

Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2023

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Background

Federal Medicaid rules allow states to cover a wide range of institutional and home and community-based long-term services and supports (LTSS). States use a combination of different programs, types of services, and delivery models to serve people who need LTSS. This brief presents the national distribution of Medicaid users and expenditures across different home and community-based services (HCBS) and institutional categories for 2023,² based on data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).³ This brief also describes trends in HCBS and institutional users and expenditures between 2022 and 2023.

Key findings

- In 2023, 8.4 million HCBS users accounted for \$145.9 billion in HCBS spending. HCBS users and expenditures increased by 7.5 percent and 12.8 percent, respectively, from 2022 to 2023.
- In 2023, 1.5 million institutional service users accounted for \$82.7 billion in institutional spending. Institutional users and expenditures increased by 3.0 percent and 16.5 percent, respectively, from 2022 to 2023.
- Fee-for-service (FFS) accounted for 48.2 percent of LTSS users and 61.6 percent of LTSS expenditures in 2023, whereas managed care accounted for 59.1 percent of LTSS users and 38.4 percent of LTSS expenditures.¹

The following 10 HCBS categories used in this analysis include section 1915(c) waiver programs, section 1915(i) state plan HCBS benefit, section 1915(j) self-directed personal assistance services (PAS) option, section 1915(k) Community First Choice option, the Program of All-Inclusive Care for the Elderly (PACE),

¹ The percentage of users who received LTSS through FFS versus managed care does not sum to 100 because some beneficiaries received both FFS and managed care services at some point during the year.

² This analysis includes data for all 50 states and the District of Columbia. It does not include data for U.S. territories because they do not generally cover LTSS, and only three territories (Guam, Puerto Rico, and the Virgin Islands) report Transformed Medicaid Statistical Information System (T-MSIS) data.

³ For more information on the user and expenditure rebalancing ratios, refer to "Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures," available at

<https://www.medicare.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.

and the following section 1905(a) state plan benefits: personal care services, home health services, rehabilitative services, case management services, and private duty nursing services.^{4,5}

We defined four institutional categories that align with previously published expenditure analyses:⁶ nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), mental health facility, and mental health facility disproportionate share hospital (DSH) payments.^{7,8}

When interpreting findings, please note that completeness, quality, and consistency of the TAF data vary by state. To support interpretability of findings in this brief, we created LTSS TAF data quality measures to identify potential data quality issues that may affect states' LTSS expenditure and user results. These measures can be found in accompanying documentation.^{9,10}

⁴ We assigned each claim to one category, with program-based services, for which enrollment information exists, assigned first (including section 1915(c) waiver programs, section 1915(i) state plan HCBS benefit, section 1915(j) self-directed PAS option, section 1915(k) Community First Choice option, Money Follows the Person [MFP] demonstration, and PACE, followed by state plan benefits. State plan benefits refer to section 1905(a) state plan services. MFP demonstration services are included as an individual category in accompanying table output, but they are not included in the aggregate calculations of total HCBS or total LTSS expenditures or users in this brief. For more information about the categories of HCBS included in total user and expenditure calculations, refer to the document titled "Methodology for Identifying Medicaid Long-Term Services and Supports Expenditures and Users, 2019-2021," available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.

⁵ Sections 1915(c), 1915(i), 1915(j), and 1915(k) refer to section 1915 of the Social Security Act.

⁶ LTSS expenditure reports for prior years are available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.

⁷ Data for mental health facilities include institutions for mental diseases (IMD) for people ages 65 and older and inpatient psychiatric facilities for people younger than 21. In addition, data on mental health facilities may have included services furnished in accordance with section 1915(l) of the Act - services provided to Medicaid beneficiaries ages 21 through 64 who have at least one substance use disorder diagnosis and reside in an eligible IMD. Some states cover services for adults ages 21 to 64 in IMDs through section 1115 demonstration authority or as an "in lieu of service or setting" (ILOS) under managed care in accordance with 42 CFR 438.3(e)(2) and 438.6(e); however, we could not ensure this group was included in the mental health facilities category because there was no recommended (tested) method of reliably identifying this population in the TAF. Hospitals are not included in the definition of institutional LTSS, although these are Medicaid facilities. CMS has not historically counted hospitals as part of institutional LTSS for tracking LTSS expenditures and use.

