An Exploration of the Elderly and Disabled Participation Rate in the Medicaid Home and Community-Based Service (HCBS) Program in the State of Alabama

by

Arnita Hicks

Helms School of Government, Liberty University

Doctor of Philosophy

Dr. Greg L. Mathison, Chair

Dr. Eva C. Johnson, Reader

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Abstract

This dissertation explored elderly participation rates in the Medicaid Home and Community-Based Service (HCBS) program in the state of Alabama. This descriptive quantitative study explored the factors that impact elderly participation rates in the Alabama Medicaid HCBS program. This study identified the primary barriers preventing elderly participation in the Medicaid HCBS program, as well as presented the limitations of participation in long-term care services. This study found that as the largest source of healthcare in Alabama, the elderly and disabled populations have not utilized the Medicaid HCBS program to its potential.

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Chapter I: Introduction

In the United States, nearly two million elderly aged 65 and older with disabilities live at home and require home and community-based service (HCBS) programs (Norman et al., 2018). Despite the need, many elderly face barriers in trying to coordinate these services. Most elderly lack knowledge concerning the availability of services in their areas. They may also not know how to pay for or how to apply for services (Norman et al., 2018). Even though Medicaid covers HCBS programs, elderly adults in need of services might not meet Medicaid's eligibility requirements (Norman et al., 2018). As a result of not meeting the requirements, many elderly individuals must pay out of pocket.

To help mitigate such barriers, home-bound primary care (HBPC) provides long-term, in-home preventive care to at-risk clients with limited mobility, all of which help to reduce costs, as well as maintain quality care for elderly who want to live at home (Norman et al., 2018). With homebound elderly adults, the need for HCBS remains a challenge. Although HBPC collaborates with HCBS and the Area Agency on Aging (AAA) through case management services (Norman et al., 2018), these partnerships have not proven to be as sufficient. According to Norman et al. (2018), there is a gap in comprehending the best way to coordinate HCBS services with providers, as well as a gap in meeting clients' needs. As a result of these gaps, the elderly population is more likely to be disconnected from the HCBS and AAA resources, thus delaying overall enrollment processes. Given these existing barriers, elderly participation in HCBS programs may be underrepresented.

Overview of Medicaid

Medicaid is the main health insurance plan in the nation for low-income Americans (Rudowitz et al., 2017). Medicaid can also fund health care and long-term care services coverage that elderly and disabled individuals are eligible to use (Accius & Flinn, 2017). Administered by the body of federal regulations and by the Social Security Act Title XIX, Medicaid interprets federal provisions, state alternatives, and jurisdictions (Rudowitz et al., 2019).

The Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS) establish policies and are the major budgetary resource for all Medicaid services (Rudowitz et al., 2019). Medicaid ensures healthcare coverage for 78.9 million persons, with 20% being spent on long-term care services for the elderly and disabled population (Brooks-LaSure et al., 2021). According to Accius and Flinn (2017), there are "nearly 17.4 million individuals who depend on Medicaid for health care coverage, and 5 million receive long-term care services through Medicaid coverage" (p.1). Medicaid roughly covers care for 7 million seniors annually (Greenstein, 2018). Along with long-term care services, Medicaid covers long-term services and support and nursing home care that Medicare does not cover (Greenstein, 2018).

Medicaid funding consists of state and federal funds, that are administered at the state level (Accius & Flinn, 2017). Medicaid's total spending is $604 billion, 35.6% is financed by the state and 64.4% is funded by the federal administration (Rudowitz et al., 2020). One and six dollars are spent on more than half of healthcare systems and long-term support services that are accounted for by Medicaid (Rudowitz et al., 2020). These Medicaid funds impact the need for long-term support services as well as access to HCBS funds (LTSS) (Accius & Flinn, 2017). For elderly individuals, Medicaid directs 50% of its funds toward long-term care services (Musumeci

& Young, 2017). According to Accius and Flinn (2017), the increase of Medicaid funds for HCBS programs can assist in avoiding and delaying nursing home placements, keeping more elderly individuals in their homes, as well as in helping more elderly integrate into their communities. Musumeci and Young (2017) reported that more Medicaid funding could increase enrollment in the HCBS programs. Medicaid enrollment accounts for 23% of the elderly and disabled population, with 64% of Medicaid spending (Musumeci & Young, 2017).

Medicaid Home and Community-Based Program

Borrayo et al. (2004) stated that "[t]he majority of older adults in the United States reside in the community, and when faced with deteriorating health status and functional ability, they overwhelmingly prefer to avoid institutionalization and remain at home" (p. 120). Medicaid created HCBS, originally called the "home care and community-based services, to assist the elderly and disabled individuals with chronic health conditions, as well as to improve their quality of life" (Borrayo et al., 2004, p.121). According to Weaver and Roberto (2017), "Home and community-based services (HCBS) are designed to supplement the care provided by families" (p. 540).

One of Medicaid's available long-term care services to the elderly population is Medicaid's Home and Community-Based Service (HCBS) program (Cobb, 2022). Medicaid HCBS is a waiver program that offers medical services to persons who meet the program's qualifications and to those who require a nursing home level of care. To qualify for HCBS services, a person needs to meet the financial eligibility criteria or qualify medically with Medicaid coverage (Cobb, 2022). HCBS services are a long-term care (LTC) program that implements security, wholesome, and self-worth to eligible individuals. HCBS help elderly and

disabled individuals in continuing in-home care while reducing the rate of Medicaid nursing home facility care by helping the qualified in their homes or within their communities.

Medicaid HCBS represents the largest long-term care services and in-home support benefits for the aging population (McLean et al., 2020). The HCBS programs consist of emergency transportation and nonmedical services, meals, in-home nursing, assistive technology, respite care, and wheelchairs (McLean et al., 2020). In other words, the HCBS program provides needed services to aging adults.

Enrollment and Funding of Home and Community-Based Services

As one of Alabama's largest health insurers, Medicaid has an average yearly enrollment of 55 million individuals nationwide (Watts et al., 2020). In 2018, Medicaid HCBS served 2,505,300 people nationwide. Twenty-nine percent of the population included elderly, disabled individuals (Watts et al., 2020). Of those served nationally, Medicaid HCBS enrolled 15,100 people in the state of Alabama. Of those individuals, only 8,900 were elderly with physical disabilities (Watts et al., 2020).

