
Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

Committee on Energy and Commerce
Subcommittee on Health
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Written Testimony of Barbara Merrill, Chief Executive Officer, American Network of
Community Options and Resources (ANCOR)

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Chair Guthrie, Ranking Member Pallone, Subcommittee Chair Griffith, Vice Chair
Harshbarger, Ranking Member DeGette, and members of this Subcommittee:

Thank you for the opportunity to testify before you today. My name is Barbara Merrill, and I'm the Chief Executive Officer of the American Network of Community Options and Resources, also known as ANCOR. I'm very grateful to address this subcommittee on the topic of affordability in health care—because we cannot talk about affordability, accessibility, and sustainability without talking about Medicaid, and specifically, Medicaid home- and community-based services (HCBS).

ANCOR is a national, nonprofit association representing more than 2,500 private, mostly non-profit community providers of long-term supports and services for people

with intellectual and developmental disabilities (I/DD) across the nation, along with 57 state provider associations. Combined, our members support more than one million individuals with I/DD in all 50 states, the District of Columbia and Puerto Rico across their lifespan. Our mission is to advance the ability of our members to support people with I/DD to live, work, and thrive in their communities.

Community-Based Services Support People with I/DD and the Broader Community

Community-based services funded by Medicaid are a lifeline for people with disabilities. Community providers offer a broad range of supports to help people with I/DD live full and independent lives in their homes and communities. Through Medicaid-funded community-based services, people with I/DD have access to a spectrum of person-centered supports that assist them to carry out activities of daily living, build skills, navigate their communities, take advantage of employment opportunities, and more. These supports enable people with I/DD to develop a greater level of independence and autonomy and contribute meaningfully to their communities.

Community-Based I/DD Services Are Less Costly than Their Alternatives

Medicaid HCBS are not only essential to supporting people with I/DD to live lives with dignity and independence; they are also a cost-efficient solution when compared with

the alternative of supporting people in large, state-run, institutional settings. The Medicaid HCBS program is not only the preferred model of care for people with disabilities—it is also significantly less expensive than institutional alternatives. The average per-person cost to support a person with I/DD in their homes and communities is \$70,500 annually; serving that same person in a public institutional facility is more than \$395,000.¹

Moreover, Medicaid-funded long-term services and supports enable individuals with I/DD to receive support outside of family caregivers. Providing support options for people with disabilities enables family caregivers to remain in the workforce, making it possible to continue earning wages and contribute to local economies. Conversely, when community-based services are not available, families must make difficult decisions that can have far-reaching impacts. For example, the Maine Center for Economic Policy found that Maine is missing out on over \$1 billion per year in additional economic activity as a result of people dropping out of the labor force to provide care.²

Community-Based I/DD Services Support Working Families & The Broader Economy

Community providers of I/DD services also support a robust economy, both in their role as employers of one of the fastest-growing workforces, as well as in their role as

¹ Shea Tanis, et al., [The State of the States in Intellectual and Developmental Disabilities](#), Kansas University Center on Disabilities (2025).

² Arthur Phillips, et al., [The High Cost of Undervaluing Direct Care Work](#), Maine Center for Economic Policy (Apr. 2023).

providers of services that enable people with disabilities and their families to secure and maintain employment. The direct impact of employing hundreds of thousands of individuals as direct support professionals, as well as the indirect impact of those employees' economic output in their local communities, produces positive outcomes at the state level. A recent study of Missouri's Medicaid HCBS program found that an investment of \$1.6 billion in state dollars across fiscal years 2022 to 2024 contributed almost \$6 billion to Missouri's economy.

Missouri is not an outlier in the vast contributions that home- and community-based services play in the broader community. In FY 2023, federal and state governments invested an approximate combined \$67 billion to Medicaid home- and community-based services for people with I/DD, a mere fraction of what it would have cost to support those same individuals in public residential facilities.³ In turn, this investment supported nearly \$170 billion in economic output across the nation, including more than \$79 billion in labor income and over \$24 billion in state, local, and federal taxes.⁴

Barriers to Sustainability Persist in the Community-Based I/DD Services System

To ensure a sustainable system and make good on our promise of community living for people with I/DD, Congress must support and invest in community-based services. The

³ Tanis, *supra* note 1.

