

**STATE MEDICAID HOME CARE POLICIES:  
INSIDE THE BLACK BOX**

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This study was supported by grants from the Kaiser Commission on Medicaid and the Uninsured and National Institute on Disability and Rehabilitation Research. The views expressed in this report are those of the authors and do not necessarily reflect those of either sponsor.

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**Abstract**

With Medicaid now the largest budget item for many states and the biggest payer of home and community-based services (HCBS), there is increasing interest in the policies used by states on their three main Medicaid HCBS programs: 1915(c) waivers, state plan personal care, and home health. This article presents an analysis of annual national surveys (2002-2004) of Medicaid HCBS programs that investigate the four main features over which states have discretion: (1) eligibility criteria, (2) services offered (including consumer-direction), (3) discretionary cost controls (financial caps, service limits, and wait lists), and (4) workforce issues including the use of independent providers. The findings advance knowledge of state policy trends within each of the three programs and variations between them.

**Keywords:** Medicaid, long-term care, home and community-based services, policies, cost controls, eligibility, workforce.

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**INTRODUCTION**

State Medicaid long term care (LTC) systems are wrestling with tight budgets, the financial demands of institutional care (e.g., nursing homes), and pressures to extend alternative home and community-based services (HCBS). Beyond reports that Medicaid HCBS served a total of 2.3 million persons at a cost of \$25.3 billion in 2002, little is known about the operation of the three main Medicaid HCBS programs: 1915(c) waivers, state plan personal care services [PCS], and home health (Kitchener, Ng, and Harrington, 2006; Harrington, LeBlanc, Wood, Satten, and Tonner, 2002). While previous studies have compared the cost of Medicaid HCBS waivers with institutional care (Kitchener, Ng, and Harrington, 2006) and examined policies used on individual Medicaid HCBS programs in a single year, none has opened the black box to investigate trends in policies across all three Medicaid HCBS programs (LeBlanc, Tonner, and Harrington, 2000; Kitchener, Ng, and Harrington, 2004; Harrington, LaPlante, Newcomer, Bedney, Shostak, Summers, Weinberg, & Basnett, 2000; Harrington, Carrillo, Wellin, Norwood, and Miller, 2001).

This article presents an analysis of annual national surveys (2002-2004) of Medicaid HCBS programs that investigate the four main features over which states have discretion: (1) eligibility criteria, (2) services offered (including consumer-direction), (3) discretionary cost controls (financial caps, service limits, and wait lists), and (4) workforce issues including the use of independent providers. The findings advance knowledge of policy trends within each of the three programs and variations between them.

This paper contains four main sections. The first outlines the current context of Medicaid HCBS policy and compares the policy frameworks of the three programs considered in this study. Section two describes the study design and methods. The third section presents the study findings and the paper concludes with a discussion of policy implications.

## **Medicaid HCBS**

**Policy context.** With 43 states reporting budget deficits in 2003 and the Deficit Reduction Act (DRA) of 2005 seeking to reduce federal Medicaid expenditures by \$11.5 billion over the next five years, states face two major pressures to expand Medicaid HCBS programs (Crowley, 2006; Kaiser Commission on Medicaid and the Uninsured, 2003; Boyd, 2003). First, the public increasingly displays a preference for Medicaid LTC services provided at home or in the community rather than in institutions (AARP, 2003; Institute Of Medicine, 2001). Second, following the 1999 *Olmstead* Supreme Court decision (prohibiting states from refusing to provide HCBS when they are available and appropriate) consumers have brought compliance lawsuits against some states (Stewart, Teitelbaum, and Rosenbaum, 2002).

In addition to the pressures to expand HCBS provision, consumer advocacy and policy initiatives encourage two changes to the operation of state Medicaid HCBS programs (Kitchener and Harrington 2004). First, there is mounting pressure to allow independent providers (persons who are not not-agency employed and who may be relatives, where allowed) to enroll (be paid) as caregivers (e.g., personal attendants). While some HCBS consumers have long-demanded to be able to use independent providers including family members, the change has more recently been proposed as a response to workforce shortages. Second, consumer-directed models of care have been promoted to allow HCBS users greater capacity to manage their care providers through combinations of hiring and firing, training, and supervision. Following the Cash and

Counseling demonstration projects in three states, the DRA permits states greater freedom to allow for self-direction of personal assistance services (Crowley, 2006).