In the United States, "there were 707,000 individuals on the Medicaid HCBS waiting list, with over one-quarter being seniors and adults with disabilities" (Musumeci et al., 2019, p.1). Medicaid aimed to meet the elderly's and the disabled's basic needs and to decrease the waiting list numbers (Musumeci et al., 2019). By 2050, a projected 12 to 27 million persons will have a rise in aging and disability (Friedman et al., 2019).

The federal government and the state of Alabama spent $116 billion on elderly and disabled individuals on HCBS in the fiscal year of 2020 (Lee, 2022). Nationally, the HCBS population is "2.2 million people, which is comprised of 4 % of the Medicaid population" (Valdez et al., 2022, p. 2). According to Valdez et al. (2022), "Two-thirds of the HCBS

population are dually eligible for Medicare and Medicaid" (p. 2). The mean age for the HCBS population is "56 and the mean age among the dually eligible population is 67" (Valdez et al., 2022, p.2). In Alabama, there is a total of 38,000 individuals that received HCBS, with 15,806 being elderly and disabled 65 years and older (Valdez et al., 2022). Due to states having the authority to limit enrollment into HCBS waivers, states reported waiting lists for HCBS, totaling over 665,000 nationally (Lee, 2022). Due to differences in state policies, however, it is challenging to compare waiting lists across states annually because each state's waiting list measurements do not completely reflect the program's needs or the state's capacity (Lee, 2022). Overall, policies at the federal and state levels impact program participation in Medicaid HCBS.

Home and Community-Based Services Across States

Changes in state policies may improve elderly participation in the HCBS programs. Ng et al. (2015) reported how the elderly limitations to the Medicaid HCBS waiver program are due to state policies: "The increased adoption of state cost control policies has led to large increases in persons on waiver wait lists" (Ng et al., 2015, p. 21). Also, "access could improve standardizing and liberalizing state HCBS policies, but state fiscal concerns are barriers to rebalancing between HCBS and institutional services" (Ng et al., 2015, p. 21). With the fiscal concerns, as well as rebalancing barriers, HCBS, and institutional services, are affected which limits elderly participation in HCBS programs.

Data collection plays a significant role in gathering information regarding the HCBS programs across states. According to Ng et al. (2015), "the HCBS 1915(c) waiver program was the largest Medicaid HCBS program, with 1.4 million persons served in 288 waivers across 47 states and the District of Columbia at a total cost of more than $36.6 billion" (p. 27). Data collected from four data sources across state Medicaid programs show differences in procedures

of the important HCBS programs of the period researched (Ng et al., 2015). The four data sources consisted of CMS Form 372, which includes "the participants numbers, services, and expenditures for HCBS 1915(c) waivers, national surveys of Medicaid home health policies, the national surveys of Medicaid 1915(c) waiver policies, and national surveys of Medicaid optional state plan personal care policies" (Ng et al., 2015, p. 28).

The survey included "questions about policies such as cost control measures and financial eligibility criteria" (Ng et al., 2015, p. 28). This researcher conducted surveys to collect data regarding policy regarding the HCBS programs. As Ng et al. (2015) stated,

> Survey requests (using e-mail, fax, and telephone) of state officials produced responses from about 90% of all reported waivers each year. In October 2011, responses were gathered from all survey recipients (51 home health programs, 32 state plan personal care programs, and 288 HCBS waiver programs) about policies in 2005 and 2010. (p. 28).

The state of Alabama had a 46% HCBS participation ratio, and a 32% expenditures participation ratio (Ng et al., 2015). The eligibility threshold for the state of Alabama for the HCBS elderly waiver was 300%, and the waiting list number was 3,750 (Ng et al., 2015).

Medicaid HCBS policies differ across states and state programs as well as influence access to various plans (Ng et al., 2015). States have chances to change policies to increase access to different programs, such as expanding coverage to the medically needy. Financial eligibility policies can increase coverage to the medically in need since HCBS is currently not an option:

> Twenty percent of states (10) had more restrictive criteria than 300% of SSI for the categorically needy. In addition, three states had varying financial eligibility criteria across some waivers, which can cause confusion for Medicaid consumers and can limit access. Moreover, most states have not changed their financial eligibility requirements over time to allow for greater access. The standardization and liberalization of income requirements for 300% of SSI and medically needy spend-down across the various HCBS programs would improve access to HCBS. (Ng et al., 2015, p. 41)

CMS must work to track Medicaid HCBS policies and make data available to the public so that others can gather vital information that links policy variations and outcomes of HCBS access, costs, quality, and satisfaction (Ng et al., 2015). As the HCBS programs expand in size, challenging to track HCBS policy and programs (Ng et al., 2015).

"Research has shown that only 20% of the elderly population aged 60 and above receive HCBS" (Siegler et al., 2015, p.1). According to Siegler et al. (2015), "the elderly individuals who receive these services need these services, and 90% of them suffer from many chronic conditions that correspond with deficits with ADLs (p.2). Due to the expected rise in growth in the elderly population, many elderly persons benefit from the HCBS programs (Siegler et al., 2015). However, many of the elderly who may qualify for the HCBS program are not knowledgeable of the scale of services or do not know how or where to access information about the programs (Siconolfi, 2021). Healthcare providers are one of the main resources to relay information about the HCBS programs, but few individuals contact the HCBS providers (Siegler et al., 2015). There are many ways for elderly individuals or family members to navigate the system themselves to learn about the HCBS. Eligibility information for the HCBS program may

be found online, and the site informs the recipient that benefits depend on many individual factors as well as agency/service related (Siegler et al., 2015).

Elderly Participation in Home and Community-Based Services

Some elderly individuals participate in the HCBS program and receive services; however, many of their needs have not been met. HCBS programs assist in the expansion of Medicaid eligibility as well as offer benefits specific to a targeted population (Musumeci et al., 2019). The HCBS program enables states to choose, but also to limit how many individuals receive services (Musumeci et al., 2019). As Musumeci et al. (2019) noted, the state's ability to cap HCBS enrollment can result in individuals being placed on a waiting list when the number of individuals in need of services exceeds the available waiver slots.

Watts and Musumeci (2018) introduced three main HCBS programs in which elderly individuals are enrolled and receive services: 1) home health, 2) personal care, and 3) section 1915. According to Musumeci et al (2019), "the HCBS program assists states in expanding their Medicaid financial eligibility, as well as in offering benefits to elderly and disabled individuals participating in the programs (p. 1). The state of Alabama's HCBS waiver programs can choose the number of individuals allotted to serve and limit the number of individuals on the program.

