Medicaid Home and Community-Based Services for the Elderly: Trends in Programs and Policies

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This article presents the latest available expenditure and participation trends (1999-2002) for three Medicaid home and community-based (HCBS) programs that serve the elderly (home health, waivers, and personal care services [PCS]) and reports a national survey of policies used on these programs in 2002. Although the trend data show a rise in elderly waiver and PCS programs and participation, they also reveal falling per participant expenditures in PCS programs, declining annual growth in total HCBS expenditures, and large interstate variations in elderly waivers. The use of cost control policies such as spending caps and large waiver waiting lists in many states contribute to the gap between demand and supply for Medicaid HCBS for the elderly.

Keywords: *home and community-based care; Medicaid; waiver policy; state variation*

The federal-state Medicaid program paid for 43% of the nation's $139.3 billion in long-term care (LTC) expenditures in 2002 (Levit et al., 2004). With 43 states posting budget deficits in 2002, it was reported that some states began to implement or extend strategies to control Medicaid LTC spending for the elderly and other population groups such as the younger disabled (Boyd, 2003; Coughlin & Zuckerman, 2005; Kaiser Commission on Medicaid and

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the Uninsured, 2003). At the same time, however, state LTC systems faced conflicting pressures to increase Medicaid spending on both institutional care for the elderly (e.g., in nursing homes) and alternative home and community-based service (HCBS) programs such as home health.

This article analyzes the most recent and comprehensive available data to present three sets of information on the three Medicaid HCBS programs that serve the elderly: optional 1915(c) waivers (called HCBS waivers), the optional state plan personal care services (PCS) benefit, and mandated home health. First, we locate our analysis within the historical development of the Medicaid program (1992-2002), which includes rising total expenditures, a growing proportion of LTC expenditures for the elderly going to HCBS rather than institutional care, and growth in the number of Medicaid HCBS programs. Second, we present participation and expenditure trend data (1999-2002) for each Medicaid HCBS program, elderly HCBS waivers alone, and total Medicaid HCBS. Third, we report findings from a national survey of eligibility and cost control policies used on Medicaid HCBS programs in 2002.

Background: Medicaid LTC for the Elderly

As total Medicaid LTC expenditures increased by 67% between 1992 and 2002 (see Table 1), the proportion of Medicaid spending on LTC remained stable around one third. Despite this, as the national economy experienced a recession in the early 21st century, Medicaid LTC cost containment became a major policy goal of the federal and state administrations. At the same time, two forces combined to act against Medicaid LTC cost containment. First, between 1992 and 2002, the political strength of provider lobbies helped ensure that Medicaid institutional LTC spending increased by 36%, with spending on nursing home care alone (primarily to the growing elderly population) increasing by 49% (Table 1).

Second, social and legal pressures mounted on all state Medicaid administrations to "rebalance" their LTC systems away from the situation that existed in 1992 whereby 85% of all Medicaid LTC expenditures were consumed by institutions (Table 1). For decades, consumers and other stakeholders called for Medicaid to fund more HCBS alternatives to institutional care to address unnecessary institutionalization and unmet need for HCBS (Kitchener & Harrington, 2004; Kaiser Family Foundation, 2001). More recently, the push to rebalance Medicaid LTC systems has been supported by the 1999 *Olmstead* Supreme Court ruling that limiting HCBS alternatives to nursing home care constitutes discrimination (Stewart, Teitelbaum, & Rosenbaum, 2002) and federal policies such as the presidents' New Freedom

Table 1. National Medicaid Long-Term Care (LTC) Expenditures, 1992, 1999-2002 (Inflation Adjusted)[a]

Program/Measure	*1992*	*1999*	*2000*	*2001*	*2002*	*Percentage Change (1992-2002)*	*Percentage Change (2001-2002)*
Total Medicaid LTC ($ million)	49,799	68,559	72,330	76,777	83,195	67	8
Institutions[b] ($ million)	42,398	49,699	51,753	53,918	57,768	36	7
Home and Community-Based Services[c] ($ million)	7,401	18,860	20,577	22,859	25,427	244	11
Medicaid Home and Community-Based Services as percentage of Medicaid LTC	15	28	28	30	31	107	3

a. Consumer Price Index–adjusted expenditures reported in constant 2002 dollars.
b. Burwell, Sredl, and Elken (2005).
c. University of California, San Francisco (UCSF) annual waiver program survey (1994-2005) and UCSF annual survey of state Medicaid home health and personal care services (PCS) state plan programs (2000-2005) for all data except 1992-1998 home health and PCS expenditure data taken from Burwell et al. (2005).