While the nature of states' management of Medicaid HCBS programs is influenced greatly by local politics and finance, the differing policy frameworks of the three Medicaid HCBS programs present certain opportunities and constraints.

**Medicaid HCBS Programs and Policies.** The only Medicaid LTC benefits that states are mandated to provide are institutional care and home health for people who are eligible for institutional care (Harrington, Carrillo, Wellin, Norwood, and Miller, 2001). In 2002, the 51 state Medicaid home health programs served a total of 722,257 participants<sup>1</sup> with skilled nursing care at a cost of \$2.8 billion (Kitchener, Ng, and Harrington, 2004). States may also pay for Medicaid HCBS through two optional programs: 1915(c) HCBS waivers; and the state plan PCS benefit. In 2002, the national total of 252 waiver programs served 917,260 participants at a cost of \$16.8 billion and the 32 state plan PCS benefits served 683,099 participants<sup>1</sup> at a cost of \$5.6 billion (Kitchener, Ng, and Harrington, 2004). Recognizing that the three Medicaid HCBS programs are not substitutes for each other, Table 1 compares them in terms of the four key dimensions: (1) eligibility criteria (financial and functional), (2) services offered (including consumer-direction), (3) cost controls (financial caps, service limits, and wait lists), and (4) workforce issues including use of independent providers, rates, benefits, and training.

Table 1 here

**Eligibility criteria.** For the Medicaid home health program, participants are required to have a professionally-authorized skilled nursing facility level of care need, and a categorical financial need which is most typically 100 percent of Supplemental Security Income (SSI)

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<sup>1</sup> Participants on each of the Medicaid HCBS programs may also be served on the other programs so participant counts duplicated

(Harrington et al., 2000). As with all HCBS programs, states can also opt to include the medically needy (those who spend down to the state standard because of medical expenses), including the elderly. The financial requirement for the PCS benefit is also categorical need but, in contrast to the home health program, the functional need criteria for the PCS benefit are set by states and assessed by professionals.

While members of all Medicaid target groups (e.g. Mentally Retarded/Developmentally Disabled [MR/DD] or elderly) are eligible for home health and PCS programs, each waiver can serve only members of specified target groups (e.g., elderly, MR/DD, and physically disabled). The financial eligibility requirement for waivers is that persons (of the target group) are either categorically eligible or meet the (more generous) financial criteria for Medicaid institutional care (300 percent of SSI). Because all waiver participants must also meet the level of care need for an institution (nursing home, hospital or ICF-MR), the need criteria used by waiver programs is typically stated as either “same as for institutional care” or “more stringent than for institutional care.”

**Services offered.** In terms of the services provided under the three Medicaid HCBS programs, the key difference is that while home health and the PCS benefits concentrate on a single service (skilled nursing care and personal assistance respectively), waivers provided a wide range of HCBS to participants irrespective of which target group they cover. The Medicaid home health program provides only skilled nursing care and 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. Under the Medicaid personal care services benefit, programs typically involve non-medical assistance with activities of daily living such as bathing and eating (LeBlanc, Tonner, and Harrington, 2001). Waivers allow states to provide a

wider range of HCBS to each target group including optional Medicaid benefits (e.g., personal assistance), home health, and benefits not otherwise authorized by Medicaid (e.g., home modifications).

While none of the three Medicaid HCBS programs is prohibited from allowing consumer directed models of care, the skilled nature of care provided in the home health program may limit the consumers' capacity for direction. Previous studies of consumer direction in HCBS have reported a variety of approaches emerging in both the waiver and PCS programs which, in some cases, allow clients to hire and fire agency-employed providers.

