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Abstract

The number of Americans needing long-term services and supports (LTSS) is projected to more than double in the coming decades largely due to an aging baby boomer population, meaning paying for LTSS will become an even greater challenge for American families and the country. Despite the benefits of aging in place, there remains a long-standing institutional bias within the Medicaid program, where services in nursing facilities are mandatory while home and community-based services (HCBS) are mostly optional for states to cover. This study examined HCBS 1915(c) waivers (n = 61 waivers) for older adults in order to categorize and compare service priorities. Findings revealed waivers for older adults were primarily focused on supporting individuals in their own homes to age in place. However, findings also revealed HCBS waivers are an underutilized mechanism for funding the LTSS of older adults. As states continue to deal with an increasing population of aging adults, with and without disabilities, the HCBS waiver option will continue to be an important component of a state's service system.

Keywords: older adults; Medicaid Home and Community Based Services (HCBS) 1915(c) waivers; aging in place; community living

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The number of Americans needing long-term services and supports (LTSS) is projected to more than double in the coming decades, from 12 to 27 million by 2050, largely due to an aging baby boomer population and the prevalence of disability increasing with age (SCAN Foundation, 2012). With longer life spans, higher rates of chronic conditions, fewer family caregivers and increasingly limited federal, state and family resources, paying for LTSS will become an even greater challenge for American families and our country (Federal Commission on Long-Term Care, 2013). Medicaid is currently the primary funder of LTSS in the U.S., financing approximately 62% of all LTSS costs (National Health Policy Forum, 2014). However, the Medicaid program requires older adults and people with disabilities to impoverish themselves. Moreover, there remains a long-standing institutional bias within the Medicaid program, where services in nursing facilities are mandatory while home and community-based services (HCBS) are mostly optional for states to cover. For these reasons, the aim of this study was to explore Medicaid HCBS 1915(c) waivers for older adults.

Significant progress has been made over the past two decades in shifting the balance from institutional services to HCBS within states. In 1995, only approximately 18% of national Medicaid LTSS spending was devoted to HCBS (Eiken, Srel, Burwell, & Woodward, 2017). By 2015 (the most recent year for which data is available), HCBS accounted for 55% of total national Medicaid LTSS spending. However, despite overall national progress, significant variations remain across states and different populations receiving services. For example, while HCBS accounted for 75% of total Medicaid LTSS spending for individuals with intellectual and developmental disabilities, HCBS only accounted for 44% of total Medicaid LTSS spending for

older individuals and individuals with physical disabilities. Seven states spend 20% or less of their LTSS expenditures for older adults and individuals with physical disabilities on HCBS.

States have numerous authorities and a great deal of flexibility in how they design Medicaid HCBS program. Three primary authorities that states have used are: 1) mandatory home health services state plan benefit; 2) optional state plan amendments (i.e. personal care services, 1915(i) HCBS state plan option, and 1915(k) Community First Choice option); and 3) optional 1915(c) HCBS waivers. The home health services state plan benefit is the only mandatory Medicaid HCBS benefit. Yet, while every state provides this benefit, services are predominately medically oriented and account for a smaller percentage of HCBS spending than other authorities. A majority of states offer some HCBS through state plan amendments. Although states can design programs in ways to contain expenditures, when states provide services through state plan amendments they must them available to all eligible individuals, without imposing caps or waiting lists. Approximately 32 states offer personal care services through state plan amendments, 14 states offer services through 1915(i) HCBS state plan option, and 8 states have adopted the 1915(k) Community First Choice state plan option to provide personal attendant services and supports (NASUAD, 2018).

The 1915(c) HCBS waiver program has been the main authority states have used to provide HCBS. In 2013, 1915(c) expenditures accounted for 55% of all HCBS expenditures (Eiken et al., 2016a). The program was established by Congress in 1981 under Section 1915(c) of the Social Security Act to shift services to the community and away from institutional settings (Miller 1992). By the 1990s, nearly all states had one or more 1915(c) HCBS waiver programs (Miller, Ramsland, & Harrington, 1999). In 2013, 47 states and the District of Columbia operated 317 1915(c) waivers serving over 1.53 million people (Eiken et al., 2016a).