Initiative to extend HCBS (The White House, 2002). There is some evidence that states have moved some way to rebalancing their Medicaid LTC systems. For example, Table 1 shows that between 1992 and 2002, the share of national Medicaid LTC expenditures consumed by HCBS doubled from 15% to 31%. However, as more states reported budget deficits and total Medicaid LTC expenditures continued to rise, fears mounted about states' capacities and motivations to further rebalance their Medicaid LTC systems by expanding the three main Medicaid HCBS programs described in the following.

Medicaid HCBS for the Elderly

Although Medicaid is the largest single payer of LTC, the only mandated benefits for the elderly (and all other populations) are institutional care and one form of HCBS, home health for people who are eligible for institutional care (Harrington, Carrillo, Wellin, Norwood, & Miller, 2001; Harrington et al., 2000). States may also pay for Medicaid HCBS to the elderly through two optional programs: HCBS waivers and the state plan personal care services benefit. The following section compares the main features of the three Medicaid HCBS programs, emphasizing that they are not direct substitutes for each other.

HCBS waivers. Since 1981, states have used authority under Section 1915(c) of the Social Security Act to request a waiver of certain federal Medicaid requirements (including statewide program coverage) to establish new HCBS programs (this is why they are called waivers). These programs attract federal matched funds and allow states to provide a wide range of HCBS to participants, including the elderly, who would otherwise be in an institution (Harrington et al., 2001).

In addition to federal matched funding and the capacity to provide broad packages of HCBS, the program also allows states to control costs in four main ways (Bogart, Chiplin, Gottich, & Stein, 1997; Harrington et al., 2000). First, states must demonstrate for each waiver that Medicaid per participant costs are no greater than per participant costs for institutional care at the comparable level of care (e.g., nursing home). Second, states set limits on the number of available participant "slots" on each waiver. Third, states have discretion to set medical and financial eligibility criteria for waivers and to cap spending on the services provided. Fourth, states may limit waiver programs to certain geographical areas (i.e., a county) and population groups such as the elderly or persons with mental illness (Harrington et al., 2001).

Personal care services. For many elderly persons, the provision of PCS allows them to maintain independence outside of nursing homes. Since 1975, states have had the option of paying for PCS as a Medicaid benefit (LeBlanc, Tonner, & Harrington, 2001). States have considerable discretion in defining PCS, but programs typically involve nonmedical assistance with activities of daily living such as bathing and eating. Unlike waivers, the PCS benefit must be available to all categorically eligible groups, including the elderly, and states can opt to include the medically needy (those who spend down to the state standard because of medical expenses) (Harrington et al., 2000). Although few national studies have examined PCS programs, states are known to vary in the amount and scope of services provided (LeBlanc et al., 2001).

Home health (HH). Whereas Medicaid home health is an allowed service within optional HCBS waivers in many states, it is a mandatory benefit for all Medicaid participants who are eligible for institutional care, including seniors who are eligible for nursing home care. States can vary the amount, scope, and duration of benefits offered as long as these remain sufficient to reasonably achieve their purpose and are the same for all eligibility groups (Harrington et al., 2000). Although research has reported falling utilization of Medicare HH nursing since the Balanced Budget Act of 1997, little is known about the Medicaid HH benefit (McCall, Petersons, Moore, & Korb, 2003).

Method

This study conducted descriptive analyses of a unique dataset compiled from four main sources: (a) Centers for Medicaid and Medicare Services (CMS) Form 372 waiver reports, (b) the authors' national surveys of PCS and HH programs, (c) CMS Form 64 expenditure data for Medicaid HH and PCS, and (d) the authors' national survey of waiver policies (each survey uses a separate instrument; copies are available on request from the first author). All data are coded using standard protocols and entered into either an Excel spreadsheet (program data) or a SPSS dataset (policy data) for analysis. Although most programs and states report data by federal fiscal year, some report by calendar or state fiscal year. For simplicity in this analysis of national trends, all data are reported as being by year.