⁸ As required by federal law, state Medicaid agencies distribute DSH payments to institutions that serve a large number of Medicaid beneficiaries and people without insurance to support the institutions' financial stability. These direct provider payments can be viewed as part of a state's overhead cost for providing institutional LTSS to people with low resources.

⁹ State data and anomaly notes and LTSS TAF data quality rating results are included in the document titled "Data Notes for Medicaid Transformed Medicaid Statistical Information System Analytic File Long-Term Services and Supports Annual Expenditures and Users, 2023," available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.

¹⁰ Details on the LTSS TAF data quality analysis using 2023 data can be found in the document titled "Analysis of Data Quality in the Transformed Medicaid Statistical Information System Analytic Files for Identifying Medicaid Home and Community-Based Services and Institutional Long-Term Services and Supports, 2023," available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.

Distribution of Users and Expenditures by HCBS Category

HCBS users by category. Nationwide, 8,435,224 people received HCBS in 2023 through a variety of Medicaid HCBS waiver programs and section 1905(a) state plan benefits.¹¹ The largest share of HCBS users received section 1905(a) state plan rehabilitative services (2,132,351, or 25.3 percent); section 1905(a) state plan home health services (1,962,629, or 23.3 percent); section 1915(c) waiver programs services (1,959,443, or 23.2 percent); and section 1905(a) state plan case management services (1,928,816, or 22.9 percent) (Figure 1). Fewer HCBS users received HCBS through other programs and options, including section 1905(a) state plan personal care services (1,064,280, or 12.6 percent); section 1915(j) self-directed PAS option¹² (999,558, or 11.9 percent); section 1915(i) state plan HCBS benefit (976,537, or 11.6 percent); section 1915(k) Community First Choice option (171,919, or 2.0 percent); section 1905(a) state plan private duty nursing services (106,235, or 1.3 percent); and PACE (85,859, or 1.0 percent).

HCBS expenditures by category. The ordering of HCBS categories by expenditures is much different from the ordering of categories by user counts. This could be due to the cost of services per unit, different populations served, and variation in the intensity and duration of services for different categories of HCBS (Figure 1). These factors result in larger variation across the categories for expenditures. HCBS expenditures totaled \$145.9 billion nationwide in 2023, with the largest share for people receiving section 1915(c) waiver programs services (\$70.3 billion, or 48.2 percent). Much smaller shares of HCBS expenditures were spent on the section 1915(j) self-directed PAS option (\$18.6 billion, or 12.8 percent); the section 1915(i) state plan HCBS benefit (\$16.1 billion, or 11.1 percent); section 1905(a) state plan personal care services (\$12.6 billion, or 8.6 percent); section 1905(a) state plan home health services (\$6.9 billion, or 4.7 percent); section 1905(a) state plan rehabilitative services (\$6.8 billion, or 4.6 percent); section 1915(k) Community First Choice option (\$4.9 billion, or 3.4 percent); section 1905(a) state plan case management services (\$4.1 billion, or 2.8 percent); PACE (\$4.0 billion, or 2.7 percent); and section 1905(a) state plan private duty nursing services (\$1.6 billion, or 1.1 percent).