**Cost Controls.** Costs control on the home health and PCS programs may only include 'hard' cost caps (e.g., per participant expenditure limits per week) and service limits (e.g., restricting the number of care hours per week). In contrast, states must operate two cost controls on all waiver programs: (1) cost neutrality (keeping Medicaid costs per participant at no greater cost than institutional care), and (2) limiting the number of participant 'slots'. Additionally, states may also use other costs controls on waivers including cost caps, service limits, waiting lists, and limiting services to specified regions (e.g., county) (Harrington, Carrillo, Wellin, Norwood, and Miller, 2001).

Despite the cost controls in use on the waiver program, between 1999 and 2002, large increases in participation and expenditures (31 percent and 53 percent respectively) were accompanied by a 7.7 percent jump in inflation adjusted per participant expenditures (Kitchener, Ng, and Harrington, 2004). In contrast, between 1999 and 2002, inflation adjusted expenditures per participant fell on the PCS program by 3.2 percent and reduced by 0.03 percent in the home health program.

**Workforce Issues.** Under each of the three Medicaid HCBS programs, states have considerable discretion over most workforce policies including, reimbursement rates and requirements concerning provider benefits and training. In one exception, while states can allow independent providers to serve waiver and PCS programs, home health providers must be licensed or certified home health agencies.

## **STUDY DESIGN AND METHODS**

**Data Sources.** Because information on the policies used by states on Medicaid HCBS programs is not reported by CMS, this study developed questionnaires to collect such information from all Medicaid waiver, PCS, and home health programs. Instruments were devised to investigate the four main program features over which state Medicaid agencies have discretion (see Table 1): (1) eligibility criteria, (2) services offered including consumer direction, (3) cost controls (financial caps, service limits, and wait lists), and (4) workforce issues (rates, benefits and training).

Starting in the spring of 2002, the questionnaires were distributed annually by email to officials for each Medicaid HCBS program. If no response was received within a month, or if queries with responses arose, the officials were contacted by telephone or fax. By the end of the data collection period in December 2005, responses were received for the following proportions of each program: (1) Waivers, 250 of 252 in 2002, 254 of 267 in 2003, and 254 of 268 in 2004; (2) PCS, 30 of 32 in each year of the study period; and (3) HH, 44 of 51 in each year of the study period. Each survey uses a separate, standard instrument; copies are available on request from the first author. 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.

**Data Analysis and Reporting:** All survey responses were coded using a standardized protocol and then stored as an SPSS dataset. At the end of the data collection period, all coding was re-checked by the research team and descriptive statistics for each survey item were produced. Because there was little variation in responses between years, this paper concentrates on reporting findings from the most recent study year (2004). Data for earlier years and trends are reported only when variations emerged.

## **FINDINGS**

### **Eligibility Criteria**

Figure 1 here

In 2004, 40 of the 44 state Medicaid home health programs that responded to our survey used a financial eligibility criterion that was 150 percent of SSI or lower (of these states, all but one used 100 percent of SSI; Illinois used 150 percent of SSI). The other four state Medicaid home health programs reported used one of two ‘other’ criteria: (1) 300 percent SSI (Arizona, Colorado and Virginia), or (2) \$759 individual monthly income (Massachusetts). Over the study period, 3 state Medicaid Home health programs reported moving from 300 percent of SSI to adopt a more stringent criterion of 100 percent of SSI (Georgia, New Jersey and Texas).

In 2004, of the 30 reporting state Medicaid PCS programs, 28 used a financial eligibility criterion that was 150 percent of SSI or lower (all these used 100 percent SSI). Of the other two PCS programs, Florida used 88 percent of poverty level and Texas used 300 percent SSI. There was no variation over the study period in the financial eligibility criteria used by state PCS programs.

In 2004, while 182 waivers (72 percent) employed between 151 and 300 percent of SSI as the financial eligibility criterion, 72 waivers (28 percent) used the more stringent criterion of 150 percent of SSI or below. This means that more than a quarter of waivers used more stringent financial eligibility standards than the nursing facilities that they provide an alternative to. There was very little variation in the use of financial eligibility criteria between waivers targeted towards different population groups. The more stringent criterion (150 percent SSI and less) was used on 24 elderly/disabled waivers (24 percent of those waivers), 25 MR/DD waivers (27 percent of MR/DD waivers), and 24 other waivers (40 percent of those waivers) including those for children, and persons with mental illness.