The participation rate of HCBS for Alabama is 38,200 individuals, with 15,806 classified as elderly, age 65 and older (Valdez et al., 2022). The average rate for Alabama is 77.04%, with 41.38% being the rate for individuals aged 65 and older (Valdez et al., 2022). There are still limitations in the elderly individuals receiving HCBS, as well as those who do not participate in HCBS programs. Whereas research has shown that national participation in HCBS is estimated at 2.234,716 million (Valdez et al., 2022), the participation for the elderly, age 65 and older, is

975,576 (Valdez et al., 2022). The average national participation rate for the HCBS is 43.66%, with 78.52 % being the average for ages 65 and older (Valdez et al., 2022).

Problem Statement

Medicaid HCBS is a program for the elderly to receive in-home services; however, many of the elderly do not partake due to a lack of access to the essential services and support needed to live at home. According to Christ and Kean (2021), "21% of older adults reported difficulties moving from place to place, 8% had difficulties with self-care, 8% had difficulties with cognitive ability, and 14% reported difficulties with dependent living in 2018" (p. 2). "Elderly aged 85 and older (20%) and 75 and older (8%) reported needing assistance with personal care" (Christ & Kean, 2021, p.2). However, when asked, the elderly stated that they would like to remain in their own homes and receive in-home support services to help them live in the community and avoid or delay being placed in a nursing home (Christ & Kean, 2021).

Nine out of ten elderly expressed a longing to live in their own home as they become older (Christ & Kean, 2021). With the Covid-19 pandemic, there is a more critical need to grant their desires. Along with epidemics and loss of life, senior meeting areas have been the most dangerous places for the elderly to be:

> The more than year-long separation from family and friends that those living in nursing facilities and other congregate settings have experienced is leading to severe distress and, in some cases, early death. Unfortunately, the reality is that many older adults cannot make the choice to live at home because they do not have access to the necessary support and services. (Christ & Klean, 2021, p. 2)

Also, due to the average long-term support services (LTSS), spending on HCBS has been 56%; 44% of LTSS spending has gone towards institutionalization care (Christ & Klean, 2021). While

Medicaid HCBS programs show significant barriers, the barriers have been greater for the elderly (Christ & Kean, 2021). According to Christ and Kean (2021), “Eight states spend above 50% on LTSS HCBS programs for the elderly, while 25 states spend less than 35 %, suggesting that over half of the states spend twice as much on institutional care than on HCBS for the elderly individuals” (p. 9). Alabama is one of the states that has spent below the median 33% of LTSS HCBS (Christ & Kean, 2021). Even though the state offers HCBS, its care caps access to these HCBS programs due to available funds: “Access to HCBS varies widely from state to state and even within states because many HCBS programs are operated through waivers of federal law” (Christ & Kean, 2021, p. 9). According to Christ and Klean (2021), the elderly have difficulties making the decision whether are not to remain at home and receive HCBS due to the limited access to the support and services needed for the programs.

HCBS is an optional service. According to Medicaid’s federal law, HCBS is not a required service to be provided to all populations in need of LTSS; therefore, population-based inequities and race may often arise and intersect (Christ & Kean, 2021). The elderly individual without housing will be unable to participate in the HCBS program and will more than likely be forced into a nursing facility institution (Christ & Kean, 2021). While research has examined Medicaid HCBS programs, there is a need for more research to identify the factors that impact the participation rate and what can be done to improve the participation of the elderly in the Medicaid HCBS program.

Purpose of the Study

The purpose of this study is to examine Alabama’s Medicaid Home and Community-Based Service (HCBS) program and elderly individuals’ participation rates. This study identifies the factors that negatively impact the participation rate and recommend strategies for improving

participation rates. Although HCBS is a program for the elderly to receive in-home services, many elderly individuals have not been able to participate due to their lack of access to the essential services and support needed to live at home (Christ & Klean, 2021). The study also addresses participation rate disparities among states demographically similar to Alabama. Further, this study addresses the factors that impact Alabama's participation rate, as well as recommends improvements to the Medicaid HCBS program.

Significance of the Study

Three significant approaches relate to Medicaid HCBS: 1) empirical, 2) theoretical, and 3) practical. Empirically, there is a specific study that researches the limitations of Medicaid HCBS nationally. According to Grossman (2018), the research centers on the barriers of Medicaid HCBS programs targeting the disabled population. This study aims to fill in the gaps by identifying Medicaid HCBS limitations that target the elderly population in Alabama.

Theoretically, this study applies the social theory and person-centered theory (PCT). The social theory focuses on meeting the needs of the elderly and disabled population geared toward participation, whereas the person-centered theory focuses on the client perspective, as well as the elderly and disabled. Practically, this study serves as a foundation to identify limitations within the Medicaid HCBS program that hinders elderly participation as well as to address improvements in Medicaid HCBS.

This study helps to identify limitations in participation rates in the Medicaid HCBS elderly and disabled programs in Alabama. This study identifies limitations that impact the participation rates, waiting lists, and funding that hinders the elderly and disabled participation in Alabama. This study would provide information to consider on the participation rate in Alabama

and in similar states regarding the HCBS elderly and disabled program, which would assist with funding the HCBS waiver programs.

Research Questions

The study is guided by the following research questions:

1. How many elderly and disabled participants are in the Alabama HCBS program?
2. What are the expenditures spent on participating in the Alabama HCBS programs?
3. What are the waiting list numbers in Alabama?
4. How do Alabama's participation rate and waiting list compare with similar states?
5. What factors, if any, encourage or limit participation in home and community-based services?

Methodology

To meet the goals of this study, this researcher utilized a descriptive quantitative research method. This quantitative research method examines the Medicaid Home and Community-Based Service (HCBS) program and identifies the limitations of elderly individuals participating in the program. The descriptive quantitative research method assists the researcher in decision-making, asking specific questions, narrowing questions, analyzing data, collecting quantifiable data from resources, and conducting inquiries in an objective way (Haradhan, 2020). The researcher used methods such as interviews with the assistant commissioner of the Alabama Department of Senior Services and the administrator of the Alabama Medicaid Agency. Other methods used consisted of secondary data, journal articles, and websites including the Centers for Medicare and Medicaid, Alabama Medicaid, and the Agency for Health Research and Quality.