The developmental disabilities community has heavily utilized the 1915(c) to fund community-based services and supports for this population (Braddock et al., 2015). In 2013, Section 1915(c) programs targeting people with developmental disabilities accounted for 72% of all 1915(c) spending (Eiken et al., 2016a). Programs targeting older adults and people with physical disabilities accounted for approximately 26%. The remaining small percentages of expenditures were for programs targeting other populations, including individuals with brain injuries, medically fragile children, people with HIV/AIDS and people with serious mental illness or serious emotional disturbance.

While trends can be seen in overall expenditures, it is difficult to assess how states have utilized the waiver for various populations. Due to the unique, state-specific nature of HCBS programs, and inadequacies in Medicaid claims data, national level analyses are difficult. In fact, to our knowledge, only one study (Meucci et al., 2018) has examined waivers for older adults, and it did so in combination with waivers for physical disabilities, and across waiver types, rather than only 1915(c) waivers; Meucci et al. (2018) also did not examine service expenditures. However, previous analyses have explored how the intellectual and developmental disability (IDD) services system has utilized the 1915(c) waiver by exploring waiver applications (Friedman, 2017; Rizzolo, Friedman, Lulinski-Norris, & Braddock, 2013). The current study adopts a similar approach to examine services and supports provided by 1915(c) waivers specifically serving older adults. To determine priorities across states and waivers, we developed an older adult waiver taxonomy specifically tailored to services and supports for older adults in order to categorize and compare service priorities. We also examined service allocation (i.e., total projected expenditures, unduplicated participants, average spending per participant, and average length of stay) across states and waivers.

Methods

Medicaid HCBS 1915(c) waivers were gathered from the Centers for Medicare and Medicaid Services (CMS) Medicaid.gov website (n = 502). The first exclusion criteria required waivers to be 1915(c) and serve people older adults (60 years and older) (n = 84). Waivers that targeted all other populations were excluded. Next, waivers that did not include fiscal year (FY) 2016 were excluded. While most often this was the state fiscal year (FY) (July 1, 2015 to June 30, 2016), other states used the federal FY (October 1, 2015 to September 30, 2015) or the 2016 calendar year (January 1, 2016 to December 31, 2016). We use the term FY for consistency. This process resulted in the collection of 61 HCBS older adult waivers from 37 states and the District of Columbia.

CMS requires waivers to describe: CMS assurances and requirements; levels of care; waiver administration and operation; participant access and eligibility; participant services, including limitations and restrictions; service planning and delivery; participation direction of services; participant rights; participant safeguards; quality improvement strategies; financial accountability; and cost-neutrality demonstrations (Disabled and Elderly Health Programs Group et al., 2015). This information was utilized to develop an older adult waiver taxonomy specific to HCBS 1915(c) older adult waivers, mirroring Rizzolo et al.'s (2013) HCBS IDD waiver taxonomy. The newly developed HCBS older adult waiver taxonomy allowed us to determine priorities across states and waivers, including the service category frequency and spending.

A CMS rule allows waivers to combine target populations. Both waivers that provided only for older adults, and waivers that combined older adults with other population (i.e., physically disabled, disabled other) were obtained through our data collection process. As spending and utilization between older adult and people with other disabilities in the combined

waivers could not be differentiated, older adult only waivers were separated out from combined waivers for additional analyses. This allowed us to also examine waiver utilization in depth, particularly analyzing the projected number of users, total projected spending, average annual service allocation per participant, and the average length of stay. Moreover, we were able to determine what service categories received the most funding from older adult only waivers.

Findings

HCBS Older Adult Waiver Service Taxonomy

Services were examined and organized into a HCBS older adult waiver taxonomy. The waiver taxonomy included the following service categories and subcategories: adult day health; care coordination; chore; community transition and integration supports; companion and supervision; family training; financial support services; health and professional services (clinical and therapeutic services; dental; and, nursing and home health); homemaker; individual goods and services; meals; personal care; residential habilitation; respite; specialized medical equipment and assistive technology (assistive technology and environmental modifications; personal emergency response system (PERS); and, specialized medical equipment); supported employment; and, transportation (Table 1).

