kept when it started lifting the cap in 2025.

PART 5

Institutional quality: the federal staffing rule is dead, twice over

PRIOR BROKEN

3.48
HPRD IN THE DEAD FEDERAL RULE

29
STATES BELOW 3.5 HPRD

+11%
MORTALITY AT PE-OWNED HOMES

The 2024 federal nursing-home minimum-staffing rule was not merely under litigation risk — it is dead. Two federal courts vacated it, Congress barred CMS from implementing it until September 30, 2034, and CMS formally repealed it effective February 2026. State law is the surviving lever, but it is an uneven one: before the federal rule existed there was no numeric federal staffing floor at all, and 29 states still require under 3.5 hours per resident day, 15 under 2.5. No state staffing law has been struck down — but New York shows statutory survival isn't enforcement: roughly 400 violating facilities identified with almost no penalties for years.

Federal Register (Dec 2025 repeal) · Pub. L. 119-21 §71111 · 42 CFR 483.35 · Health Affairs, March 2026, 22-state staffing panel

Separately, on much stronger evidence: private-equity ownership raised short-stay mortality by 11% for the patients steered into those homes, in a 4.2-million-patient study designed specifically to correct for which patients end up where. No direct econometric rebuttal has been found — and the authors themselves report the harm falls on a subset of patients, with small benefits for others.

Gupta, Howell, Yannelis & Gupta, Review of Financial Studies 37(4), 2024

PLAIN TALK

The federal rule meant to force better nursing-home staffing is dead — courts killed it, then Congress barred it until 2034. Separately: nursing homes bought by private equity have measurably higher death rates for the patients most likely to end up in them, and nobody has published a direct rebuttal.

PART 6

Assisted living's blind spot: still the smaller setting, and still uncounted

This inquiry assumed assisted living had overtaken nursing homes in resident count. The data says otherwise — roughly 1.24 million nursing-home residents versus 1.016 million in assisted living — but the comparison is three years stale on one side, and since nursing-home census is flat-to-declining while assisted living keeps growing, the actual current gap could be smaller or closed. What holds: the federal government still can't see this setting. GAO found in 2018 that 26 of the 48 states it studied couldn't report how many critical incidents happened in Medicaid-funded assisted living; GAO found in 2026 that Washington can't even count what it spends there — "at least $12 billion" in 2024, which GAO itself calls likely an undercount. Two different blind spots, eight years apart. The incident-reporting fix won't take effect until 2027 at the earliest.

CDC/NCHS NPALS (2022) · KFF/CMS CASPER (2025) · GAO-18-179 (2018) · GAO-26-107884 (2026)

> PLAIN TALK
>
> Assisted living is still smaller than nursing homes by headcount, not bigger as we first assumed — though the comparison is stale enough that the gap could have closed since. What's certain: nobody's counting assisted-living incidents properly yet, and nobody can say what the federal government spends there either.

PART 7

Family caregivers: no honest dollar figure, one genuine trial

KILL CONDITION FIRED

63M	$234B–$1.01T	19.6%
FAMILY CAREGIVERS, US	RANGE OF "THE" VALUE	CAREGIVERS W/ POOR MENTAL HEALTH

This inquiry's own kill condition fired: unpaid family caregiving's economic value cannot be reconciled to a single defensible figure. Independent, credible estimates run from $234 billion to $1.01 trillion — and part of that spread is simply that they measure different years, from 2011 data to 2024 data. Strip the calendar out and two estimates for the same era still differ by more than 2× ($234B and $522B), on population scope, wage-rate assumption, and hours source: three named, defensible methodological choices, not chaos. There is no "the" number.

AARP/NAC, Valuing the Invaluable (2026) · CBO (2013) · RAND (2014)

What is solid: 63 million Americans provide unpaid care, over a quarter reduced work hours because of it, and CDC's own national health survey shows caregivers reporting worse mental

health than non-caregivers, with the gap wider at the end of the last decade than the start — though that endpoint sits inside the pandemic, so read the level as solid and the trend as suggestive. The one architecture in this entire report anchored by an actual randomized controlled trial — Cash and Counseling, which lets Medicaid recipients hire their own caregivers, including family — measurably improved satisfaction and health. It did not save money; it delivered more of the authorized care rather than the same amount more cheaply.

CDC BRFSS Caregiver Module (2021) · ASPE, Cash and Counseling Demonstration

> PLAIN TALK
>
> There is no trustworthy single dollar figure for what family caregivers' unpaid labor is worth — that's a finding, not a gap. What's solid: caregivers report worse mental health than non-caregivers, and the one genuinely strong trial in this area says paying them directly works — it just isn't cheaper.