CMS Form 372. Since 1994, the authors have collected annually from state officials the CMS Form 372s that report unduplicated participant and

expenditure data for each waiver program. Although the CMS Form 64 data reported annually by Medstat (Burwell, Sredl, & Eiken, 2005) provide an alternative source of information on waiver expenditures, they do not report participant data. In contrast to the PCS and HH programs, all waivers specify one of six target groups (e.g., aged, aged/disabled, and children). This study concentrates on waiver services for elderly and combines two waiver target groups: aged and aged/disabled.

Data requests through September 2006 (using e-mail, fax, and telephone) produced all 218 waiver reports for 1999, 226 of 227 reports for 2000, 230 of 232 reports for 2001, and 248 of 252 reports for 2002. For the 4 missing reports, participant and expenditure data were estimated from the previous years' reports, with expenditures adjusted for inflation.

Surveys of PCS and HH programs. Since 2000, the authors have surveyed state officials annually to collect program and policy data for all Medicaid PCS and HH programs. Each year, a standardized form is used to collect unduplicated participant and expenditure data and information concerning policies including financial eligibility, cost controls, and service packages. Unlike the CMS Form 372 reports, participant data are not reported by population group, and accurate data are not reported elsewhere. Thus, although this study can consider elderly waivers separately (from all other waivers), it is not possible to identify elderly expenditures or participants within Medicaid PCS and HH programs.

Data requests through September 2006 (using e-mail, fax, and telephone) produced HH data from all 51 states for 1999, 2000, and 2001 and 47 states for 2002 ($n = 51$ states including District of Columbia) and PCS data from 28 of the 29 participating states for 1999, 29 of the 30 PCS states for 2000 and 2001, and 31 of 32 PCS states for 2002. Because state officials are unable to report accurate HH and PCS program data for earlier years, we use CMS Form 64 expenditure data (Burwell et al., 2005). As noted earlier, CMS Form 64 does not report participant data, so no accurate prior year data exist for PCS and HH participants.

Waiver policy survey. In the spring of 2003, state officials responsible for each waiver were surveyed to collect information on the use of policies including eligibility requirements and waiting lists in 2002. Through September 2006, requests (using e-mail, fax, and telephone) produced responses from 250 of the total 252 waivers reported in 2002, which included responses for all 72 aged waivers.

Results

Growth in Medicaid HCBS Programs for the Elderly, 1992-2002

Between 1992 and 2002, total HCBS waivers and elderly waivers grew rapidly in terms of number of programs, participants, and expenditures (Table 2). As a result, HCBS waivers continued to be the largest Medicaid HCBS program in terms of expenditures (67%) and participants (39%). However, between 1992 and 2002, when compared with all HCBS waivers, elderly programs grew at a slower rate by three important measures: (a) growth in number of programs (63% vs. 53%), (b) participants (292% vs. 211%), and (3) inflation-adjusted expenditures (510% vs. 346%).

Between 1999 and 2002, the number of states offering PCS as a Medicaid state plan optional benefit increased from 29 to 32. With 2 new states (North Dakota and Vermont) providing PCS in 2002, the annual rate of participant growth was 17%. However, annual expenditures growth did not keep pace, increasing by only 2%. Interestingly, although Delaware and Rhode Island were approved to offer the PCS benefit between 1999 and 2002, both states reported zero participants and expenditures for each year.

Between 1999 and 2002, when compared with large increases in participation on the two optional Medicaid HCBS programs waivers and PCS (34% and 31%, respectively), home health participant increased by only 17%. Similarly, although inflation-adjusted expenditures on waivers and PCS increased by 42% and 22%, respectively, expenditures on the Medicaid home health program rose by 22%.

Although development of the two new "active" PCS programs helped fuel annual growth in total Medicaid HCBS participants from 5% in 2001 to 12% in 2002, the annual rate of total HCBS expenditure growth (inflation adjusted) remained constant at 11% in 2001 and 2002.