This study found very little change over time in the use of waiver financial eligibility criteria. When compared with the first study year (2002), 16 waivers in five states (Alabama, California, Illinois, Indiana, and Rhode Island) adopted more generous financial eligibility criteria while 13 waivers in three states (Oregon, California, and Arkansas) became more stringent.

In 2002, in terms of functional need criteria used on the waiver program, only four percent used the “more stringent than institutional” approach. In terms of change during the study period, 7 waivers relaxed their need criteria to adopt the more generous “same as institutional” approach while 4 waivers adopted the more stringent approach. In one unusual approach, a Missouri waiver reported differing need criteria for various services within the waiver. As with the financial eligibility criteria, there was very little variation in the use of need eligibility criteria between waivers targeted towards different population groups. In 2004, the more stringent than institutional criterion is used on only 5 elderly/disabled waivers (5 percent of

those waivers), 1 MR/DD waiver (1 percent of MR/DD waivers), and 2 ‘other’ waivers (3 percent of the waivers covering groups including children and persons with AIDS).

This study found that most waivers in 2004 served either persons with MR/DD (36 percent) or the elderly/disabled (40 percent) with little change over the study period. In 2004, MR/DD waiver services were provided in all states except New Hampshire while Montana was the only state that did not operate an elderly/disabled waiver. The remaining quarter of all waivers serve other target groups including children, persons with mental health problems, and persons with HIV/AIDS and traumatic brain injuries.

Given the requirement that home health and PCS programs serve all eligible groups it was surprising that the Florida PCS program reports serving only persons living in residential care settings.

## **Services offered**

Table 2 here

In 2004, all Medicaid home health and PCS programs report providing assistance with activities of daily living (ADLs) such as eating and bathing. However, while all but one of the PCS programs (Rhode Island) also provide services to assist with instrumental activities of daily living (IADLs) such as shopping and cooking, only 15 percent of home health programs assist with IADLs. These findings confirm the concentration in home health upon skilled services associated with the traditional medical model of care.

Table 2 also illustrates additional variations that have emerged in the profile of services offered between and within Medicaid PCS and home health programs. In one example, while 39 home health programs provide therapies not provided under any PCS program (primarily speech

and occupational), 16 PCS program provide ‘cuing’ services to assist clients with cognitive impairments perform tasks for themselves.

**Consumer Direction.** In 2004, 21 percent of home health programs and more than 63 percent of PCS benefit programs report that clients are allowed to direct their care to the extent that they can hire and fire care providers. Despite much talk in the literature and among policy makers about the growth of such consumer-directed care, there was no change in these figures over the study period. Similarly for the waiver program, there was no variation over the study period in the 109 waivers that reported operating consumer direction. In 2004, in response to a new question on our survey, of the 109 waivers reporting some aspect of consumer direction, 37 waivers reported that they allocated individual budgets to participants.

### **Discretionary Cost Controls**

Figure 2 here

Between 2002 and 2004, the percentage of waivers using the most popular form of discretionary cost cap (expenditure limits per participant) fell slightly from 38 percent to 32 percent. This reduction involved 13 waivers in eight states (Alabama, Colorado, Georgia, Maine, Missouri, North Dakota, New Mexico, and Rhode Island). On the other hand, the percentage of waivers reporting no forms of discretionary cost controls increased from 50 percent to 53 percent in 2003 and 2004. Among home health and PCS programs, about 50 percent of the programs reported no discretionary program caps while the other half only utilized service time limits over the study period.

Twelve waivers (5 percent) did not provide coverage across the entire state and instead used discretion allowed under the program to operate some form of geographic restriction. For example, a children’s waiver in Indiana serves 10 counties while two aged/disabled waivers in

New Jersey serve only 1 county. A small number of waivers (23), home health programs (3) and PCS programs (1) utilize a combination of limits that include limits on costs, hours of care and/or location of service.