Frequency of service categories. Specialized medical equipment was the most frequently provided service category across the 61 older adult waivers, with approximately three-quarters of waivers providing this service (Table 2). The following categories were provided by between 50% and 75% of waivers: personal care (73.8%); adult day health (73.8%); health and professional services (70.5%); respite (65.6%); care coordination (63.9%); meals (59.0%); community transition and integration services (55.7%); and, residential habilitation (54.1%). The following categories were provided by between 25% and 50% of waivers: transportation

(49.2%); homemaker (42.6%); chore (31.1%); and financial support services (26.2%). The following service categories were provided by a small minority of waivers – between 0% and 25% of waivers: companion and supervision (24.6%); family training (19.7%); individual goods and services (14.8%); and, supported employment (13.1%).

Service frequencies differed across older adult and combined waivers (see Table 2). While the most frequently provided service categories were specialized medical equipment and assistive technology, personal care, and adult day health for both older adult and combined waivers, 100% of older adult waivers provided these types of services while 71.4%, 69.4%, and 69.4% of combined waivers provided these services. The largest difference across the two waivers was residential habilitation. Residential habilitation ranked as the 7th most frequently provided service category for combined waivers (59.2%), while it was the 14th most frequently provided for older adult waivers (36.4%). Meanwhile, many more older adult waivers provided companion and supervision services (63.6%) than combined waivers (16.3%). While ranked fairly similarly for both types of waivers, there was also a large difference in the frequency of chore between older adult and combination waivers. Approximately 63.6% of older adult waivers provided chore services while only 24.5% of combined waivers did.

Utilization and Expenditures (Older Adult Only Waivers)

Total unduplicated participants. The 11 older adult only waivers projected serving approximately 105,000 participants in FY 2016 (Table 3). While these waivers provided for 9,552 participants on average, the number of total unduplicated participants ranged from 97 participants for Oklahoma's Sooner Services (OK0809.01.00) waiver to 36,421 for Pennsylvania's PA0279.R04.04 waiver.

Total projected spending. In FY 2016 the total projected spending for older adult only waivers was $1.42 billion. The total projected spending ranged by waiver from $2.2 million for Oklahoma's OK0809.01.00 waiver to $755.0 million for Pennsylvania's PA0279.R04.04 waiver; on average the waivers projected $128.65 million. The average spending per capita was $20.70 across the older adult only waivers. Connecticut ($71.74), Pennsylvania ($58.97), and Iowa's ($30.95) waivers had the highest spending per capita while California ($1.02), Oklahoma ($0.57), and Alabama's ($0.53) waivers the lowest (Table 3). Fiscal effort was used to determine a "state's commitment to I/DD services after controlling for state wealth. Fiscal effort is theoretically based on the competitive struggle for government funding" (Braddock et al., 2015, p. 14). On average the 11 older adult only waivers had a fiscal effort of $0.39 per $1,000 of aggregate state personal income. Pennsylvania ($1.20), Connecticut ($1.07), and Iowa's ($0.69) waivers had the highest fiscal efforts while California ($0.02), Alabama ($0.01), and Oklahoma's ($0.01) waivers had the lowest.

Average spending per participant. Average spending per participant for older adult only waivers ranged from $3,372 (California's CA0141) to $22,970 (Oklahoma OK0809), with an average projected spending $12,136 per participant. 9% of waivers (*n* = 1) projected spending between $1 and $4,000 per person on average, 18% (*n* = 2) between $4,001 and $8,000, 27% (*n* = 3) between $8,001 and $12,000, 9% (*n* = 1) between 12,001 and $16,000, 18% (*n* = 2) between $16,001 and $20,000, and 18% (*n* = 2) between $20,001 and $24,000.

Average length of stay. The average length of stay (ALOS) marks how many days the average participant is on the waiver in a year. Across the older adult only waivers the average ALOS was 287 days, ranging from 267 days to 320 days.

Service category spending. The majority of the $1.42 billion of older adult only waiver spending (66.2%) was projected for personal care services in FY 2016, making it the largest service category. The second largest service category was care coordination (8.9%) while the third was homemaker (6.4%). The rest of the service categories each comprised less of 4% or less of spending: Companion and supervision (4%); adult day health, meals, and health and professional services (3% each); specialized medical equipment and assistive technology (2%); residential habilitation (1%); transportation, financial support services, chore, community transition and integration supports, supported employment, individual goods and services, and family training (<1% each). See Table 4.