Standardized Medicaid HCBS Program Participation and Expenditure Trends, 1999-2002

Although the standardized annual rate of participant growth on the waiver program was 8% in 2002, inflation-adjusted expenditures rose by only 6% from 2001. Meanwhile, the annual rate of participant growth (per 1,000 elderly population) on elderly waivers was 6% in 2002, and inflation-adjusted expenditures rose by only 2%. Similarly, participants per 1,000 population in the PCS program increased by 27% between 1999 and 2002, and the addition

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Table 2. National Medicaid Home and Community-Based Services (HCBS) Summary Program Trends, 1992, 1999-2002

						Percentage Change	
Program/Measure	*1992*	*1999*	*2000*	*2001*	*2002*	*1992-2002*	*2001-2002*
All waivers[a]							
Programs	155	218	227	232	252	63	9
Participants	235,580	687,982	769,723[c]	841,209[d]	922,485[e]	292	10
Expenditures ($ million)	2,164	11,016	12,605[c]	14,346[d]	16,936[e]	683	18
Consumer Price Index–adjusted expenditures ($ million)	2,775	11,896	13,168	14,573	16,936	510	16
Elderly waivers[a]							
Programs	47	64	66	68	74	57	12
Participants	155,836	375,522	419,887	451,220	484,328[f]	211	7
Expenditures ($ million)	573	2,163	2,516	2,937	3,279[f]	472	12
CPI-adjusted expenditures ($ million)	735	2,335	2,628	2,984	3,279	346	10
Home health[b]							
Programs (states)	51	51	51	51	51		
Participants	n/a	656,006	672,555	702,645	767,011[g]	n/a	9
Expenditures ($ million)	1,259	2,366	2,535	2,895	3,115[g]	147	8
CPI-adjusted expenditures ($ million)	1,614	2,554	2,648	2,941	3,115	93	6
Personal care services state plan[b]							
Programs (states)	n/a	29	30	30	32	n/a	7
Participants	n/a	519,878[h]	578,532[h]	582,655[h]	683,615[i]	n/a	17
Expenditures ($ million)	2,349	4,083[h]	4,557[h]	5,262[h]	5,377[i]	129	2
CPI-adjusted expenditures ($ million)	3,013	4,409	4,760	5,345	5,377	78	0.6
Total Medicaid HCBS participants	n/a	1,863,866	2,020,810	2,126,509	2,373,111	n/a	12
Expenditures ($ million)	5,772	17,465	19,696	22,503	25,427	341	13
CPI-adjusted expenditures ($ million)	7,401	18,860	20,577	22,859	25,427	244	11

a. University of California, San Francisco annual waiver program survey (1994-2005).
b. University of California, San Francisco annual survey of state Medicaid home health (HH) and personal care services (PCS) state plan programs (2000-2005) for all data except 1992-1998 home health and PCS expenditure data taken from Burwell, Sredl, and Eiken, (2005).
NOTE: n/a = no data available. Estimated data: (c) 1 AR waiver; (d) 1 SC and 1 NH waiver; (e) 2 LA, 1 NE, and 1 NH waiver; (f) 1 LA waiver; (g) CA, MO, SD, and VT; (h) FL; (i) MO and VT; (j) VT. All states except AZ operate 1915(c) waivers. AZ operates a 1115 waiver and reports Medicaid HH program data. CPI-adjusted expenditures reported in constant 2002 dollars. Total Medicaid HCBS includes all waivers, home health, and PCS state plan. Although personal care services are a Medicaid optional state plan benefit in Delaware and Rhode Island, the states report zero expenditures and recipients.

Table 3. Standardized Program Trends in National Medicaid Home and Community-Based Services (HCBS), 1999-2002

Program/Measure	*1999*	*2000*	*2001*	*2002*	*Change 1999-2002*	*Change 2001-2002*
All waivers[a]						
Participants per 1,000 population	2.47	2.73[c]	2.95[d]	3.20[e]	30	8
Consumer Price Index–adjusted expenditures per participant ($)	17,291	17,108[c]	17,324[d]	18,359[e]	6	6
Elderly waivers[a]						
Participants per 1,000 elderly population (65+)	10.73	12.72	13.57	14.42[f]	34	6
CPI-adjusted expenditures per participant ($)	6,219	6,259	6,613	6,770[f]	9	2
Home health[b]						
Participants per 1,000 population	2.35	2.38	2.46	2.66[g]	13	8
CPI-adjusted expenditures per participant ($)	3,894	3,938	4,185	4,061[g]	4	–3
Personal care services state plan[b]						
Participants per 1,000 population	1.86[h]	2.05[h]	2.04[h]	2.37[i]	27	16
CPI-adjusted expenditures per participant ($)	8,482[h]	8,228[h]	9,174[h]	7,865[i]	–7	–14
Total Medicaid HCBS						
Participants per 1,000 population	6.68	7.16	7.46	8.24	23	10
CPI-adjusted expenditures per participant ($)	10,119	10,183	10,750	10,715	6	–0.3