⁴ [Fact Sheet: Economic Impact of Medicaid Home and Community-Based Services](#) (March 2026). (Analysis conducted by ANCOR using IMPLAN System which sources industry and employment data to trace spending through an economy and measure the cumulative effects of the spending.)

data is clear that increased federal investments help to strengthen and sustain community-based services.

Recently, temporary federal funding for the Medicaid HCBS program was authorized through the American Rescue Plan Act (ARPA). This funding was instrumental for states in strengthening their community-based services. Every single state and the District of Columbia used ARPA funding to invest in strengthening their direct support workforce.⁵

Data from ANCOR's annual survey assessing the impact of recruitment and retention challenges within our labor force demonstrates that, during this time period, even though community-based providers continued to experience workforce staffing shortfalls, substantially fewer providers indicated they were closing programs or services.⁶ For example, in 2022, 63% of survey respondents reported closing programs or services. After the release of additional federal funding through ARPA, that figure dropped to 44% in 2023, 39% in 2024, and 29% in 2025.⁷

⁵ Centers for Medicare and Medicaid Services, [Overview of State Spending under American Rescue Plan Act of 2021 \(ARP\) Section 9817, as of the Quarter Ending December 31, 2023](#) (July 2024).

⁶ American Network of Community Options and Resources, [The State of America's Direct Support Workforce Crisis 2025](#) (Dec. 2025).

⁷ *Id.*

Insufficient Increases in Provider Rates Means Long-Term Workforce Shortages

Yet, Medicaid I/DD services remain in a fragile state. There is, and has been for many decades, a workforce crisis in community-based settings, due to insufficient Medicaid reimbursement rates and the inability of providers to offer wages that enable them to compete with industries offering hourly wage positions, such as fast-food restaurants or retail and convenience stores.

Because of these low reimbursement rates, which are beyond the control of providers, direct support professionals supporting Americans with I/DD are among the lowest-earning professionals in the broader human services industry, earning a median hourly wage of just over \$18. These low wages are despite the fact that direct support professionals require substantial training and deliver complex, person-centered care to millions of Americans. HCBS are committed to improving compensation for their workforce, but current funding levels make it difficult to offer wages that are competitive without risking service reductions or program closures.

For people with I/DD, this workforce crisis is the greatest barrier to accessing community-based support. The latest edition of ANCOR's aforementioned survey found that in 2025, 88% of providers experienced moderate or severe staffing challenges in the past year, resulting in 62% of providers turning away new referrals and 52% of

providers considering further cuts to programs.⁸ We continue now, as we have always, to urge collaborative solutions to addressing stagnant and insufficient Medicaid payment rates which prevent competitive wages for all workers.

Reduced Medicaid Funding Has Significant Impacts on Community I/DD Services

Within an already-fragile system of services, providers now face looming state budget cuts that threaten to derail any progress made in recent years to shore up community-based services.

Even when not targeted specifically at cuts to Medicaid HCBS, reductions in Medicaid funding authorized through the Fiscal Year 2025 budget reconciliation bill, or H.R. 1, will have a significant impact on access to services for people with disabilities. Because community-based services are not federally mandated, they are especially vulnerable to Medicaid funding reductions. Historically, when states face Medicaid funding shortfalls, non-mandatory services like HCBS have been among the first to be scaled back, restricting access to essential supports for people with disabilities. In fact, data shows that between 2010 and 2012, in response to a reduction in federal funding in the wake of the Great Recession, every single state and the District of Columbia cut spending to one or more of its HCBS programs, either by reducing inflation-adjusted, per-beneficiary

⁸ *Id.*

spending, or by reducing the number of beneficiaries.⁹

Throughout the budget reconciliation process last year, members of Congress repeatedly reassured disability service providers that H.R. 1 would not harm disability services; noting that the legislation was meant to make Medicaid services more sustainable for those with disabilities. Unfortunately, this has not been the experience of community providers supporting people with I/DD in their states. States are already addressing budget shortfalls in preparation for the implementation of H.R. 1's Medicaid provisions, and several states are doing this in ways that cut or limit access to HCBS programs that essential for people with I/DD.¹⁰ For example, this year, Idaho proposed eliminating HCBS programs altogether as a potential solution to a budget shortfall following a 4% across-the-board reduction to its Medicaid program last fall.¹¹

However, these attempts to balance state budgets by reducing access to services for people with I/DD are deeply short-sighted and run contrary to the stated goal of saving taxpayer dollars. The need for care does not disappear when HCBS funding is reduced. In many cases, those individuals who lose access to home- and community-based services simply end up in more costly institutional facilities.