Scope of the Study

This study includes southern states within the United States, with similar elderly-related demographics as those found in Alabama. These states include Mississippi and Arkansas due to their demographic similarities with the state of Alabama. This study examines the most current findings reported.

Population

The Medicaid HCBS program consists of the elderly and disabled population. The population for this study is limited to the state of Alabama and individuals who are aged 65 or older. Those who qualify have been defined as elderly who meet nursing home levels of care. The individual who has been interviewed is the Chief Administrator of the Home and Community-Based Services program with the Alabama Department of Senior Services.

Limitations of the Study

The limitations of this study were in obtaining statistical data, as well as in gathering resources less than five years old. Other limitations included individuals from the Alabama Department of Senior Services, with whom the researcher contacted, and the related lags in timely responses about the numbers served on waiting lists and the average costs for servicing the elderly in the state of Alabama.

Definition of Terms

The definition of terms has been limited to the meaning and scope of the study:

1. ACA-Affordable Care Act-- establishes common-sense consumer protections and creates a more transparent marketplace (Brooks-LaSure et al., 2021).
2. ADL-Activity of Daily Living--the individual's daily self-care of daily activities according to toileting, bathing, and dressing (Harris-Kojetin et al., 2019).

3. CMS-Center for Medicare and Medicaid Service-- a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program, and health insurance portability standards (Brooks-LaSure et at., 2021).
4. DSP-Direct Service Provider-- personal care attendants, direct support professionals, paraprofessionals, therapists, and others. DSPs provide a variety of health-related HCBS that will support elderly, disabled individuals (Walensky, 2022).
5. HCBS-Home and Community-Based Services-- "an array of services and supports delivered in the home or other integrated community setting that promote the independence, health and well-being, self-determination, and inclusion of a person of any age who has significant long-term physical, cognitive, sensory, and/or behavioral health needs" (Lipson, 2019, p. 1).
6. HHS-Department of Health and Human Services-- a program that will enhance the health and well-being of all Americans, by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services (U.S. Department of Health and Human Services, 2021).
7. LTC-Long-Term Care—"services include a broad range of health, personal care, and supportive services that meet the needs of frail older people and other adults whose capacity for self-care is limited because of a chronic illness; injury;

physical, cognitive, or mental disability; or other health-related conditions" (Harris-Kojetin et al., 2016, p.2).

8. LTSS-Long-Term Service Support-- services provided to older adults or individuals with disabilities who need support because of age, cognitive, physical, developmental, or chronic health conditions, or other limitations that hinder their abilities to take care of themselves (Brooks-LaSure et al., 2021).
9. PACE-Programs of-All Inclusive Care-- a type of HCBS that provides medical services and supports everyday living needs for certain elderly individuals, most of whom are eligible for benefits under both Medicare and Medicaid (Brooks-LaSure et al., 2021).
10. PCP-Person-Centered Planning- "a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community" (Barkoff, 2021, p. 1).

Organization of the Study

This study is organized into five chapters, and each chapter examines the conventional areas of the research. Chapter I has provided the introduction, related background, problem statement, research questions, the purpose of the study, and definition of terms. Chapter II includes the literature review and theoretical framework, while Chapter III covers the research methodology, research design, and research model. Chapter IV presents the data collection, data analysis, and findings. Chapter V provides the summary, conclusions, and recommendations for further research.

Summary

The Medicaid HCBS program provides in-home services for elderly and disabled individuals and offers an ample collection of services administered by state agencies that meet the requirements. The program aims to meet the needs of the elderly and disabled population; however, a number of the elderly population's needs are not being met. This study addresses the limitations of the elderly who are not participating in the Medicaid HCBS long-term care services in the state of Alabama. This study recommends improving elderly individuals' participation in the Medicaid HCBS long-term care services in the state of Alabama.

Chapter II: Literature Review

The Medicaid Home and Community-Based Services (HCBS) program continues to experience barriers that impact the elderly's participation rate within the state of Alabama. The purpose of this chapter is to review the extant literature on elderly participation rates in the Medicaid Home and Community-Based Service (HCBS) program. In the state of Alabama, the Medicaid HCBS participation rate must be addressed. The challenges that Alabama has had to overcome include finding ways to service the elderly that are qualified for HCBS and avoiding waiting lists for lengthy periods. Also, the factors that hinder qualified elderly from participating or being referred to the program must be considered. The challenges and pressures that the state has to face when trying to address these issues were explored using the social construction theory. Further, this review incorporates the person-centered theory to explore the HCBS programs' organization and selection processes.

The literature review considers what barriers impact the elderly participation rate in HCBS programs that can cause less enrollment and increase waiting lists. Relevant literature includes lack of funds, lack of workers or shortages in long-term support services, and caregiver hardship. The nationwide section includes the lack of coordination, increased pressure, and lack of knowledge. All of these areas are guided by the research questions and bring the most important elements of the research forward as it relates to the elderly participation rates in the Medicaid HCBS programs.

This literature review is organized as a thematic approach. The literature was used to expand on the understanding of the Medicaid HCBS programs and how they may impact the elderly participation rate. This literature review centers on the factors that impact the participation of the elderly within the HCBS programs. The literature review provides selective

research on how the HCBS has been studied along with the different methods applied in theory. The literature review addresses studies about factors and limitations affecting participation in Medicaid HCBS programs.

Theoretical Framework

The theoretical framework of this quantitative study is social theory. Harrington (2020) introduced social theory as explanatory speculations, arguments, thought experiments, ideas, and hypotheses or structures of societies that are created, acquired, and changed over time. Social theory can be perceived as integrating normative interests that are set on the events of the social life of the person and its value, and how social life should be as well as the ways that overlap concerns in legal philosophy, morals, and politics (Harrington, 2022). However, the social life experience of the elderly and disabled represents the at-risk population that is marginalized and is unable to participate in the in-home support services that assist them to remain in their homes. According to Rainer (2014), "In terms of social capital and cohesion, the participation of elderly and disabled people can offer great treasure for every community" (p. 780). However, before there are any changes made to the HCBS programs, government officials must meet, and decisions must be made that could reflect the participation of the elderly and disabled services.

