

# Home Improvements Can Help People Age Independently. But Medicare Seldom Picks Up the Bill.

CAPABLE helps elders and some younger people with disabilities who want to remain at home but have trouble with daily activities.

March 11, 2025 By Joanne Kenen and KFF

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Chikao Tsubaki had been having a terrible time.

In his mid-80s, he had a stroke. Then lymphoma. Then prostate cancer. He was fatigued, isolated, not all that steady on his feet.

Then Tsubaki took part in an innovative care initiative that, over four months, sent an occupational therapist, a nurse, and a handy worker to his home to help figure out what he needed to stay safe. In addition to grab bars and rails, the handy worker built a bookshelf so neither Tsubaki nor the books he cherished would topple over when he reached for them.

Reading “is kind of the back door for my cognitive health — my brain exercise,” said Tsubaki, a longtime community college teacher. Now 87, he lives independently and walks a mile and a half almost every day.

The program that helped Tsubaki remain independent, called Community Aging in Place: Advancing Better Living for Elders, [or CAPABLE](#), has been around for 15 years and is offered in about 65 places across 26 states. It helps people 60 and up, and some younger people with disabilities or limitations, who want to remain at home but have trouble with activities like bathing, dressing, or moving around safely. Several [published studies](#) have found the program saves money and prevents falls, which the Centers for Disease Control and Prevention says contribute to the deaths of [41,000 older Americans](#) and cost Medicare about \$50 billion each year.

Despite evidence and accolades, CAPABLE remains small, serving roughly 4,600 people to date. Insurance seldom covers it (although the typical cost of \$3,500 to \$4,000 per client is less than many health care interventions). Traditional Medicare and most Medicare Advantage private insurance plans don't cover it. Only four states use funds from Medicaid, the federal-state program for low-income and disabled people. CAPABLE gets by on a patchwork of grants from places like state agencies for aging and philanthropies.

The payment obstacles are an object lesson in how insurers, including Medicare, are built around paying for doctors and hospitals treating people who are injured or sick — not around community services that keep people healthy. Medicare has billing codes for treating a broken hip, but not for avoiding one, let alone for something like having a handy person “tack down loose carpet near stairs.”

And while keeping someone alive longer may be a desirable outcome, it’s not necessarily counted as savings under federal budget rules. A 2017 [Centers for Medicare & Medicaid Services evaluation](#) found that CAPABLE had high satisfaction rates and some savings. But its limited size made it hard to assess the long-term economic impact.

It’s unclear how the Trump administration will approach senior care.

The barriers to broader state or federal financing are frustrating, said Sarah Szanton, who helped create CAPABLE while working as a nurse practitioner doing home visits in west Baltimore. Some patients struggled to reach the door to open it for her. One tossed keys to her out of a second-story window, she recalled.

Seeking a solution, Szanton discovered a program called ABLE, which brought an occupational therapist and a handy worker to the home. Inspired by its success, Szanton developed CAPABLE, which added a nurse to check on medications, pain, and mental well-being, and do things like help participants communicate with doctors. It began in 2008. Szanton since 2021 has been the dean of Johns Hopkins University School of Nursing, which coordinates research on CAPABLE. The model is participatory, with the client and care team “problem-solving and brainstorming together,” said Amanda Goodenow, an occupational therapist who worked in hospitals and traditional home health before joining CAPABLE in Denver, where she also works for the CAPABLE National Center, the nonprofit that runs the program.

CAPABLE doesn’t profess to fix all the gaps in U.S. long-term care, and it doesn’t work with all older people. Those with dementia, for example, don’t qualify. But studies show it does help participants live more safely at home with greater mobility. And one study that Szanton co-authored estimated Medicare savings of [around \\$20,000 per person](#) would continue for two years after a CAPABLE intervention.

“To us, it’s so obvious the impact that can be made just in a short amount of time and with a small budget,” said Amy Eschbach, a nurse who has worked with CAPABLE clients in the St. Louis area, where a Medicare Advantage plan covers CAPABLE. That St. Louis program caps spending on home modifications at \$1,300 a person.

Both Hill staff and CMS experts who have looked at CAPABLE do see potential routes to broader coverage. One senior Democratic House aide, who asked not to be identified because they were not allowed to speak publicly, said Medicare would have to establish careful parameters. For instance, CMS would have to decide which beneficiaries would be eligible. Everyone in Medicare? Or only those with low incomes? Could Medicare somehow ensure that only necessary home modifications are made — and that unscrupulous contractors don’t try to extract the equivalent of

a “copay” or “deductible” from clients?

Szanton said there are safeguards and more could be built in. For instance, it’s the therapists like Goodenow, not the handy workers, who put in the work orders to stay on budget.

For Tsubaki, whose books are not only shelved but organized by topic, the benefits have endured.

“I became more independent. I’m able to handle most of my activities. I go shopping, to the library, and so forth,” he said. His pace is slow, he acknowledged. But he gets there.

Kenen is the journalist-in-residence and a faculty member at Johns Hopkins University School of Public Health. She is not affiliated with the CAPABLE program.

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