HCBS users and expenditures by delivery system. More HCBS users received services through managed care (60.4 percent) compared with FFS (46.3 percent).¹³ However, HCBS delivered through FFS accounted for a higher proportion of expenditures (62.8 percent for FFS compared with 37.2 percent for managed care).¹⁴

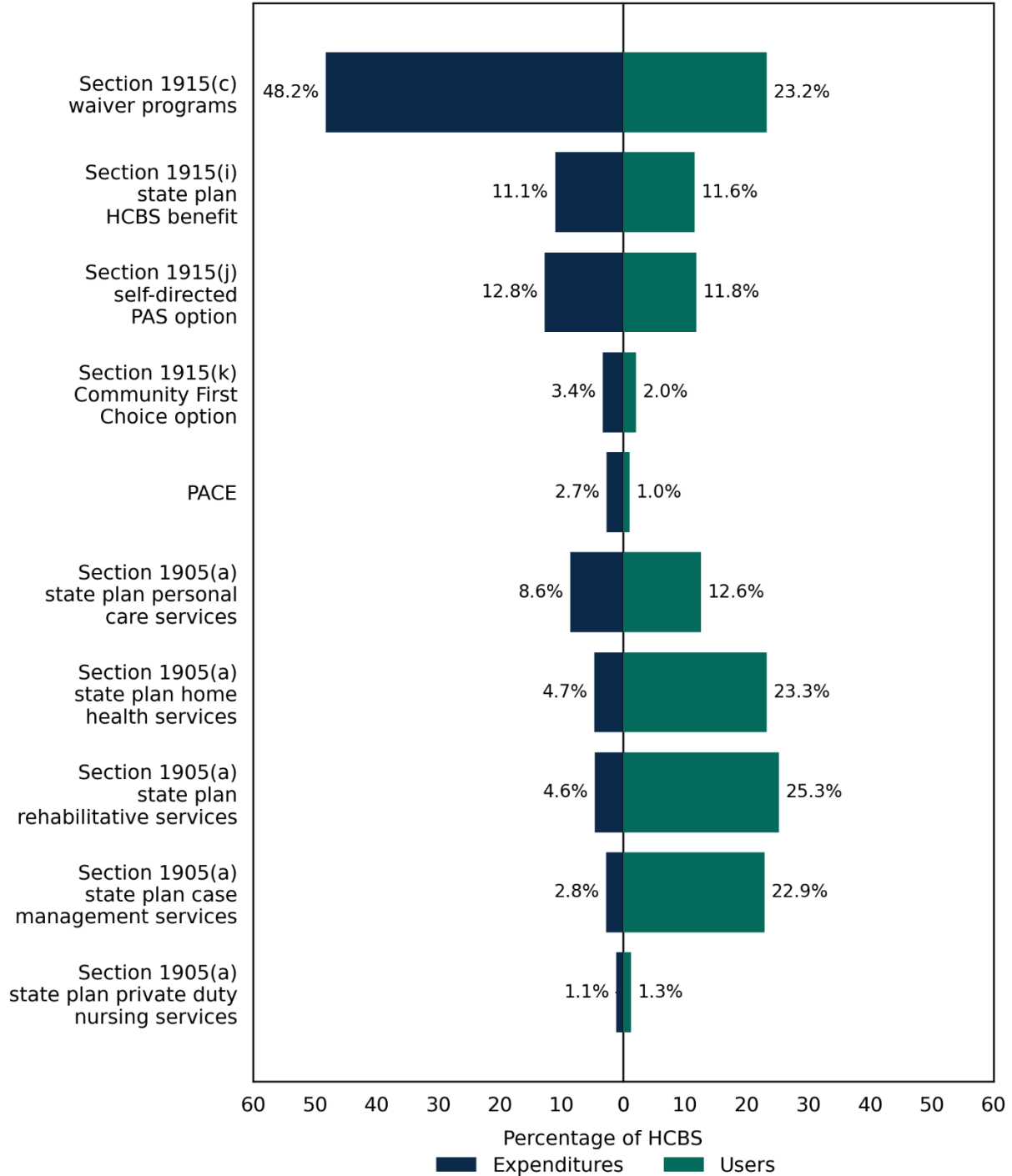
¹¹ The percentage of users across different HCBS categories does not sum to 100 because some beneficiaries received more than one type of HCBS during the year.