Social theory is the best theoretical framework for this research because of its focus on ideas, structures, desirable values of social change, and the individual whole being. According to Lumen and Openstax (2021), social theory assesses how the individual understands the world around them as well as focuses on nature and how it relates to reality. Lub (2019) examined the importance of the use of theories in the participation of the elderly and disabled population. In the review of social theory and participation among the elderly and disabled, the research examines how social workers use the theories to promote participation toward the target

population. In a review of the theory, the governmental officials focus on having "a stronger theoretical and scientific underpinning of the profession of social work, to be utilized for 'the support and activation of citizens through their network and within their social environment, rather than direct support from professionals" (Lub, 2019, p. 3).

In a review of the social theory, the profession of social work plays an important role in the shift toward the participation state of the elderly and disabled population (Lub, 2019). According to Lub (2019), the social worker's theme is centered around social participation as it relates to social theory. According to Lub (2019), "the social theory is designed to offer support and care as well as methods or practices to the elderly and disabled, which helps ensure that they remain healthy and can meet each other's needs (Gezondheidsraad, 2014, p. 43)" (p.7). According to Aroogh and Shahboulaghi (2020), social participation is an important and effective factor that influences the health and welfare of the elderly and disabled as well as a vital issue of the elderly and disabled people's rights.

Social theory assists in the comprehension of how social theory is being used by social workers in the participation of the elderly and disabled services. Lub (2019) shared three points to consider with theory. The first point, in theory, provides a grip of complexity (Lub, 2019). The purpose of this theory focuses on behavioral or social change (Lub, 2019). The second point, in theory, assists with evaluation (Lub, 2019). This theory assists with deciding what works and why as well as promoting factual assessments (Lub, 2019). The third point, in theory, is a critical function (Lub, 2019). The theory is not just geared toward behavioral determinants, but causal pathways, and influencing factors. The theory is one organized principle that is an instrumental positivistic viewpoint of theory building (Lub, 2019).

According to Lub (2019), social theory is based on the predictions of behaviors of the elderly and disabled perceptions of others (Lub, 2019). On the other hand, social participation is derived from structuralism. Lub (2019) introduced structuralism as the idea that the elderly and disabled are not responsible for their success or behavior, but it is decided by the structures to which the individual belongs. With this structure, the elderly and disabled are the beginning process, and the approach is the level of significance (Lub, 2019). Methods and underlying theories that are liberating and empowering should be focused on social participation in the structures of the elderly and disabled in-home support programs (Lub, 2019). To allow the elderly and disabled to participate, the methods used need to have a database that prioritizes the establishment of the social environment that is supported by the theories such as the social theories: social cognitive theory and social action theory (Lub, 2019). To solve the issues of the elderly and disabled population, the social network must look at how they function and how they subsequently resolve the solution (Lub, 2019).

Another theoretical framework used in this quantitative study is the person-centered theory. The person-centered theory is an approach introduced by psychologist Carl Rogers in 1942 (Murphy & Joseph, 2019). The theory aimed to present an affinitive way that valued clients' knowledge of their individual needs (Murphy & Joseph, 2019). The person-centered theory assists with evaluating the application of the Medicaid HCBS program and the elderly participation in HCBS. An approach of the person-centered theory is person-centered planning (PCP). Person-centered planning (PCP) is defined as "a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community" (Barkoff, 2021, p. 1). PCP is a service managed by the older adult or person who receives the care (Barkoff, 2021). As a part of the HCBS, the PCP will identify the individual's

goals, medical needs, strengths, and desired outcomes (Barkoff, 2021): “PCP helps the person construct and articulate a vision for the future, consider various paths, engage in decision-making and problem-solving, monitor progress, and make needed adjustments promptly. It highlights individual responsibility, including taking appropriate risks” (Barkoff, 2021, p. 1). PCP also includes assisting individuals with creating an emergency plan (Barkoff, 2021).

The PCP process involves a representative that the individual chooses that is authorized to make health or personal decisions for the individual (Barkoff, 2021). The PCP process consists of a support system that includes caregivers, friends, legal guardians, family members, or any representatives the individuals wish to include (Barkoff, 2021). The social worker, case manager, counselor, or agency worker is not able to assist the individual in identifying and accessing the services needed to help during the planning (Barkoff, 2021). “PCP should involve the individuals’ receiving services and support to the maximum extent possible, even if the person has a legal representative” (Barkoff, 2021, p. 1).

HCBS are types of person-centered care services that are provided in the homes as well as the communities of elderly individuals (Brooks-LaSure et al., 2021). Person-centered care derives from person-centered theory. The person-centered theory was created to assist individuals deal with their obstacles, while in a therapeutic environment (O’Brien, 2021). The primary focus of the person-centered theory is on individuals and their perceptions of themselves (O’Brien, 2021):

> Rogers believed that a person could be helped and heal themselves if they were in an environment where they felt free from physical and psychological threats. Although the person-centered approach is mostly used in therapeutic settings, it has also been adapted for use in general social relationships. (p. 1)

The National Quality Forum (NQF) defined HCBS as "an array of supports and services that are delivered into the community or home setting; they promote the health and well-being, inclusion, independence, and self-determination of individuals of all ages who have significant long-term cognitive, sensory, physical, and/or behavioral health needs" (Lipson, 2019, p. 1). According to Lipson (2019), "more than 4.5 million elderly disabled individuals used Medicaid HCBS funded in 2017" (p.1). As the elderly population grows, the number is expected to increase, and as enhancements in medical technology assist disabled individuals to live longer, the number is expected to increase (Lipson, 2019). As Friedman et al. (2019) stated, "With longer life spans, higher rates of chronic conditions, fewer family caregivers, and increasingly limited federal, state, and family resources, paying for LTSS [long-term support services] will become an even greater challenge for American families and our country" (p. 245).

In this study, all Medicaid HCBS programs used two main methods that delivered person-centered care services and that met the goals of the National Quality Forum (NQF) (Lipson, 2019). The processes consist of developing a plan of care that identifies the amount and types of supplies and services needed to meet the needs of the individual and assessing the individual's preferences and needs (Lipson, 2019). The two main processes will assist the individuals in developing care plans to support the type and number of services needed and in assessing needs and preferences (Lipson, 2019). The quality measures and assessments of the person-centered care plans assist with the structure, process, and outcomes of the HCBS (Lipson 2019).