Discussion

As there has been significant progress over the past two decades in shifting the balance from institutional services to HCBS within states, the aim of this research was to explore HCBS 1915(c) waivers for older adults. In particular, this study sought to provide aggregate-level information on how states were providing services and supports within Medicaid HCBS 1915(c) waiver programs specifically serving older adults, and, because of their unique needs, develop a HCBS 1915(c) taxonomy specific to older adults. In FY 2016, 37 states and the District of Columbia provided 61 older adult waivers, 11 of which were specifically tailored to older adults. Our findings revealed waivers for older adults were primarily focused on supporting individuals in their own homes to age in place. For example, we found services such as personal care, respite, and residential habilitation were all provided by the majority of older adult waivers.

However, our findings revealed wide variation across states in waiver programs for older adults. For example, the number of unduplicated participants ranged from 100 to 36,000. Average spending per person also ranged from approximately $3,000 to $23,000. Even total

projected spending per state ranged from $2.2 million to $755.0 million; total projected spending continued to differ widely even when state size (spending per capita) and state wealth (fiscal effort) were controlled. While disparate, these discrepancies are the hallmark of the HCBS waiver system – states ability to customize waivers as they see fit results in large state by state differences (Friedman, 2017).

In addition to these large differences, across the waivers, the total unduplicated participants was only 105,000 people in FY 2016. For comparison, 1.4 million people lived in nursing homes in 2014 (Centers for Disease Control and Prevention, 2016). Moreover, the total projected spending of older adult only waivers was $1 billion in FY 2016, which may seem significant, but for comparison, approximately $26 billion was projected for waiver services people with IDD in FY 2015 (Friedman, 2017). These differences are even more significant when one considers that there are significantly fewer people with IDD in the United States (6 million) compared to older adults (46 million), and that the number of older adults will continue to grow (Boyle et al., 2011; Mather, Jacobsen, & Pollard, 2015).

As evidenced by our findings, HCBS 1915(c) waivers are an underutilized mechanism for funding the LTSS of older adults. Indeed, one of the problems with the service system for older adults is its functioning as a patchwork of a variety of different mechanisms, all of which can be confusing and inaccessible. For example, one of the main mechanisms to support older adults in the community are those supports provided under the umbrella of the Administration on Aging (AoA), which was created under the Older Americans Act (1965). The AoA includes core services such as transportation, Meals on Wheels, and Elder Rights Services. Yet, the AoA is an entity that oversees and promotes different community-based programs, rather than a single

funding stream. As funding for Older Americans Act programs has not kept pace with increasing needs, the aging network has increasingly relied on Medicaid funding.

Another, small, but viable option for some older adults is the Programs of All-inclusive Care for the Elderly (PACE). PACE is a "capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity" (Smith, Gifford, & Ellis, 2015). While PACE provides coordinated medically-necessary care and services, the PACE program is relatively small (only 45,000 participations as of February 2018 (National PACE Association, 2018)) because of the large start-up costs involved, physician buy in, coverage of only those who meet a nursing facility level of care and who live in PACE service areas, and very discreet targeted catchment areas (L&M Policy Research, 2011).

As a result of this complicated array of services, older adults can find themselves in need of community-based services and supports but may be at a loss to understand the options available and how to access services, with a variety of eligibility criteria and service delivery mechanism. Kane and Kane (1981) note, "complicated requirements regarding eligibility and coverage as well as variations in the availability of programs confuse even the most diligent physicians trying to advise elderly patients about health care services" (p. 503). To assist individuals in navigating, the federal government and states have made investments in Aging and Disability Resource Centers (ADRCs). However, additional funding provided thought the Affordable Care Act has dwindled and the fate of the future expansion of ADRCs is uncertain.

Even more problematically, this patchwork of community services, is coupled with a systemic institutional bias. The Medicaid HCBS program has had important contributions, yet the existence of alternative funding mechanisms does "not eliminate states' obligations to pay for services provided in the isolation of institutions... In Medicaid, integration is optional, but

segregation is mandatory" (Crossley, 2017, p. 5). As a result, while an individual may prefer to age at home, there may not be availability of such services.