Table 3 here

As shown in table 3, of the 1.1 million total reported waiver slots available in 2002, 17 percent were unused. However, as the number of available waiver slots increased over the study period, the number of waivers with wait lists also increased and the reported number of persons on wait lists rose by 25 percent from 193,936 in 2002 to 242,890 in 2004. Between 2003 and 2004, the average number of persons on waiting lists increased by 19 percent and the average number of months spent on wait lists increased by 43 percent. The number of persons on a waiver waiting list in 2004 ranged from 3 in a Florida Children's waiver to 66,199 in an aged/disabled Texas waiver. The average time spent on a wait list in 2004 ranged from 1 month in a Delaware elderly waiver to 84 months (7 years) in two Oregon DD waivers.

### **Workforce Issues**

Table 4 here

Reflecting long-standing concerns about the supply of HCBS workers, in 2004, 24 percent of home health programs and 40 percent of PCS programs report a shortage of care aides and attendants. These figures are unsurprising given that over the study period: pay rates remained at a little over minimum wage, health benefits were provided to workers in less than 5 percent of home health programs and less than 7 percent of PCS programs; and no PCS program reported paying sick time benefits to attendants.

Beyond these common themes, two key differences emerged in the workforce policies used on the home health and PCS programs as shown in Table 4. First, far more home health programs require providers to be trained and certified than do PCS programs. Second, while more than 50 percent of PCS programs require clients to have a case manager, less than 20 percent of home health programs operate with this requirement.

A much discussed response to personal care workforce shortages has been state authorization of independent (not agency employed) providers. In 2004, 8 PCS programs used independent providers with fiscal intermediaries, 8 PCS programs used independent providers without fiscal intermediaries, 2 states (Massachusetts and Oklahoma) used persons legally responsible for clients, and 11 states allowed other family members and friends to provide formal (paid) care.

## **DISCUSSION**

Four main findings emerged from this study of state policies used on Medicaid HCBS programs. First, over the study period during which 43 states reported budget deficits, the percentage of waivers enforcing cost or service caps declined from 50 percent in 2002 to 47 percent in 2004 (Kaiser Commission on Medicaid and the Uninsured, 2003). Moreover, the percentage of waivers utilizing the more generous medical need criteria increased from 95 percent in 2002 to 97 percent in 2004. These findings may reflect building momentum to comply with combinations of the *Olmstead* ruling and supporting lawsuits, consumer preferences, and policies such as the President's New Freedom Initiative (CMS, 2004).

Second, despite much discussion of consumer-directed Medicaid HCBS, there was no reported increase in the use of this model of care in any program between 2002 and 2004. Third,

although optional Medicaid PCS programs must be available statewide to all categorically eligible recipients, Florida reports that its PCS program is only used by persons living in residential care settings.

Fourth, and disturbingly, states increasingly report using wait lists to limit the number of persons and expenditures on many waivers. Over the study period, as the number of available waiver slots increased, the number of waiver wait list also increased. This is despite the fact that unused slots in 2002 made up 17 percent of all available waiver slots. While it is unclear why some states have unused waiver slots given the unmet need for Medicaid HCBS, it is possible that they did not receive the required state budgetary allocations to fill the slots. It could also be that a limited supply of providers has contributed to this problem in some areas of the country. By 2004, however, there were more than 242,800 persons reported to be on waiver wait lists. These people are unable to receive HCBS waiver services that may help postpone or prevent institutionalization.

Two limitations of this study signal important directions for future research. First, because it was not possible to estimate responses for non-responding waivers, some of the findings (especially the national waiting list total of 242,890 individuals in 2004) should be seen as minimum figures because it is likely that some states may have under/non-reported waiting lists for fear of negative public reactions or legal action. These issues underscore the need for policy initiatives to require the systematic recording and public reporting of state cost control techniques used by public programs. Second, because it was beyond the scope of this study to explore the nature and conditions of services provided on the programs, there is a pressing need for research to examine the scope, quality and cost of Medicaid HCBS on all three programs (Institute Of Medicine, 2001).

Overall, this study provides a basis from which to track and compare policy developments in state Medicaid HCBS programs. Of particular importance will be the ways that these programs are affected as states address the multiple goals of the DRA which include: reducing federal Medicaid spending by \$11.5 billion over five years, creating a new state option for HCBS waiver services, expanding the Cash and Counseling model of self-directed care, and aiding transitions from institutional care to HCBS through Money Follows the Person grants (Crowley, 2006).