a. University of California, San Francisco annual waiver program survey (2000-2005).
b. University of California, San Francisco annual survey of state Medicaid home health and personal care services (PCS) state plan programs (2000-2005).
NOTE: Estimated data: (c) 1 AR waiver; (d) 1 SC and 1 NH waiver; (e) 2 LA, 1 NE, 1 NH waiver; (f) 1 LA waiver; (g) CA, MO, SD, and VT; (h) FL; (i) MO and VT. All states except AZ operate 1915(c) waivers. AZ operates an 1115 waiver and reports Medicaid HH program data. Population data taken from US Census Bureau Population Estimate (1999-2002) (retrieved August 29, 2005, from http://www.census.gov). CPI-adjusted expenditures per participant reported in constant 2002 dollars. Total Medicaid HCBS includes all waivers, home health, and PCS state plan. Although personal care services are a Medicaid optional state plan benefit in Delaware and Rhode Island, the states report zero expenditures and recipients.

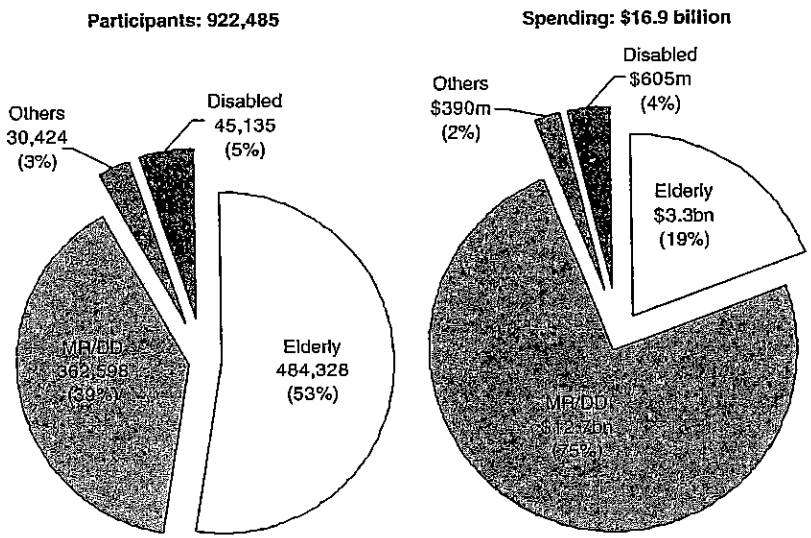

Figure 1. National Medicaid Home and Community-Based Waiver Program Data, by Target Group, 2002

SOURCE: Authors' analysis of Centers for Medicaid and Medicare Services Form 372 data.

NOTE: MR/DD is mentally retarded and developmentally disabled; other waivers include those serving children, persons with traumatic brain injury, mental disabilities, and HIV/AIDS. Elderly waivers include aged and aged/disabled waivers.

of two new PCS programs in 2002 drove a 16% annual increase in population adjusted participation. However, when adjusted for inflation, per participant PCS program spending in 2002 fell by 14% from 2001. Following a very similar pattern, in the latest year, annual standardized home health participation increased by 8%, but standardized inflation-adjusted expenditures declined by 3%.

Waiver Program Data by Target Group, 2002

In 2002, 74 waivers targeted services to the aged (53% of total waiver participants), 84 waivers provided services to mentally retarded and developmentally disabled (MR/DD) participants (39% of total waiver participants), 32 waivers served disabled participants, and 63 waivers targeted other participants including children, persons with HIV/AIDS, mental illness, or traumatic brain injuries (Figure 1). Disparities in spending by

target group continued from previous years (Harrington et al., 2001; Kitchener et al., 2005). Whereas waivers serving MR/DD participants spent 75% of total waiver expenditures in 2002, waivers targeting aged participants received only 19% of total waiver expenditures.

Interstate Variation in Medicaid HCBS Aged Waivers

In 2002, six new aged waivers started in five states (Indiana, Ohio, two in Texas, Wisconsin, and Wyoming). This contributed 25% of the 33,108 total growth in aged waiver participants between 2001 and 2002. All states (other than Arizona, which operates a 1115 waiver) have at least one aged waiver, and most states have either one or two waivers serving the aged. Florida, Rhode Island, and Texas had three aged waivers in 2002 (Table 4).