Advocates, such as ADAPT, have been pushing for the Disability Integration Act (H.R.2472 and S.910), which aims to end Medicaid's institutional bias, in favor of community based LTSS (ADAPT, n.d.). Moreover, recently, CMS has reinforced that recipients of services should have the same access to community as people not receiving services through the Medicaid HCBS settings rule (CMS 2249-F/2296-F). The settings rule is an attempt to "develop and implement innovative strategies to increase opportunities for Americans with disabilities and older adults to enjoy meaningful community living" (Medicaid Program, 2014). In doing so, it moves towards defining HCBS by the quality of participants experiences, rather than physical location.

Because of their commitment to community access and inclusion, as well as their ability to be tailored for specific needs, HCBS 1915(c) waivers for older adults are the perfect mechanism to meet the community standards set by the settings rule, as well as create a stronger community infrastructure. Compared to institutional care, aging in place allows older adults to maintain social relationships and attachments, be more independent, have more autonomy, and generally be more connected to place and community (Wiles et al., 2012). In addition to the benefits of aging in place, and the preference of older adults, community living is also significantly more cost effective compared to institutional settings (U.S. Department of Housing and Urban Development, 2013). For example, "Medicaid can pay for three people receiving community-based LTSS for every person in a nursing home" (Coughlin et al., 2017, p. 1). Mirroring the literature, the average spending per person in our study was approximately $12,000, which is a fraction of the median annual cost for nursing facilities ($91,250 in 2015)

(Genworth, 2015). The funding saved from shifting to community LTSS can then be used to expand the services provided for older adults, thereby strengthening community infrastructure.

When developing a stronger HCBS waiver system for older adults, states can also look to the IDD waiver system for a good example of an existing waiver infrastructure that provides a wide range of LTSS tailored to suit the needs of this underserved population. In addition to utilizing waivers much more frequently for people with IDD than older adults, our findings also illustrate clear differences in *how* states have used HCBS waivers to provide services and supports to older adults versus those with IDD. There are large difference in service categories utilized, funding allocation, and overall spending between waiver serving older adults and those serving adults with IDD. Compared to older adult waivers, IDD waivers tend to provide a greater variety of services (Friedman, 2017) – ones which encompass a more wholistic quality of life and social determinants of health, which could be due to a long history of advocates using waivers to promote community inclusion. For example, few HCBS waivers for older adults have included employment supports and family caregiver supports, such as training. However, analyses of the National Core Indicators-Aging and Disability (NCI-AD) have demonstrated high desires for employment supports by older adults (NASUAD and HSRI, 2017). Moreover, the AARP Long-Term Services and Supports Scorecard highlights needs to better support family caregivers (Reinhard et al., 2017).

Moreover, IDD waivers spend more per person on average (approximately $38,000 in FY 2015), compared to the older adult waivers in our study (approximately $12,000 in FY 2016). While some of these differences may be due to a more comprehensive set of services being offered in IDD waivers, it may also be due a differentiation between two different types of waivers – support and comprehensive (traditional) waivers. Traditional comprehensive waivers

are those which provide a wide range of services, most significantly residential services, whereas support services have a relatively low dollar cap because they are targeted for individuals that live with families, and in who in many cases, rely on unpaid supports from family (Smith, Agosta, Fortune, & O'Keeff, 2007). Many of the HCBS waivers currently in place for older adults resemble support waivers. While support waivers are significantly more cost effective, in the case of services for older adults, they may simply be a matter of pushing the costs to a later date as support waivers are highly dependent on unpaid family caregivers. As the population ages those caregivers will be less able to provide care. As such, it appears the IDD and older adult service systems have much to offer each other in moving forward to best serve those in need of community-based supports and services. Older adults may benefit from more robust service offerings such as those currently found in IDD waivers. Meanwhile, those in the IDD community could benefit from a wider variety and network of community-based supports such as those found in the AoA system. Moreover, both older adults and people with IDD may benefit from an expansion in number and scope of PACE programs.

Limitations and Future Research

One limitation that should be noted is that HCBS 1915(c) waivers are projections made to the federal government rather than actual utilization data. However, past research has found them to be a reasonably accurate proxy as they are based on previous years' utilization data (Rizzolo et al., 2013). Rizzolo et al.'s (2013) analysis of HCBS waivers for people with intellectual and developmental disabilities (IDD) revealed similar findings to Braddock et al.'s (2015) analysis of IDD waiver expenditures. To examine actual utilization of HCBS waivers for older adults and the prioritization of expenditures there is a need for better claims data. Currently claims data may

underreport expenditures as a few services (e.g., case management) can for paid for using administrative funds (Peebles & Bohl, 2014, E14).