¹² Based on data quality checks and feedback from states, relative to other categories, many states misreported data on users of section 1915(j) self-directed PAS option, so counts and expenditures for this category should be interpreted with caution.

¹³ The percentage of users who received HCBS through FFS versus managed care does not sum to 100 because some beneficiaries received both FFS and managed care services at some point during the year.

¹⁴ FFS expenditures represent state payments to providers, whereas managed care expenditures in this analysis represent managed care plan payments to providers (except for PACE expenditures, which represent capitation payments from states to PACE plans). Therefore, the managed care expenditures in this analysis likely underestimate the total amount states paid to managed care plans to cover HCBS for their members because the capitation

Figure 1. Distribution of Medicaid HCBS users and expenditures by category, 2023



Source: Mathematica’s analysis of the 2023 TAF Release 1.

Note: The percentage of users across the categories does not sum to 100 because some beneficiaries received more than one type of HCBS during the year. Based on data quality checks and feedback from states, relative to other categories, many

payments from states to managed care plans are based on both the amount to cover the anticipated health care costs of covered enrollees as well as payments to cover plan administration, reserves, and profit.

states misreported data on section 1915(j) self-directed PAS option claims, resulting in higher counts than expected; therefore, these counts should be interpreted with caution.

HCBS = home and community-based services; PACE = Program of All-Inclusive Care for the Elderly; PAS = personal assistance services; TAF = Transformed Medicaid Statistical Information System Analytic File.

Distribution of Users and Expenditures by Institutional Category

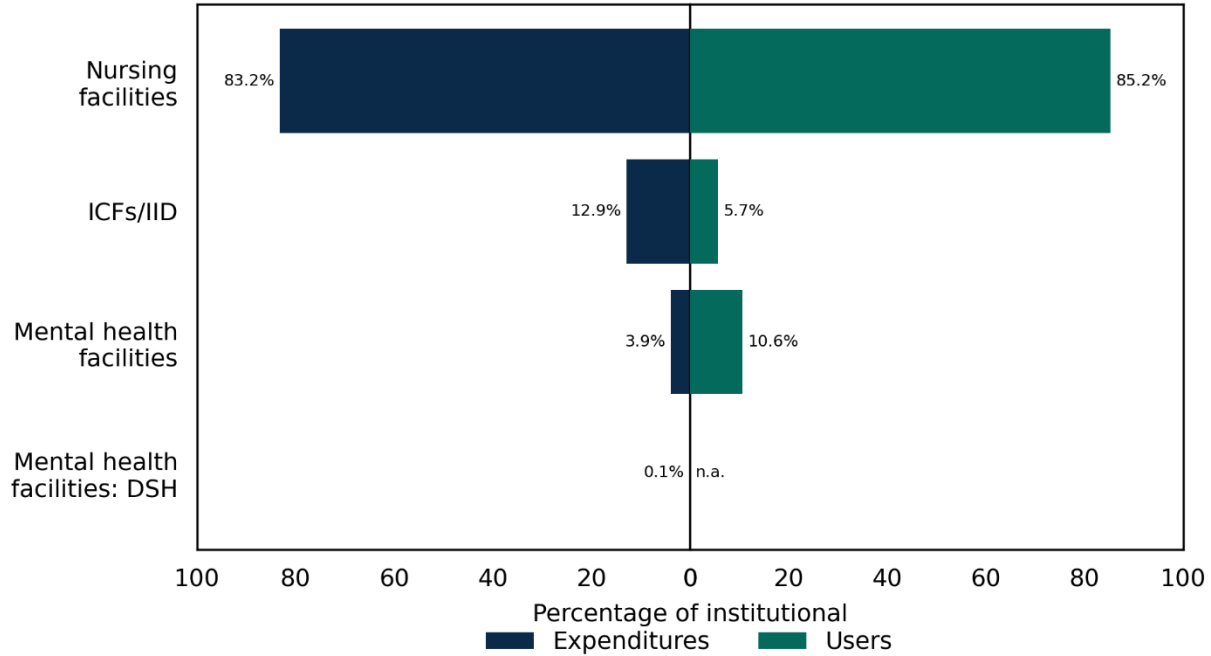
Institutional service users by category. Far fewer people (1,519,234 users) received institutional services than HCBS in 2023. There were 82.0 percent fewer users of institutional services than HCBS. The vast majority of people using institutional care received services at nursing facilities (1,294,881, or 85.2 percent) (Figure 2).¹⁵ Fewer people received services at mental health facilities (161,319, or 10.6 percent) or at ICFs/IID (86,184, or 5.7 percent).