Table 4 illustrates significant interstate differences in elderly waiver participants per 1,000 state elderly (aged 65+) population and per participant elderly waiver expenditures in 2002. In terms of the standardized measure of participation (access), the highest two ranked states were Oregon (79.89) and Washington (46.93), the U.S. average was 14.42, and the lowest two states were Tennessee (0.79) and Louisiana (2.16). Interestingly, both of the two highest ranked states operated only one elderly waiver, whereas both the lowest ranked states operated two elderly waivers. In terms of per participant elderly waiver expenditures, the highest two ranked states were North Carolina ($20,199) and Hawaii ($17,284), the U.S. average was $6,770, and the lowest ranked two states were New York ($1,327) and Massachusetts ($2,468).

Medicaid Home and Community-Based Services Policy, 2002

Findings from the policy survey reveal that although the financial eligibility criteria for most waivers include participants with incomes of more than 150% of Supplemental Security Income (SSI), only 9% of HH programs and 6% of PCS programs are as generous (Table 5). To contain costs, most HH and PCS programs use service or hourly limits such as restrictions on the number on visits. In one interesting case, Florida reports providing its PCS program only to persons in assisted living facilities and to children younger than 21.

Almost half the waivers report using a dollar limit such as restrictions on the value of services that can be spent per year on each recipient. The survey also found the use of waiting lists in 38% of all reporting waivers. In 2002, there were a reported total of 194,816 persons on waiting lists for 94 waivers across 38 states with an average wait time of 9.7 months. The state with the longest waiting lists was Texas (74,244 persons, 3 waivers), and

Table 4. National Medicaid Home and Community-Based Services Elderly Waivers Standardized Program Data by State, 2002

State	N of Elderly Waivers	Participants per 1,000 Elderly Population (Rank)	Expenditures per participant ($) (Rank)
AK	1	33.45 (7)	15,608 (4)
AL	1	12.81 (27)	5,660 (33)
AR	1	22.50 (16)	4,182 (40)
CA	2	4.0 (45)	2,883 (47)
CO	1	37.10 (3)	5,722 (31)
CT	1	23.09 (13)	6,857 (26)
DC	1	3.01 (47)	8,331 (18)
DE	2	11.26 (30)	9,557 (12)
FL	3	8.20 (36)	5,615 (34)
GA	1	20.20 (20)	5,668 (32)
HI	2	10.42 (33)	17,284 (2)
IA	1	15.28 (26)	3,335 (43)
ID	1	36.38 (4)	7,746 (20)
IL	2	16.79 (24)	3,368 (42)
IN	2	3.94 (46)	7,515 (24)
KS	1	27.39 (12)	6,354 (29)
KY	1	34.45 (5)	4,439 (39)
LA	2	2.16 (49)	6,728 (27)
MA	1	7.42 (39)	2,468 (49)
MD	1	2.56 (48)	11,295 (8)
ME	2	8.23 (35)	11,496 (7)
MI	1	7.78 (37)	2,693 (48)
MN	1	22.94 (14)	6,237 (30)
MO	1	34.33 (6)	3,307 (44)
MS	2	31.22 (9)	4,089 (41)
MT	1	12.36 (29)	12,813 (5)
NC	1	10.72 (32)	20,199 (1)
ND	1	5.34 (43)	10,437 (11)
NE	1	21.01 (17)	7,688 (21)
NH	1	17.14 (23)	7,522 (23)
NJ	2	7.44 (38)	9,101 (16)
NM	1	7.38 (40)	16,057 (3)
NV	2	7.01 (41)	4,450 (38)
NY	1	9.16 (34)	1,327 (50)
OH	2	16.38 (25)	6,509 (28)
OK	1	32.28 (8)	5,393 (37)
OR	1	79.89 (1)	7,548 (22)
PA	2	5.45 (42)	8,603 (17)
RI	3	17.58 (22)	7,310 (25)
SC	1	30.34 (10)	5,487 (36)
SD	2	11.20 (31)	3,041 (45)
TN	2	0.79 (50)	8,264 (19)
TX	3	19.65 (21)	10,741 (9)
UT	1	4.35 (44)	2,889 (46)
VA	2	12.72 (28)	9,195 (15)
VT	2	20.66 (18)	12,773 (6)
WA	1	46.93 (2)	9,351 (13)
WI	2	28.57 (11)	10,541 (10)
WV	1	20.50 (19)	9,289 (14)
WY	2	22.54 (15)	5,523 (35)
United States	74	14.42	6,770

SOURCE: Authors' analysis of Centers for Medicaid and Medicare Services Form 372 waiver data.
NOTE: All states except AZ operate 1915(c) waivers. AZ operates a 1115 waiver. Elderly waivers include aged and aged/disabled waivers.

the largest single waiting list was an MR/DD waiver in Texas (47,014 persons). In terms of aged waivers alone, there were reported to be 84,169 persons on waiting lists with only 588,031 slots available in total.