Another limitation of our study was that our examination of projected participants and expenditures was confined to older adult only waivers. The majority of waivers serving older adults in FY 2016 were combined with other populations (e.g., physical disability). In these combined waivers were not able to differentiate between spending for older adults and other populations; for this reason, we were not able to examine utilization in depth for combined waivers. However, utilizing independent samples *t*-tests we find no significant differences between older adult only and combined waivers in terms of total projected spending, projected participants, or average length of stay, suggesting the expenditure trends we found are likely applicable to the combined waivers as well.

Conclusion

Medicaid HCBS 1915(c) waivers are a useful yet underutilized mechanism for supporting community based LTSS of older adults. Waivers allow states to tailor their services to the needs of older adults and provide them with community-based services. Waivers are also more cost effective, which is particularly important in this reduced fiscal landscape. As states continue to deal with an increasing population of aging adults, with and without disabilities, who will need service and supports, budgetary constraints and unknowns, increased regulatory issues such as the HCBS Settings rule, and an ever-increasing focus on quality outcomes, the HCBS waiver option will continue to be an important component of a state's service system for older adults.

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Table 1
Service Category Definitions

Category	Definition
Adult day health	"Services generally… in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant"[a]
Care coordination	"Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services"[b]
Chore	"Services needed to maintain the home in a clean, sanitary and safe environment…includes heavy household chores... [they] are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them"[c]
Community transition and integration supports	Services involve both transition and integration services. Community transition supports are defined as "non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses"[d]. Community integration supports, aid people in "developing, retaining, or improving skills to attend social events, recreational activities, and volunteering"[e].
Companion & supervision	"Non-medical care, supervision and socialization… Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping"[c].
Family training	"Instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home" specifically for unpaid family[c].
Financial support services	Services which help the older adult or family member "manage and direct the disbursement of funds contained in the participant-directed budget; facilitate the employment of staff…and, performing fiscal accounting"[f].
Health and professional services	
Clinical & therapeutic services	"Assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan"[c].
Nursing and home health	"Provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State"[d]. Similar to nursing, home health services include "personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist"[g].
Dental	The technical guide does not specifically define dental services. The following definition is from Oklahoma Sooner Seniors waiver (OK0809.R01.02): "Dental services include maintenance or improvement of dental health as well as relief of pain and infection."
Homemaker	"The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable."[b]

Individual goods and services	"Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment."[c]
Meals	The CMS technical guideline does not provide a direct definition of meals. We compiled the following definition from the aging services definitions: home delivered meals include preparation and delivery of meals for people unable to prepare their own food. Meals should meet nutritional guidelines for optimum health. Special diets, such as for diabetic or Kosher people, should be available. Some meal programs include liquid nutritional supplements.
Personal care	"Assistance to enable waiver participants to accomplish tasks that they would normally do for themselves... This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task"[h].
Residential habilitation	"Supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight"[a].
Respite	"Services…furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant"[i].
Specialized medical equipment and assistive technology	
Assistive technology	"An item, piece of equipment, service animal or product system…that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device"[d].
Environmental adaptations	Home modifications include, "those physical adaptations to the private residence of the participant or the participant's family… that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home"[j]. Vehicle modifications include, "adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant"[j].
Specialized medical equipment	"Devices, controls, or appliances… that enable participants to: increase their ability to perform activities of daily living:… perceive, control, or communicate with the environment in which they live;… [and] address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items"[j]. It also includes medical supplies, "such other durable and non-durable medical equipment"[j].
Personal emergency response system	"An electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable 'help' button… programmed to signal a response center once a "help" button is activated… to allow for mobility"[d].

Supported employment	"Intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting… The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals"[k]
Transportation	"Offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan"[j].