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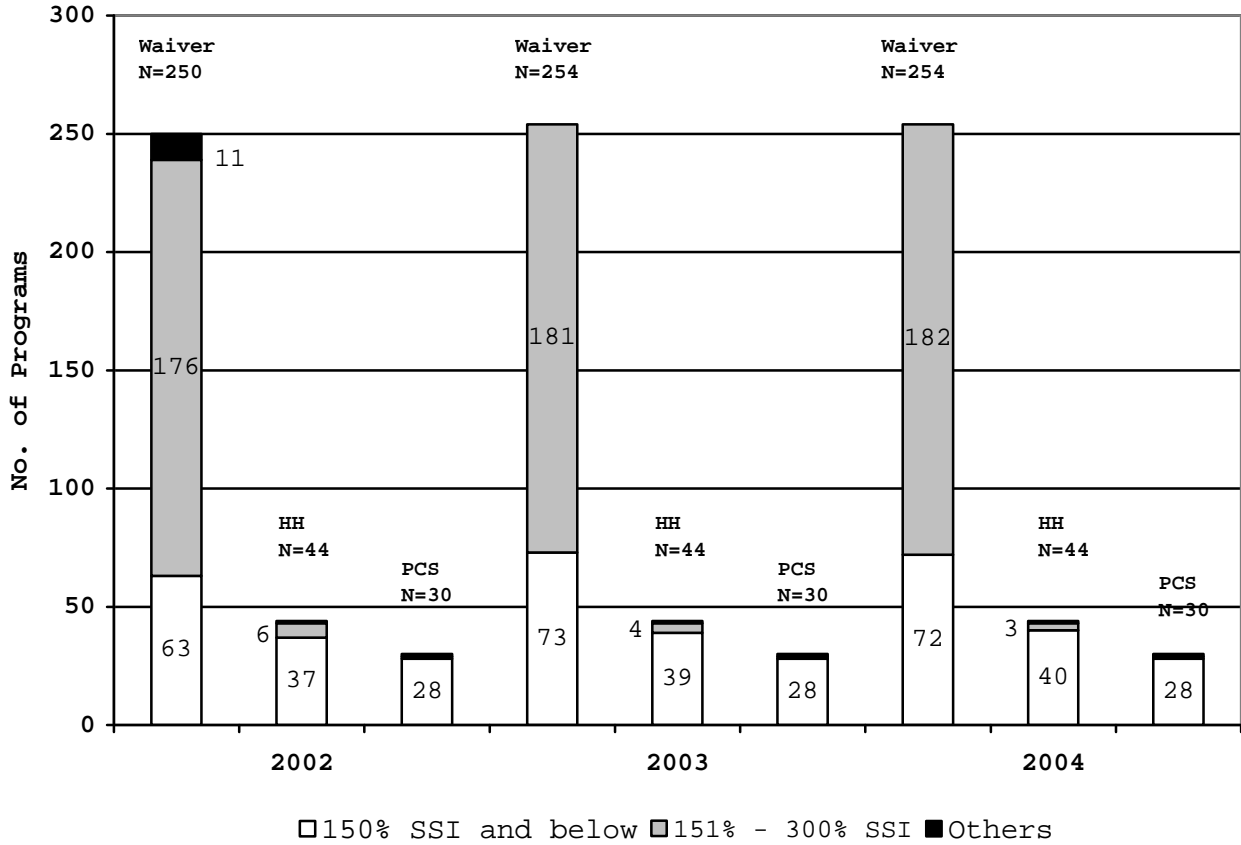
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**Table 1: Medicaid HCBS Programs**