Institutional LTSS expenditures by category. Expenditures for institutional LTSS totaled \$82.7 billion nationwide in 2023, 43.3 percent less than HCBS expenditures. Similar to the patterns for institutional service users, the vast majority of institutional LTSS expenditures were for services at nursing facilities (\$68.8 billion, or 83.2 percent) (Figure 2). Although mental health facility users outnumbered ICF/IID users, expenditures were higher for services at ICFs/IID (\$10.6 billion, or 12.9 percent). Mental health facility expenditures were a small share of total institutional expenditures (\$3.2 billion, or 3.9 percent), and mental health facility DSH payments¹⁶ accounted for about \$60.9 million, or 0.1 percent of total institutional expenditures.

¹⁵ The percentage of users across different institutional service categories does not sum to 100 because some beneficiaries received more than one type of institutional care during the year.

¹⁶ We have not directly assessed the quality and completeness of TAF data on mental health facility DSH payments and other financial transactions. Therefore, the expenditures attributed to that category should be interpreted with caution.

Figure 2. Distribution of Medicaid institutional users and expenditures by category, 2023



Source: Mathematica’s analysis of the 2023 TAF Release 1.

Note: Expenditure calculations include mental health facility DSH payments but the user counts do not include these payments, as they cannot be linked to specific Medicaid enrollees. In addition, we have not directly assessed the quality and completeness of the TAF data on mental health facility DSH payments and other financial transactions. Therefore, the expenditures attributed to that category should be interpreted with caution.

DSH = disproportionate share hospital; ICFs/IID = intermediate care facilities for individuals with intellectual disabilities; TAF = Transformed Medicaid Statistical Information System Analytic File.

Institutional LTSS users and expenditures by delivery system. FFS delivery of institutional services was more common than delivery through managed care (57.0 percent versus 50.3 percent), and FFS delivery made up a greater share of total institutional expenditures than managed care delivery did (59.5 percent versus 40.4 percent).

Trends in LTSS Users and Expenditures

LTSS user and expenditure trends by category. From 2022 to 2023, the number of HCBS users rose 7.5 percent (from 7.8 million to 8.4 million), while the number of institutional service users rose 3.0 percent (from 1.47 million to 1.5 million) (Figure 3). Expenditures for HCBS increased by 12.8 percent (from \$129.4 billion to \$145.9 billion), whereas expenditures for institutional services increased by 16.5 percent (from \$71.0 billion to \$82.7 billion).

From 2022 to 2023, the HCBS categories with the largest percentage of increases in users were the section 1915(i) state plan HCBS benefit (129.5 percent, from 425,429 to 976,537); the section 1915(j) self-directed PAS option (68.3 percent, from 593,924 to 999,558); and section 1905(a) state plan private duty nursing services (59.2 percent, from 66,711 to 106,235). In the same period, the HCBS categories with the largest