Discussion and Conclusions

With 43 states reporting budget deficits in 2002, Medicaid LTC policy makers faced conflicting demands to control expenditures, maintain institutional provision, and expand HCBS (Rowland, 2005). The study presents seven findings concerning Medicaid HCBS programs for the elderly that warrant further investigation.

First, between 1992 and 2002, when compared with all HCBS waivers, elderly waivers grew at a much slower rate in terms of number of programs (63% vs. 53%), participants (292% vs. 211%), and inflation-adjusted expenditures (510% vs. 346%). Although this may reflect to some extent the higher cost of needs of the MR/DD population, it should be noted that this population group is supported by a stronger and more coordinated political lobby when compared with the aged (Kitchener, Carrillo, & Harrington, 2003). As calls for rebalancing Medicaid LTC expenditures toward HCBS are receiving more attention among policy makers, this study suggests a basis for the senior movement to advocate for extended HCBS for elders.

Second, in the most recent study year (2002), the rate of standardized participant growth on each of the three Medicaid HCBS programs and elderly waivers increased at a faster rate than inflation-adjusted per participant expenditures. This could arise from a number of factors, including programs

Table 5. Medicaid Home and Community-Based Services Policies, 2002

	Waiver (N = 250)		*Aged Waiver (N = 72)*		*Home Health (N = 45)*		*Personal Care Services (N = 31)*	
	N	%	N	%	N	%	N	%
Financial eligibility								
150% and below SSI	72	29	18	25	30	67	22	71
151% to 300% SSI	178	71	54	75	4	9	2	6
Other	0		0		11	24	7	23
Groups served								
Aged and disabled	105	42	n/a		45	100	27	87
MR/DD	86	34	n/a		44	98	25	81
Others	61	24	n/a		45	100	24	77
Cost controls								
Hourly/service limits	13	5	3	4	23	51	14	45
Cost limits	117	47	29	40	6	13	1	3
Other limits	14	6	9	13	6	13	1	3
Waiting lists	94	38	24	33	n/a		n/a	
Persons on wait lists	193,912		84,169		n/a		n/a	
Slots	1,105,824		588,031		n/a		n/a	

SOURCE: Authors' waiver survey (2002) and authors' survey of state Medicaid home health and personal care services state plan programs (2002).
NOTE: n/a = not applicable; SSI = Supplemental Security Income; MR/DD = mentally retarded and developmentally disabled.

becoming more efficient, access being improved to beneficiaries with lower levels of need, or reduced quality in terms of, for example, limitations placed on services received.

Third, this study reports that growth in Medicaid HCBS waiver expenditures and participants outpaced the development of the home health and PCS programs. Although recognizing from the outset that the three Medicaid HCBS programs are not direct substitutes (see introduction), this finding raises the question as to why states chose to expand waiver expenditures rather than PCS or home health. Among a number of explanations that warrant investigation, it could be that states are more willing to increase expenditures on waiver programs over which they have control over enrollment when compared to state plan services that must be made available to all eligible participants statewide.

Fourth, between 1999 and 2002, participation and expenditure growth in the mandatory HH program lagged behind the other three Medicaid programs. This likely reflects a combination of dynamics including states diverting clients away from the more expensive (per hour) HH nursing program toward waivers and PCS and possibly federal Medicare home health for dually eligible clients. That said, this study reports that in 2002, average expenditures per PCS participant were more than double that for HH participants, probably because PCS is for long-term care, whereas home health usually focuses on (shorter term) postacute care. In addition, it has been posited that the supply of rural home health providers reduced after payments for "extra drive time" to rural clients was eliminated following the Balanced Budget Act. Finally, stagnant growth in the Medicaid HH program may reflect policy makers' continued concerns about home health care agencies that prompted the introduction of prospective payment under Medicare (the same agencies are funded by both programs). Targeted research is therefore required to examine the nature and implications of stagnation in the development of the Medicaid HH program.