⁹ Jessica Schubel et al., Health Affairs, [History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People](#) (Apr. 16, 2025).

¹⁰ Tony Leys, KFF Health News, [Trump's Cuts to Medicaid Threaten Services that Help Disabled People Live at Home](#) (Mar. 5, 2026).

¹¹ Kyle Pfannenstien, Idaho Capital Sun, [Records Detail Idaho Medicaid Services that Could Be Cut, but Not 'Potential New Costs'](#) (Jan. 22, 2026).

In other cases, these individuals end up without access to support at all, meaning that simple care needs escalate into emergencies that require immediate intervention. The result is that people with I/DD seek care in under-resourced emergency rooms at an average cost of \$3,297 per inpatient day.¹² For example, during a three-month data collection period in 2022 across 52 New York hospitals, there were \$169 million in estimated costs due to discharge delays from an absence of care options for people with complex care needs.¹³ This places additional pressure on hospital infrastructure and emergency services that should remain available for patients experiencing acute medical crises.

In other words, reducing access to community-based supports not only harms people with disabilities—it diverts critical hospital resources from those who truly need them.

Overly Broad Enforcement Mechanisms Put HCBS at Risk

We support efforts to ensure Medicaid programs are secure and not subject to waste, fraud, and abuse, but we are deeply concerned about the potential for overly broad enforcement mechanisms that would harm access to the fragile network of HCBS. Efforts to minimize waste, fraud, and abuse should be precise, targeted, and narrowly tailored to avoid harming community-based services for people with I/DD and the

¹² KFF, [Hospital Expenses per Adjusted Inpatient Day](#) (2024).

¹³ Healthcare Association of New York State, [The Complex Case Discharge Delay Problem](#) (2021).

workforce that supports them. Cutting off funding from entire service delivery systems, including services provided in good faith, is overly punitive and will only serve to limit access, force closure of services, and harm families and vulnerable individuals reliant on those services.

Robust and sustained funding for HCBS is essential to maintain the integrity and stability of Medicaid services. Without proper funding, states and providers will not have the necessary supervision, training, and tools to adhere to compliance measures targeting waste, fraud, and abuse in the system.

A much more productive approach, rather than cutting federal funding, is for state agencies to work with providers, people with disabilities, and other community partners to develop and implement sound methodologies, strategies, and plans to identify and eliminate fraud in Medicaid programs. This will ensure that the fragile network of community services for people with disabilities is not collateral damage in an effort to identify potentially fraudulent activity.

Federal Investments Are Needed to Make Services Sustainable

If community-based services are reduced, more people with disabilities will remain on waiting lists for longer, languishing without access to the support they need to live in their homes and communities. Across the country, more than 552,000 people with I/DD

are already on states' waiting lists for HCBS.¹⁴ Wait times are often several years to decades long, forcing people with disabilities to either go without the support they need or be forced into hospital emergency rooms, nursing homes, and large, high-cost, state-run institutions. Service reductions will only grow these years-long waiting lists, putting community supports for people with disabilities out of reach for thousands more families and raising unnecessary costs for states to cover health care in more expensive settings.

Our communities are at their best when *all* people, including people with disabilities, have the opportunity to achieve greater independence, contribute to the community, and successfully reach their goals. Sufficient Medicaid funding and a robust community provider network are foundational to building a stronger America for everyone. The most effective way to lower long-term health care costs while improving outcomes for people with disabilities is to strengthen Medicaid home- and community-based services and the provider network that delivers them.

Thank you again for the opportunity to deliver this testimony.

¹⁴ KFF, [Number of People Waiting for Medicaid Home Care \(HCBS\), by Target Population and Whether States Screen for Eligibility](#) (2024).