PART 8

What other countries did: three systems, all mid-crisis, none a finished blueprint

Germany, Japan, and the Netherlands are the usual comparators for LTC financing, and all three show real, current strain rather than a settled model to import. Germany's contribution rate rose again for 2025, and reporting says federal loans were needed to hold the 2026 rate steady — a claim we have not been able to source to a German government document, so treat it as reported rather than verified. Japan projects a 570,000-worker shortfall by 2040 and is already proposing copay increases toward 30%. The Netherlands' 2015 reform is documented as working against its own cost-containment goal, with a projected 266,000-worker shortfall by 2035. Score all three as donors of design fragments — partial coverage, age-40 pre-funding, severity-tiered financing splits — not whole-system precedents.

Geyer et al., NBER w31870 (German LTC structure) · MHLW 9th LTCI plan · PMC11984009 (Wlz)

> PLAIN TALK
>
> The three countries usually held up as models for funding elder care are all currently raising rates, proposing to tighten benefits, or short-staffed themselves — none is a finished blueprint to copy. What's exportable are pieces. One correction we owe: we previously put a "110% rise in German care vacancies" on this page and cited it to a paper that doesn't contain it. Withdrawn until we can source it.

PART 9

The scorecard: the best-evidenced fix is already law in every state, and nobody has measured whether scaling it

worked

ARCHITECTURE	COST	QUALITY	WORKFORCE	CAREGIVER RELIEF	AUTONOMY
FEDERAL LTC INSURANCE	2	3	2	3	3
HCBS DE-CAPPING	2	3	4	3	4
WAGE FLOOR	3	3	3	3	3
CASH & COUNSELING	1	3	3	5	4
CREDIT FOR CARING ACT	—	—	—	2–3	—
PACE EXPANSION	—	—	—	—	—
FEDERAL AL STANDARDS	3	3	4	3	3
OAA/NFCSP EXPANSION	3	3	3	3	3
PRIVATE LTC INS. REFORM	2	3	3	3	3
CASH (COMPARATOR)	3	3	3	3	3

Nine candidate architectures, scored 1–5 against five objectives. Only Cash and Counseling is anchored by an actual randomized trial rather than a projection, a single-state study, or plausibility. It wins decisively on caregiver relief regardless of weighting — but its own trial data show a real cost increase, so an honest scorecard lets that pull its cost-containment rank down too. It does not win "no matter what," and our first-pass scorecard overstated that it did.

Then a second, harder re-score moved 25 of these 40 cells, and the most important thing it found was how little this board actually knows. Our first re-score was told not to look at the scorecard; this one was structurally prevented from reaching it. It caught a defect in our own scoring scale: an architecture nobody had researched got marked *down*, because "no evidence found" was a low score while a high score required evidence. Twenty cells sitting at 1 or 2 turned out to rest on no evidence at all — in either direction. Corrected, 30 of the 40 cells sit at dead neutral, and the differences between most of these instruments disappear. **We are withdrawing the finding we stated most confidently:** that private long-term-care insurance reform "ranks last under all three weightings, with no exceptions — the clearest, most stable negative finding in the whole scorecard." Four of that row's five cells were empty. It was the least stable finding on the board, not the most. The wage floor also no longer leads on workforce, where it now ties the do-nothing cash comparator — which means our own sequencing argument gets no support from our own scorecard, and we say so rather than let the two look like they agree.

Then a steelman pass went after the three things this filing says loudest, and two of them broke. We had headlined this section "the best-evidenced fix isn't the one anyone's proposing."

That is withdrawn: it is false. Congress enacted the Cash and Counseling design as a permanent state-plan option in 2005 (42 U.S.C. §1396n(j)) and again in the ACA as Community First Choice (§1396n(k)), which pays states a **six-percentage-point** federal match bonus to adopt it. Self-direction now runs in all fifty states and DC and about **1.5 million people** use it, up 23% since 2019. Our own research file said so; this page said the opposite. Worse for us: the one study that evaluated the statutory version found **nothing** — the same paper we cite for this board's strongest positive cell reports no significant workforce effect for Community First Choice (1.51%, CI –12.77% to 15.79%) alongside the Balancing Incentive Program's +13.24%, and we published only the half that helped. The Cash and Counseling trial still stands, and it is still the only randomized evidence on this board. What falls is the idea that this is an untried fix waiting to be proposed. It has been law for twenty years, it has been scaled, and nobody checked.