	<b>Home Health</b>	<b>1915(c) Waivers<sup>1</sup></b>	<b>Personal Care Services</b>
<b>POLICIES</b>			
<b>Financial Eligibility Criteria</b>	Categorical	Categorical or same as facility	Categorical
<b>Functional (Need) Eligibility Criteria</b>	Nursing home level, all target group	Institutional level (minimum), specified target groups	Authorized, all target groups
<b>Services Allowed</b>	Skilled nursing, some IADLs.	Wide range including personal care, case management etc	IADLs, cuing, transport etc.
<b>Consumer direction</b>	State policy	State policy	State policy
<b>Mandated cost controls</b>	None	Cost neutrality, slots, target group	None
<b>Optional cost controls</b>	Cost caps, service limits	Cost caps, service limits, wait lists	Cost caps, service limits
<b>Workforce issues Independent providers</b>	No	State policy	State policy
<b>Rates, benefits, training</b>	State policy	State policy	State policy

<sup>1</sup> All states except AZ operate 1915(c) waivers, AZ operates an 1115 research and demonstration waiver for its LTC system

**Figure 1: Medicaid HCBS Programs Financial Eligibility Criteria, 2002-2004**



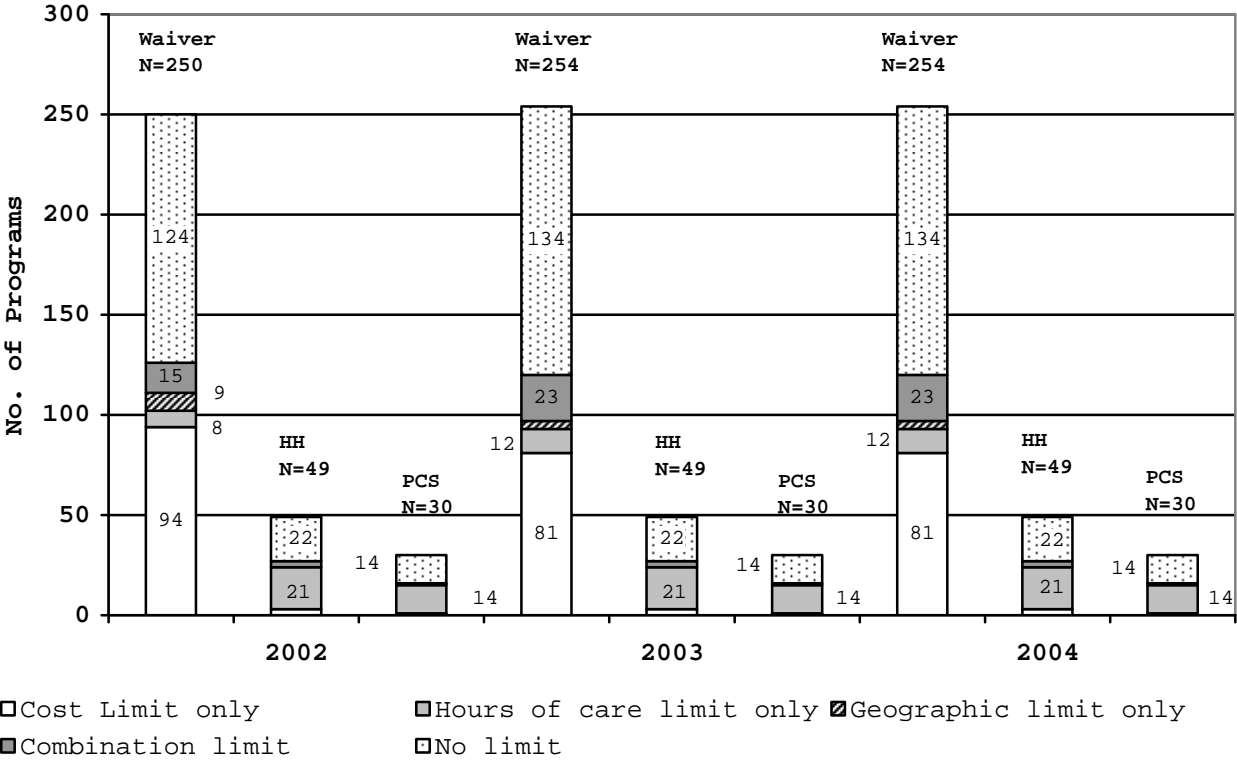
Note: State Supplemental Security Payments are not considered in this analysis