In 2014, individuals who qualified for the HCBS program had to partake in the person-centered planning process (Brooks-LaSure et al., 2021). The person-centered process addresses long-term services as well as health needs in a way that reflects individual goals and preferences

(Brooks-LaSure et al., 2021). The requirement for person-centered planning is organized by the individual who needs HCBS services and may include the representative chosen to assist in the process (Brooks-LaSure et al., 2021). The person-centered planning process as well as the results in the process will help with HCBS effectiveness and HCBS participation in assisting the individual in achieving community goals, contributing to the assurance of welfare and health, and ensuring service delivery in a aspect that reflects personal choices and preferences (Brooks-LaSure et al., 2021). Centers for Medicare and Medicaid Services (CMS) worked on procedures focused on the operationalization of person-centered care services for the program to follow state rules and regulations (Brooks-LaSure et al., 2021).

Research Strategy

This study's focus on Medicaid's HCBS program and the elderly participation rate is due to research obtained on the barriers, gaps, policy issues, lack of funds, lack of workforce, hardships, and streamlining of services. This research is supported by academic databases such as ProQuest, EBSCO, JSTOR, Journal Articles, and Google Search, using keywords such as Medicaid HCBS, elderly, nonparticipation in elderly of Medicaid HCBS, elderly HCBS program in Alabama, and elderly barriers in HCBS programs. This section of the literature challenged the elderly encounter when trying to find the needed in-home support services to remain at home and avoid nursing home placement. Challenges experienced were interfaced with synthesis and analysis. Systemic fundamentals were analyzed regarding the HCBS and the elderly participation rate in the State of Alabama.

Relevant Literature

This research on the Medicaid HCBS programs in the State of Alabama contributes to others gaining a better accepting of the existing literature and debates relevant to the

participation rate of the elderly as well as present research on previous research. According to Friedman et al. (2019), “One of the limitations reported regarding the HCBS 1915 waivers were projections made to the federal government rather than actual utilization data” (p. 254). As previously stated, various Medicaid HCBS waivers serve different purposes but are covered by the control of Sections 1915 and 1115 of the Social Security Act (Cobb, 2022). According to past research reported by Rizzolo et al. (2013) found that projections were accurate subject to prior years’ usage data (Friedman et al., 2019). “To examine actual utilization of HCBS waivers for older adults and the prioritization of expenditures, there is a need for better claims data. Claims data may underreport expenditures because a few services (e.g., case management) can be paid for using administrative funds” (Friedman et al., 2019, p. 255).

Friedman et al. (2019) reported a second limitation of the HCBS the “examination of projected participants and expenditures confined to older adults–only waivers” (p. 255). As they stated, “The majority of waivers serving older adults in FY 2016 were combined with other populations (e.g., physical disability)” (p. 255). With the waivers being combined, the state is not able to make a distinction between allocating for elderly individuals and other populations. The state will not be able to examine the utilization of the HCBS programs in their entirety due to the waivers being combined.

Friedman et al.’s (2019) study reported the total number of unduplicated spending for participants and the average spending for the State of Alabama. The total projection of spending for waiver services was 1 billion dollars (Friedman et al., 2019). The total projected spending for the HCBS waiver for the elderly only for Alabama was $2,556.511, the unduplicated number of participants was 200, the average spending per participant is 12,783, spending per capita was $0.53, and fiscal effort was $0.01 (Friedman, et al., 2019).

Sowers et al. (2016) explained that the Medicaid HCBS programs exemplify a 35-year gradual path to system design. In an attempt to enhance HCBS influential partiality by inventing advanced incentives and authorities for states to propose HCBS, Congress amended the current law many times since 1985 (Sowers et al., 2016). The focus is to increase individuals' access to the HCBS programs and to help provide options, contributing to the state's administrative complexity and confusion for the individuals who seek services (Sowers et al., 2016). Policymakers discussed ways in which the elderly and states can help streamline Medicaid's state plan authority (Sowers et al., 2016).

Streamlining would ease some of the complications and administrative costs connected to the Medicaid HCBS programs as well as support the progress in advancing access to HCBS. The increase in the elderly access to HCBS programs contributes to Alabama's administrative involvement (Sowers et al., 2016). States are fiscally challenged, which limits enrollment in HCBS programs, as well as challenges utilization controls on services (Sowers et al., 2016).

Sowers et al. (2016) focused on key policy questions that assist in streamlining the Medicaid HCBS program. Streamlining the program is the next process is expanding access for the elderly to receive community-based care (Sowers et al., 2016). As the demographics shift in the aging population, access to the HCBS program, technological advances, and medical advances must be improved to facilitate the elderly living longer and being more independent in their homes (Sowers et al., 2016). The intent of streamlining services is to reduce the complexity states experienced in servicing the elderly and their caregivers in steering the range of HCBS programs that have developed in the 35 years gradual approach to system design (Sowers et al., 2016).

According to Sowers et al. (2016), the "potential obstacles to streamlining include how to finance community-based services for eligible beneficiaries and how to manage program enrollment given state budgetary pressures" (p. 9). The five key policy questions on streamlining the Medicaid HCBS that policymakers are focused on include the following:

1. How will financial eligibility for HCBS be determined?
2. How will states manage program enrollment?
3. How will beneficiaries functionally qualify for services?
4. How will the HCBS program be incentivized?
5. How will the program be administered, monitored, and evaluated?

Spetz et al. (2019) reported that the elderly who receive HCBS have unmet needs due to a lack of workforce. As they noted, "Nearly a million people work as home health or personal care aides, providing hands-on care for frail older adults and younger people with serious illness living in their own homes, assisted living, or other noninstitutional residential settings" (p. 902). However, in spite of the growth and value of the workforce, they are oftentimes unnoticed and face many challenges (Spetz et al., 2019). "These factors result in a high turnover as well as increased occupational injury rates (Spetz et al., 2019).

Research shows little scholarship on high-quality home care that affects worker training and client outcome, and on regulations that affect access to the quality of home care services (Spetz et al., 2019). The direct service providers' supervisors should seek to: fill the gaps in providing knowledge; implement Medicaid reimbursement strategies; provide timely, training programs; improve working conditions; reform regulations that now prevent full utilization of the workers; and establish sustainable career pathways in providers' policies (Spetz et al., 2019).