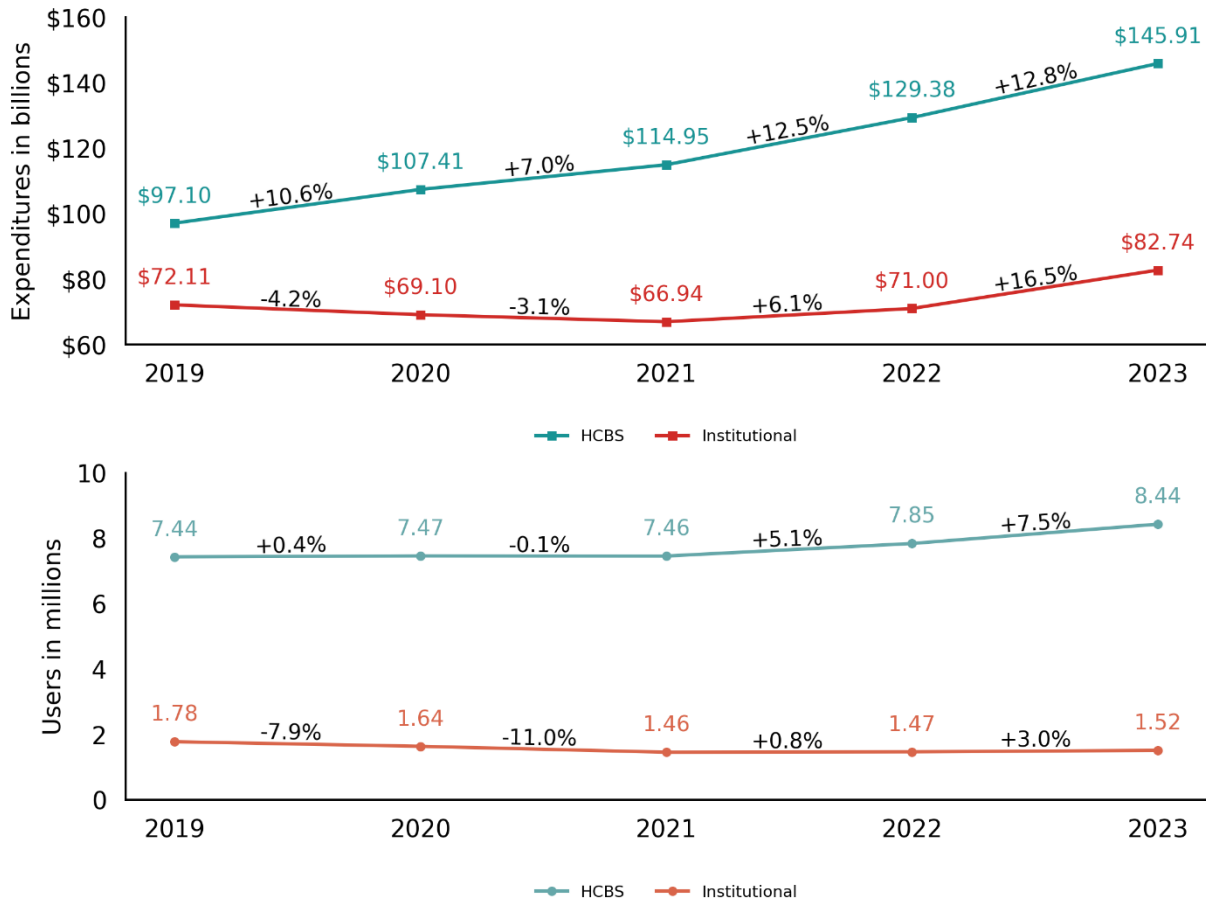
percentage of increases in HCBS expenditures were the section 1915(j) self-directed PAS option¹⁷ (24.8 percent, from \$14.9 billion to \$18.6 billion), PACE (22.7 percent from \$3.2 billion to \$4.0 billion), and the section 1915(i) state plan HCBS benefit (20.9 percent from \$13.3 billion to \$16.1 billion). Three of the HCBS categories had decreases in users, expenditures, or both from 2022 to 2023; section 1905(a) state plan rehabilitation service users decreased 10.1 percent (2.4 million to 2.1 million); section 1905(a) state plan private duty nursing service expenditures decreased 14.9 percent (\$1.9 billion to \$1.6 billion); section 1905(a) state plan home health service users and expenditures decreased 17.1 percent (2.4 million to 2.0 million) and 12.3 percent (\$7.8 billion to \$6.9 billion), respectively.