[a]Disabled and Elderly Health Programs Group et al. (2015, p. 146-147). [b]Disabled and Elderly Health Programs Group et al. (2015, p. 141-142). [c]Disabled and Elderly Health Programs Group et al. (2015, pp. 170-172). [d]Disabled and Elderly Health Programs Group et al. (2015, pp. 164-166). [e]citation removed for review. [f]Disabled and Elderly Health Programs Group et al. (2015, pp. 176-177). [g]Pennsylvania's Aging Waiver (PA0279R0405). [h]Disabled and Elderly Health Programs Group et al. (2015, p. 144). [i]Disabled and Elderly Health Programs Group et al. (2015, p. 156). [j]Disabled and Elderly Health Programs Group et al. (2015, p. 161-163). [k]Disabled and Elderly Health Programs Group et al. (2015, p. 152).

Table 2
Older Adult Waiver Services

	AL 068	AL 0878	CA 0006	CA 0141	CA 0431	CA 0855	CT 0140	DC 0334	FL 0962	GA 0112	IA 4155	ID 1076	IL 0326
Older adult only waiver		x		x			x				x		
Services:													
Personal care	x	x	x	x	x		x	x	x	x	x	x	
Care coordination	x	x	x	x	x	x	x	x	x	x	x		
Respite	x	x	x	x			x	x	x	x	x	x	
Homemaker	x	x	x		x		x	x	x		x	x	
Companion & supervision	x	x		x			x		x		x	x	
Adult day health	x	x	x	x			x	x	x	x	x	x	
Meals	x	x		x		x	x		x	x	x	x	
Health and professional services		x	x	x		x	x	x	x	x	x	x	
Specialized medical equipment & assistive technology		x	x	x		x	x	x	x	x	x	x	
Residential habilitation			x		x	x	x	x	x	x		x	x
Transportation			x	x			x		x		x	x	
Financial support services				x			x			x	x		
Chore				x			x	x			x	x	
Community transition & integration supports		x	x	x	x		x	x					
Supported employment											x		
Individual goods & services								x			x		
Family training									x				
Other													

Table 2
Older Adult Waiver Services

	IN 0210	KS 0303	KY 0967	LA 0121	LA 0866	MA 0059	MA 1027	MA 1028	MD 0265	MD 0645	ME 0276	ME 0995	MI 0233
Older adult only waiver		x				x							
Services:													
Personal care	x	x	x		x	x	x		x		x	x	
Care coordination	x		x	x	x				x		x	x	x
Respite	x		x		x	x	x		x		x		x
Homemaker	x		x			x	x				x		
Companion & supervision						x							
Adult day health	x	x	x	x	x	x	x	x	x	x	x		x
Meals	x				x	x			x				x
Health and professional services	x	x	x		x	x	x	x	x		x	x	x
Specialized medical equipment & assistive technology	x	x	x		x	x	x	x	x		x	x	x
Residential habilitation	x		x		x	x		x	x				
Transportation	x				x	x	x	x			x		x
Financial support services		x	x								x		x
Chore						x	x						x
Community transition & integration supports	x		x	x	x	x			x			x	x
Supported employment			x				x	x				x	
Individual goods & services			x										x
Family			x				x		x				x

training		
Other	x	x

Table 2

Older Adult Waiver Services

	MI 1126	MN 0025	MO 0026	MS 0255	MS 0272	MS 0355	MT 0148	NC 0132	ND 0273	NE 0187	NH 0060	NV 0152	NV 4150
Older adult only waiver									x			x	
Services:													
Personal care	x	x			x			x	x		x	x	x
Care coordination		x			x		x	x	x			x	x
Respite	x	x	x		x		x	x	x	x	x	x	x
Homemaker		x	x				x		x		x	x	x
Companion & supervision		x					x					x	
Adult day health	x	x	x		x		x	x	x	x	x	x	
Meals	x	x	x		x		x	x	x	x	x		x
Health and professional services	x	x	x		x		x		x		x		
Specialized medical equipment & assistive technology	x	x					x	x	x	x	x	x	x
Residential habilitation		x				x	x		x	x	x		x
Transportation	x	x					x		x	x	x		
Financial support services	x						x	x					
Chore	x		x				x		x	x		x	x
Community transition & integration supports	x	x			x		x	x	x	x	x		
Supported employment							x		x				
Individual goods & services							x	x					
Family training		x					x						
Other							x	x		x			