According to Spetz et al. (2019), there are two million people that work as personal care aides, and 800,000 work as home health aides. These two occupations are the fastest growing in the United States and are estimated to grow 40 percent more from 2016-2026 (Spetz et al., 2019). Research has shown that the elderly population pays 63% of personal care aides' salaries; however, publicly funded programs such as the Medicaid HCBS programs fund 28%, while both the elderly population and public programs fund 9% of personal care aides' salaries (Spetz et al., 2019). According to Spetz et al (2019),

> In 2017 the average national wage of home health and personal care aides was $11.12 per hour. Because of this low wage, 49 percent of home care worker households are dependent on some form of public assistance, with 51 percent living on incomes below 200 percent of the federal poverty level. The low level of compensation contributes to the difficulty of attracting people to these jobs. (p. 903).

Spetz et al., (2019) reported that long-term service and supports face many barriers when trying to staff personal care aides. These barriers include poor wages, inadequate benefits, a lack of high-quality training and education, a lack of societal value, and job-related stigma (Spetz et al., 2019).

The result of the study stresses the importance of elevating the value of direct service workers (Spetz et al., 2019). The aging population is growing, and the lack of available workers will only get worse (Spetz et al., 2019). According to Spetz et al. (2019), policy experts are advocating for better working conditions, training for personal care aides, and higher pay (Spetz et al., 2019). However, there are still multiple barriers to face (Spetz et al., 2019). The workforce for the aging with serious illnesses is faced with many challenges; however, there is a lack of research and data to support evidence-based on a change of policy (Spetz et al., 2019). It is

important for the programs as well as for policies to address the need to increase the employment and economic viability of home care workers, reduce high turnover, provide opportunities for professional advancement, and support personal care aides with person-centered care (Spetz et al., 2019). Without available direct service workers to provide care for the elderly, participating in HCBS programs will suffer. This will also affect the number of elderly individuals served, leading them to be placed on in-home services waiting lists.

Chong et al. (2022) assessed the association between the unmet needs for HCBS programs and the health and community living outcomes of Medicaid users in multi-state programs. Data for this study included results from the 2017-2018 National Core Indicators Aging and Disability (NCI-AD) survey and consisted of older adults and adults with physical disabilities who received Medicaid HCBS across 13 states (Chong et al., 2022). Chong et al. (2022) performed a descriptive analysis of the unmet needs of the Medicaid HCBS across five domains: 1) activities of daily living, 2) home modifications, 3) transportation, 4) assistive technology, and 5) sufficiency of services for meeting the client's goals and needs

Across the five domains, 21% of unmet clients' needs ranged from not receiving services to assisting with their activities of daily living (Chong et al., 2022). Fifty-four percent noted unmet needs for receiving assistance with assistive technology. Individuals who experienced unmet needs also consistently declined in health and community living, rather than those who reported unmet needs after adjusting to social, demographic, and functional characteristics (Chong et al., 2022). Research shows that older adults who report unmet needs for HCBS are significantly and consistently associated with community living outcomes and poor health among Medicaid users (Chong et al., 2022). These older adults receive little long-term support services through the Medicaid HCBS programs (Chong et al., 2022).

Results from the study reveal that "'unmet need' for HCBS was consistently associated with adverse health and community living outcomes, supporting the relationships hypothesized in our conceptual framework" (Chong et al., 2022, p. 6). The unmet needs and outcomes of older adults provide evidence for the policymakers to act and address HCBS programs' specific needs (Chong et al., 2022). Results from the study also show that by addressing the unmet needs of HCBS, participants can reduce hospitalization, improve health and well-being, and reduce overall elderly healthcare costs. (Chong et al., 2022). This action would reduce the overall costs of the Medicaid HCBS program, as well as increase the participation rate among the elderly (Chong et al., 2022).

Wang and Wu (2018) assessed the causes of the hardships caregivers face in working with the frail elderly, including financial difficulties, Medicaid HCBS interventions, and governmental financial support used to alleviate hardships. Caregivers and families play the primary roles in supporting elderly individuals (Wang & Wu, 2018). The policy focus and protective focus are more on the caregiver recipients' needs than on the informal caregivers' needs (Wang & Wu, 2018). As Wu and Wang have stated, "The states are facing barriers to service access; informal caregivers often undertake employment-related costs, out-of-pocket expenditures, and unpaid labor, which lead to financial hardships" (p. 396). With there being a hardship, the caregiver and families are challenged with seeking ways in compensating for gaps in the system for the at-risk elderly population (Wang & Wu, 2018).

According to Wang & Wu (2018),

> . . . research has estimated the economic value of informal caregiving for the elderly to the country, and the United States has several LTC [long-term care] policies and

> programs to support informal caregivers, alleviate financial hardships, and remove barriers to care. (p. 396)

However, the program's effectiveness has not been explored (Wang & Wu, 2018). "Medicaid's Long-Term Support and Service (LTSS) covers less than 10% of the U.S. population" (p. 396). Caregivers for the elderly often struggle to keep their employment (Wang & Wu, 2018). Research has been performed, regarding seniors and programs needed once they become frail. However, the program's effectiveness has not been explored (Wang & Wu, 2018). There are several long-term care programs and policies that support caregivers, remove barriers to care, and remove financial hardships. Yet, no research has explored the effectiveness of elderly programs, especially with less than 10% of the United States population being covered by Medicaid's Long-Term Support Services (Wang & Wu, 2018). Sixty percent of caregivers work and seek accommodations such as reduced work hours and personal leave to help them take their elderly recipient to the doctor, provide transportation, make sitter arrangements, and deal with emergencies (Wang & Wu, 2018).

Medicaid and out-of-pocket expenses are the two ways to pay for nursing home and in-home care expenditures (Wang & Wu, 2018). According to Wang and Wu (2018), "[T]wo thirds of LTC Medicaid spending is for nursing home care, and some states fail to provide enough HCBS for people to access" (p. 399). States cover in-home personal care services that do not have to be skilled care through Medicaid (Wang & Wu, 2018). Qualifications for the Medicaid HCBS include low-income and medically needy populations; these populations provide individualized support and services to maintain eligible clients in their communities or homes to prevent nursing home placement (Wang & Wu, 2018). Wang and Wu (2018) suggested that HCBS manages elderly independence, which is cost-effective compared to nursing facility care.