Fifth, this analysis illustrates large interstate variations in participation and expenditures in Medicaid HCBS waivers for the elderly. In terms of the participation per state 1,000 aged population, states ranged from Oregon (79.89) to Tennessee (0.79) with a U.S. average of 14.42. As both of the two highest rankedstates operate only one elderly waiver and both the lowest ranked states operated multiple elderly waivers, it may be that a single elderly waiver provides a better strategic option for improving access, perhaps by centralizing resources. In terms of per participant elderly waiver expenditures, states ranged from North Carolina ($20,199) to New York ($1,327) with a national average of $6,770. Because such variations in participation and expenditures may reflect access and quality issues, this theme warrants focused attention to complement previous analyses of HCBS expenditures and service quality (Institute of Medicine, 2001).

Table 6. Medicaid Long-Term Care (LTC) Expenditures for the Elderly, 1992, 1999-2002 (Inflation Adjusted)[a]

						Percentage Change	
Program	*1992*	*1999*	*2000*	*2001*	*2002*	*1992-2002*	*2001-2002*
Medicaid LTC for the elderly[b]	31,968	41,630	43,981	46,388	49,719	56	7
Medicaid nursing homes[c] ($ million)	31,233	39,295	41,353	43,404	46,440	49	7
Elderly waivers[d] ($ million)	735	2,335	2,628	2,984	3,279	346	10
Elderly waivers as percentage of Medicaid LTC for the elderly	2.3	5.6	6	6.4	6.6	187	3

a. Consumer Price Index–adjusted expenditures reported in constant 2002 dollars.
b. Medicaid LTC for the elderly is Home and Community-Based Services elderly waivers plus nursing homes.
c. Burwell, Sredl, and Eiken (2005).
d. University of California, San Francisco (UCSF) annual waiver program survey (1994-2005) and UCSF annual survey of state Medicaid home health and personal care services (PCS) state plan programs (2000-2005) for all data except 1992-1998 home health and PCS expenditure data taken from Burwell et al. (2005).

Sixth, the findings from our survey indicate how states control the costs of (and access to) Medicaid HCBS programs for the elderly through the use of spending caps, waiver waiting lists, and some "innovative" policies. In one example, although the financial eligibility criteria for most (75%) elderly waivers include participants with incomes of more than 150% of SSI, only 9% of HH programs and 6% of PCS programs are as generous. A number of reasons may explain this finding, including policy makers' relative comfort about expanding access to optional HCBS waiver programs on which they can limit total participation (in contrast to state plan programs). Among the more "innovative" set of policies identified in this study, two examples that warrant targeted examination are the inactive PCS programs in Delaware and Rhode Island and the Florida PCS program that only serves persons in assisted living facilities and children younger than 21 years old. Given the financial difficulties of most states, the extension of cost control policies of Medicaid HCBS for the elderly (e.g., managed care and block grants) can be

anticipated and may hinder the capacity of states to address inequalities of access to Medicaid HCBS.

Finally, this study provides some indication of how efforts to rebalance state LTC systems have impacted on services for the elderly. Although Medicaid nursing home expenditures increased by 49% between 1992 and 2002, this study reports that elderly waiver expenditures rose by 346% (Table 6). As a result, the amount spent on HCBS elderly waivers as a percentage of total Medicaid LTC spending for the elderly (waivers plus nursing homes) rose from 2.3% to 6.6%. Such movements toward "rebalancing" state LTC systems for the elderly have recently been supported by federal policies such as the Deficit Reduction Act of 2005, which contains three initiatives concerned with Medicaid HCBS (Kaiser Commission on Medicaid and the Uninsured, 2006). First, states can apply for competitive awards to help transition persons from institutions into community settings (through the Money Follows the Person Demonstrations). Second, states have the option of offering all HCBS as a state plan option. Third, states are encouraged to expand consumer-directed personal care through the Cash and Counseling Option.

As the dynamics of Medicaid LTC spending controls, rebalancing policies, and attempts to gain greater parity of HCBS expenditures for seniors compared with other groups play out, it will be increasingly important to both address the research questions raised from this analysis and continue to track the trends of Medicaid HCBS in programs and policies for the elderly.

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