Table 2
Older Adult Waiver Services

	OH 0198	OH 0446	OH 1035	OK 0256	OK 0809	OR 0185	PA 0279	SC 0405	SD 0189	SD 0264	UT 0247	UT 0331	UT 0439
Older adult only waiver					x		x				x		
Services:													
Personal care	x		x	x	x		x	x	x	x	x	x	x
Care coordination				x	x	x	x	x		x	x		x
Respite	x		x	x	x			x	x		x		x
Homemaker	x		x						x		x		x
Companion & supervision	x							x	x		x		
Adult day health	x		x	x	x		x	x	x		x		x
Meals	x		x	x	x		x	x	x		x		x
Health and professional services	x		x	x	x		x		x	x	x		x
Specialized medical equipment & assistive technology	x		x	x	x		x	x	x	x	x	x	x
Residential habilitation		x	x	x	x				x				x
Transportation	x		x		x		x	x			x		x
Financial support services											x	x	x
Chore	x		x								x		x
Community transition & integration supports	x	x	x	x	x		x	x			x		x
Supported employment													
Individual goods & services					x		x						
Family training					x		x						x
Other													

Table 2
Older Adult Waiver Services

	VA 0321	VA 40206	WA 0049	WA 0443	WA 1086	WI 0367	WV 0134	WY 0236	WY 0369
Older adult only waiver Services:									
Personal care	x		x	x		x	x	x	
Care coordination	x					x	x	x	x
Respite	x					x		x	
Homemaker									
Companion & supervision									
Adult day health	x		x			x		x	
Meals			x			x		x	
Health and professional services			x	x	x	x	x	x	
Specialized medical equipment & assistive technology	x		x	x	x	x			
Residential habilitation		x	x		x	x			x
Transportation			x			x	x	x	
Financial support services						x		x	
Chore									
Community transition & integration supports	x		x			x			
Supported employment						x			
Individual goods & services				x					
Family training				x		x			
Other			x			x			

Table 3
Older Adult Only Waivers (FY 2016)

State	Waiver	Total projected spending	Unduplicated Participants	Average spending per participant	Average length of Stay	Spending per capita	Fiscal effort
Alabama	AL0878.R00.00	$2,556,511	200	$12,783	320	$0.53	$0.01
California	CA0141.R05.00	$40,011,031	11,864	$3,372	295	$1.02	$0.02
Connecticut	CT0140.R06.00	$257,595,513	15,549	$16,567	296	$71.74	$1.07
Iowa	IA4155.R05.00	$96,695,352	13,238	$7,304	280	$30.95	$0.69
Kansas	KS0303.R04.00	$62,140,988	7,179	$8,656	284	$21.34	$0.47
Massachusetts	MA0059.R06.00	$170,407,790	16,982	$10,035	267	$25.08	$0.41
North Dakota	ND0273.R04.00	$7,880,715	477	$16,521	270	$10.41	$0.19
Nevada	NV0152.R06.00	$16,269,204	2,524	$6,446	283	$5.63	$0.13
Oklahoma	OK0809.R01.00	$2,228,089	97	$22,970	272	$0.57	$0.01
Pennsylvania	PA0279.R04.04	$754,999,877	36,421	$20,730	291	$58.97	$1.20
Utah	UT0247.R05.00	$4,380,221	540	$8,112	298	$1.46	$0.04

Table 4
Spending by Category (Older Adult Only Waivers)

	Projected spending (millions)	%
Personal care	$936.31	66.2%
Care coordination	$126.36	8.9%
Homemaker	$91.16	6.4%
Companion and supervision	$58.32	4.1%
Adult day health	$49.1	3.5%
Meals	$48.47	3.4%
Health and professional services	$40.17	2.8%
Nursing and home health	$38.22	2.7%
Clinical and therapeutic services	$1.93	0.1%
Dental	$.01	0.001%
Specialized medical equipment and assistive technology	$29.14	2.1%
Personal emergency response system (PERS)	$14.01	1.0%
Assistive technology and environmental modifications	$7.9	0.6%
Specialized medical equipment	$7.22	0.5%
Residential habilitation	$14.15	1.0%
Transportation	$5.83	0.4%
Financial support services	$5.35	0.4%
Respite	$4.82	0.3%
Chore	$4.27	0.3%
Community transition and integration supports	$1.29	0.09%
Supported employment	$.31	0.02%
Individual goods and services	$.12	0.01%
Family training	$.01	0.001%