**Table 2: State Medicaid Home Health and PCS Programs: Allowed Providers, Services, and Assessment Policies, 2002-2004**

	Home Health			PCS		
	2002 (N=46)	2003 (N=46)	2004 (N=46)	2002 (N=30)	2003 (N=30)	2004 (N=30)
<b>Provider Types Allowed by Program<sup>1</sup></b>						
Home health agencies	46	46	46	14	14	14
Hospice	17	17	17	n/a	n/a	n/a
Personal care agencies	n/a	n/a	n/a	21	21	21
<b>Service Availability</b>						
ADL Services	46	46	46	30	30	30
IADL Services	13	14	14	29	29	29
Medical transportation	n/a	n/a	n/a	8	9	9
Non-medical transportation	n/a	n/a	n/a	5	5	5
'Cuing' or monitoring	n/a	n/a	n/a	16	16	16
Physical therapy	43	42	42	n/a	n/a	n/a
Animal Assistance	n/a	n/a	n/a	4	4	4
Assistive Technology	n/a	n/a	n/a	1	1	1
Social work	8	9	9	n/a	n/a	n/a
Nutrition	13	12	12	n/a	n/a	n/a
Speech/language therapy	41	39	39	n/a	n/a	n/a
Occupation therapy	36	36	36	n/a	n/a	n/a
Companion services	2	3	3	n/a	n/a	n/a
Emergency support/respite	4	4	4	5	5	5
Task delegated by nurse	n/a	n/a	n/a	9	9	9
Case management	7	7	7	9	9	9
Other services	16	15	15	9	9	9
<b>Assessment Policies</b>						
Non-physicians assess client's needs	27	28	28	27	27	27
Need assessment based on a scoring system	6	6	6	18	18	18
Non-physicians authorize services?	17	17	17	23	23	23

Note: <sup>1</sup> The figures reported here show the number of state programs that allow specified types of providers. They do not refer to the number of any type of provider allowed within any state. Hence, the table shows that, in 2002, all of the responding 46 states reported allowing home health agencies to provide service on their state Medicaid home health programs.

**Figure 2: Medicaid HCBS Programs Discretionary Cost Caps, 2002-2004**



**Table 3: Medicaid HCBS Waivers Wait List, 2002-2004**

	<b>2002</b>	<b>2003</b>	<b>2004</b>
Waivers with wait list	92	104	107
Total persons on wait lists	193,936	198,744	242,890
Ave. persons on wait list	2,108	1,911	2,270
Ave. months on wait list	10	7	10
Available slots	1,106,424	1,156,775	1,157,625
Unused slots <sup>1</sup>	189,164	n/a	n/a

<sup>1</sup>Unused slots = total available slots less total reported waiver participants (2003 and 2004 waiver participant data are unavailable).

**Table 4: Medicaid Home Health and PCS provider requirements and rates, 2002-2004**

	Home Health			Medicaid State Plan PCS		
	2002 (N=46)	2003 (N=46)	2004 (N=46)	2002 (N=30)	2003 (N=30)	2004 (N=30)
<b>Provider Requirements</b>						
Training	36	35	35	16	16	16
Certification	35	34	34	10	10	10
Supervision	40	39	39	24	24	24
Criminal background check	27	28	28	20	20	20
Care plan	42	41	41	25	25	25
Case manager	9	9	9	16	16	16
<b>Employee Benefits</b>						
Health benefits	2	2	2	2	2	2
Sick leave	2	2	2	0	0	0
<b>Pay rates for nursing assistants &amp; personal assistants</b>						
Agency rate	\$55.65/ visit	\$55.46/ visit	\$55.46/ visit	\$13.98/ho ur	\$14.80/ hour	\$14.79/ho ur
Provider rate	\$41.67/ visit	\$47.04/ visit	\$47.10/ visit	\$8.32/ hour	\$8.38/ hour	\$8.38/ hour
RN Rate	\$102.13 /visit	\$113.08/ visit	\$111.16/ visit	n/a	n/a	n/a
<b>States reporting shortage of providers</b>	11	11	11	12	12	12