All institutional categories had increases in users and expenditures from 2022 to 2023. Users of nursing facility services rose 1.1 percent (from 1.28 million to 1.29 million), users of mental health facility services rose 17.4 percent (from 137,368 to 161,319), and users of ICF/IID services rose 20.3 percent (from 71,659 to 86,184). Likewise, expenditures for nursing facility services rose 16.5 percent (from \$59.1 billion to \$68.8 billion), ICF/IID services rose 15.9 percent (from \$9.2 billion to \$10.6 billion), and expenditures for mental health facility services rose 21.8 percent (from \$2.6 billion to \$3.2 billion). Mental health facility DSH payments decreased 31.9 percent from 2022 to 2023 (\$89.4 million to \$60.9 million).

LTSS user and expenditure trends by delivery system. From 2022 to 2023, the number of users nationwide who received LTSS through FFS increased by 12.3 percent (from 4.2 million to 4.7 million), and the number of users who received LTSS through managed care increased by 4.9 percent (from 5.5 million to 5.7 million). Expenditures for LTSS delivered through FFS rose by 12.4 percent (from \$125.3 billion to \$140.8 billion), and expenditures for LTSS delivered through managed care rose by 17.1 percent (from \$74.9 billion to \$87.8 billion).

¹⁷ Based on data quality checks and feedback from states, relative to other categories, many states misreported data on section 1915(j) self-directed PAS option claims, resulting in higher counts than expected; therefore, counts and expenditures for this category should be interpreted with caution.

Figure 3. Medicaid HCBS and institutional LTSS users and expenditures, 2019–2023



Source: Mathematica’s analysis of the 2023 TAF Release 1. We obtained data for 2022 from Murray, Caitlin, Cara Stepanczuk, Alexandra Carpenter, and Andrea Wysocki. “Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid LTSS Users and Expenditures, 2022.” Mathematica, August 29, 2024. We obtained data for 2019 to 2021 from Stepanczuk, Cara, Michelle Eckstein, Aparna Kachalia, Alexandra Carpenter, and Andrea Wysocki. “Medicaid Long-Term Services and Supports Use and Expenditures by Service Category, 2019–2021.” Mathematica, July 24, 2024.

Note: Due to data quality concerns, national user and expenditure calculations for 2021 exclude Alabama’s data.

HCBS = home and community-based services; TAF = Transformed Medicaid Statistical Information System Analytic File.

From 2022 to 2023, the number of users who received HCBS increased at a greater rate under FFS than managed care: the number receiving HCBS through FFS rose by 15.1 percent, and the number receiving HCBS through managed care rose by 4.1 percent. Expenditures for HCBS delivered through FFS and managed care also both increased (14.2 percent and 10.5 percent, respectively).

From 2022 to 2023, the number of institutional service users increased slightly for both delivery system types. Users of institutional services delivered through FFS rose by 1.0 percent (from 858,131 to 866,527), and users of institutional services delivered through managed care rose by 9.2 percent (from 699,882 to 764,217). FFS expenditures for institutional services increased by 9.1 percent (from \$45.1 billion to \$49.2 billion), and managed care expenditures for institutional services increased by 29.7 percent (from \$25.8 billion to \$33.5 billion).

Conclusions

Far more people received HCBS than institutional services in 2023, and HCBS expenditures accounted for a larger share of LTSS spending than institutional services. States used a combination of different programs and section 1905(a) state plan benefits to deliver these services. Section 1905(a) state plan rehabilitative services were the most common among HCBS users, section 1915(c) waiver programs services comprised the largest HCBS expenditure category, and nursing facility users and expenditures accounted for the majority of institutional users and expenditures. Although fewer users received LTSS through FFS than through managed care in 2023 (4.7 million and 5.7 million, respectively), most LTSS expenditures were for services delivered through FFS (\$140.8 billion, or 61.6 percent). These trends suggest that although the use of managed care to deliver LTSS has grown considerably over time, FFS is still a major delivery model for LTSS.