One more, on the row we just moved to last place. Federal LTC social insurance ranks last under all three weightings on the corrected board, and we said it earned that "on evidence." One cell carries it: a workforce score marked down because Japan projects a 570,000-worker shortfall and the Netherlands 266,000. Those are facts about ageing countries, not measurements of what the insurance does — and the country *without* such a program, this one, faces 9.7 million direct-care openings over the same decade by our own anchor table. Score that cell at neutral, as our corrected scale says an unevidenced cell should be, and the row ties for last under all three weightings instead of holding it alone. We are publishing that as a sensitivity rather than changing the cell, but the honest summary is that our replacement headline rests on the same kind of thin cell as the headline it replaced.

9 architectures × 5 anchored objectives × 3 weightings · two independent re-scores, the second structurally blinded · a Phase 2 steelman against the verdict, the leading architecture and this headline · reconciliation log with both scale readings, committed

TWICE RE-SCORED; FACT-CHECKED; STEELMANNED; TWO HEADLINES WITHDRAWN

APPENDIX

The honesty box

The project's own headline hypothesis is unresolved. Workforce-vs-funding came back INDETERMINATE — the best available test has an unruled-out macro-wage-inflation confound. **Our scoring scale was broken, and it broke in one direction.** A cell could only score high on evidence, but scored low on the absence of it — so the instruments we researched least came out looking worst. That is why our most confident negative finding is withdrawn above. **The board is mostly flat.** Corrected, 30 of 40 cells sit at neutral; most of the apparent differences between these nine architectures were differences in how hard we looked, not in what the instruments do. **PACE is still unscored** — it now has two independent readings in the record, but entering it

needs criteria we wrote too late, and we are not backdating them. **Our best evidence has no row.** The strongest quality finding in this whole filing — an 11% mortality increase for patients steered into private-equity-owned nursing homes, in a 4.2-million-patient study — attaches to an architecture we never put on the board. **Our workforce evidence is mostly not about old people.** The Medicaid home-care spending, waiting lists and wage data behind Part 2 cover a population that is 63% under 65, and whose waiting lists are mostly people with intellectual or developmental disabilities. That does not make the INDETERMINATE verdict wrong; it does mean this filing tested its headline question on a broader population than its title implies. **Texas's numbers are unknowable, not just unfavorable. WA Cares has zero months of real performance data** — its first-ever benefit paid weeks before this report. **Twice re-scored, not final.** Two blind re-scores of a sibling filing moved entirely different cells; a third pass here would likely move cells both of ours agreed on. **We read our own sources in one direction.** A steelman pass found three places where a document we cite contains a second finding we did not carry across: the paper behind our strongest positive cell also reports a null for Community First Choice; the study we cite for "$0.74" is titled *Is there a "woodwork" effect?* and answers no, which is the best refutation of the main objection to our own leading architecture and we never published it; and the statute we cite for killing the staffing rule also contains a partial enactment of that leading architecture. Nothing was suppressed. Every time, the half that fit our frame got printed and the half that complicated it did not. **Our verdict was too broad.** "Medicare mostly doesn't pay for this" is right about custodial care, which is a statutory exclusion, and wrong as a statement about paid elder care — Medicare is the largest single payer of home health in the country, may buy non-health-related supports for chronically ill enrollees in plans covering 54% of beneficiaries, and has paid for dementia caregiver respite nationwide since July 2024. We have narrowed the verdict rather than defend it.

THE RECEIPTS · 11-workstream protocol (9 executed to findings) · pre-registered anchor table preserving our own corrected errors (we led with a 70% risk figure where the current model says 56%) · deviations log (37 entries; the digest on the sources page previously published 21 of the then-31, now all) · red-team pass (22 resolved items, run as a parallel workflow) · two independent scorecard re-scores, the second structurally blinded, with a reconciliation log that publishes both scale readings and one withdrawn headline · an independent Phase 1 fact-check (2026-08-10) against primary statute, rule and paper text, which corrected 40 claims across these pages and the record and is published in full · an independent Phase 2 steelman (2026-08-10) against the verdict, the top-ranked architecture and the scorecard headline, which withdrew two published claims and is published in full · all public.

CITE · Gubment. "Elder Care: Does Workforce or Funding Actually Cap Home Care?" Policy

Whitepaper No. 7, Aug 2026. gubment.com/elder-care · Sources & data: gubment.com/elder-care/sources