Methods

This brief contains a snapshot of LTSS user and expenditure output, focusing on trends in HCBS and institutional users and expenditures by service category. All LTSS user and expenditure calculations are based on TAF data. For these analyses, institutional LTSS include nursing facilities, ICFs/IID, and mental health facilities. Hospitals are not included in the definition of institutional LTSS, although these are Medicaid facilities. For expenditures only, institutional LTSS also include DSH payments to mental health facilities. HCBS include section 1915(c) waiver programs, section 1915(i) state plan HCBS benefit, section 1915(j) self-directed PAS option, section 1915(k) Community First Choice option, the Program of All-Inclusive Care for the Elderly (PACE), and the following section 1905(a) state plan benefits: personal care services, home health services, rehabilitative services, case management services, and private duty nursing. We reported MFP demonstration services as an individual category in accompanying table output but did not include these services in the aggregate calculations of total HCBS or total LTSS expenditures or users. Except for PACE expenditures and DSH payments to mental health facilities, LTSS expenditures include FFS expenditures, managed care plan payments to providers for managed care services, and supplemental wraparound payments that are associated with a specific beneficiary above the negotiated per-service rate; these add-on payments are distinct from the supplemental payments made under the Upper Payment Limit (UPL) demonstration. We assigned these expenditures to a specific LTSS category based on relevant codes found on TAF claims, including type of service, benefit type, program type, and waiver type. For PACE expenditures, we used capitation payment records and service-tracking claims. For DSH payments to mental health facilities, we used service-tracking claims and supplemental payment records (to account for the rare case that DSH payments appear there). Except for PACE, we identified LTSS users for each LTSS category using FFS claims and managed care encounters, based on the same codes used to identify claims for the expenditure calculations. For PACE user counts, we identified enrollees based on enrollment records. Except for dual-eligibility status, which is based on the majority of enrolled months, we based the characteristics of enrollees on the most recent valid values in the calendar year. To define subpopulations (older adults (ages 65 and older); people under age 65 with potentially disabling conditions; people with ASD/ID/DD; people with MH/SUD; other people who use LTSS), we used individual-level characteristics including age, section 1915(c) waiver programs enrollment, chronic condition indicators, and service use to classify LTSS users in our sample into the first four subpopulations. These four subpopulations are not mutually exclusive, as we allow LTSS users to be classified in all subpopulations for which they qualify. The fifth LTSS subpopulation—other people who use LTSS—comprises LTSS users in our sample who do not meet the criteria of any of the other four subpopulations. To support our understanding of states' TAF data quality, we created LTSS TAF data quality measures to identify potential data quality issues that may affect states' LTSS expenditure and user results. There are separate FFS and managed care measures covering the following topics: institutional LTSS users, institutional LTSS expenditures, HCBS users, and HCBS expenditures.

For more information, refer to the following resources:

- More information on data and methods, including a description of the LTSS TAF data quality summary measures, can be found in the document titled “Methodology for Identifying Medicaid Long-Term Services and Supports Expenditures and Users, 2023,” available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.
 - Details on the LTSS TAF data quality analysis using 2023 data can be found in the document titled “Analysis of Data Quality in the Transformed Medicaid Statistical Information System Analytic Files for Identifying Medicaid Home and Community-Based Services and Institutional Long-Term Services and Supports, 2023,” available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.
 - State data and anomaly notes and LTSS TAF data quality measure results are included in the document titled “Data Notes for Medicaid Transformed Medicaid Statistical Information System Analytic File Long-Term Services and Supports Annual Expenditures and Users, 2023,” available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.
 - Data tables for this brief, titled “Part A.1: Medicaid Long-Term Services and Supports Users by Delivery System for Calendar Year 2023” and “Part A.2: Medicaid Long-Term Services and Supports Expenditures by Delivery System for Calendar Year 2023,” are available at <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html>.
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