Wang and Wu's (2018) study assessed the HCBS provision to improve caregivers' unmet needs and the burden associated with the homebound elderly. In other words, the burden is because of the elderly. The study's results have shown that services were few in financial, employment, health insurance, housing, and transportation after a 9-month intervention (Wang & Wu, 2018). This study recommended that the policy emphasizes HCBS provision but does not result in the caregiver receiving financial assistance (Wang & Wu, 2018). This study aimed to suggest the elderly's needs for adult day care, which could help reduce conflicts between caregiving and job requirements, caregiving and family needs, and recreational constrictions (Wang & Wu, 2018). Adult daycare could also prevent the caregiver from early retirement (Wang & Wu, 2018).

There are three main HCBS services: 1) waivers; 2) state plan PCS; and cash and counseling. Wang and Wu (2018) have reported that 33% of the 11 million individuals with severe or institutional levels of long-term service support need to receive support through the state plan Personal Assistant Services and the 1915 waiver programs. The Medicaid HCBS waiver program is situated on federal-matched funds according to the state's flexibility to provide services (Wang & Wu, 2018). To ensure that the elderly participant per cost is not greater than nursing facility care, many states are limited in the number of slots financially available (Wang & Wu, 2018). The federal government strives to expand the Medicaid HCBS funds to improve the state's accessibility to HCBS programs; however, due to financial deficits in some states, caregivers and the elderly face barriers to accessing available services (Wang & Wu, 2018). Research shows that the barriers within the social public health environment include 399 policies centered around spending caps and long waiting lists (Wang & Wu, 2018).

According to Wang and Wu (2018), there were nearly 137,000 elderly, disabled individuals on the waiting list in the United States in the year of 2014.

The results of this study emphasize the significance of family caregivers to elderly participants in the Medicaid HCBS programs (Wang & Wu, 2018). These individuals not only provide primary caregiving, but they also provide physical care, emotional support, and long-term care (LTC) responsibilities without compensation (Wang & Wu, 2018). Wang and Wu (2018) reported that

> without understanding the unmet needs of informal caregivers and the insufficient funding support and integrative HCBS programs, it is difficult for U.S. society to achieve the goal of aging in place and to attain an ideal system that is person-centered, professionally rewarding, integrated, affordable, accountable, community-based, and consumer-directed. (p. 402)

It is important to assist the geriatric social worker or case manager in becoming knowledgeable of caregivers' economic needs for the elderly participant (Wang & Wu, 2018). The workers need to continue ongoing training and access to attorneys knowledgeable in elderly law (Wang & Wu, 2018). Policy reform needs to address long-term care focusing on microfinance as well as economic status related to the elderly population (Wang & Wu, 2018). This reform will address the caregiver's economic hardship in supporting and meeting the needs of the elderly participant in the Medicaid HCBS programs (Wang & Wu, 2018).

Nationwide Literature

Norman et al. (2018) reported that the "non-medical social needs of homebound older adults are assessed and addressed within home-based primary care (HBPC) practices, and how to identify barriers to coordinating HCBS for patients" (p. 1). The American Academy of Home

Care Medicine (AAHCM) conducted an online survey to examine HBPC practices and characteristics, as well as to identify social needs and coordinate HCBS programs (Norman et al., 2018). The participants in the survey included nurse practitioners, administrators, physicians, and other HBPC team members (Norman et al., 2018). According to Norman et al. (2018),

> Seventy-four percent indicated 'most' or 'all' of their patients needed HCBS in the past 12 months. Fifty-seven percent reported that coordination was 'difficult.' The most common barriers to coordinating HCBS included cost to the patient (65%), and eligibility requirements (63%). Four of the five most frequently reported barriers were associated with practices reporting it was 'difficult' or 'very difficult' to coordinate HCBS (OR from 2.49 to 3.94, p-values < .05). (p. 1)

Even though there were barriers regarding non-medical social needs, most HBPC practices assisted the elderly with some level of HCBS coordination being their high-need and high-cost level of care needed (Norman et al., 2018). However to provide the elderly with needed HCBS, "more efforts are needed to implement and scale care model partnerships between medical and non-medical service providers within HBPC practices" (Norman et al., 2018, p. 1).

Watts et al. (2020) stated that Medicaid fills in the gap as the primary funding source for long-term support service (LTSS) for HCBS due to services being unaffordable or unavailable through private insurance or Medicare. There are over 2.5 million individuals enrolled in the HCBS program (Watts et al., 2020). Due to increased pressure, state Medicaid programs will encounter challenges in meeting the growing elderly population's health and LTSS needs which stem from the economic downturn (Watts et al., 2020). Due to this downturn, states will have limited resources which will require deductions in services offered at state levels, affecting HCBS (Watts et al., 2020). The 2020 elections resulted in Medicaid HCBS considering a range

of proposals that could cause a gap in the number of individuals enrolled in the Medicaid HCBS (Watts et al., 2020).

Research has shown that enrollment in Medicaid HCBS ranges from 81,000 individuals to 1.8 million individuals who receive services through the Section 1915 state plan (Watts et al., 2020). Through joint and state spending in the HCBS section 1915 state plan, there are 1.8 million individuals receiving services (Watts et al., 2020). Across all HCBS authorities for the fiscal year (FY) 2018, Medicaid spent $92 billion on waiver services (Watt et al., 2020). Medicaid HCBS has promoted elderly and disabled individuals' self-determination and independence for people with chronic conditions, thus positioning them to receive help with activities of daily living outside nursing home care (Watt et al., 2020). "Medicaid provides substantial federal funding to help states meet their community integration obligations under Olmstead and the Americans with Disabilities Act" (Watts et al., 2020, p. 11).

Watts et al. (2020) noted that the "optional nature of most HCBS results in substantial variation across states in enrollment and spending, reflecting states' different choices about optional authorities, benefit package contents, and scope of covered services" (p. 11). With the optional nature of the HCBS program, the research reported limitations in the Medicaid HCBS program:

> The optional nature of most HCBS has implications for federal and state spending, especially during economic recessions. States face increasing pressures from revenue shortfalls during times of economic downturn. Optional Medicaid eligibility pathways and services, including HCBS, may be at risk for budget cuts as states must make difficult choices to balance their budgets. (Watts et al., 2020, p. 11)

Reductions in the program result in fewer enrollments and an increase of elderly and individuals on the Medicaid HCBS waiting list.

According to Wang et al. (2021), 15 significant problems limit elderly participation in the HCBS. This study has reported that a percentage of the elderly population 65 and older exceeds 7% (Wang et al. 2021). By this percentage, an estimated share in 2015 would increase by 247% in 2050, with the proportion of the aged population 80 and older growing faster and increasing by 522% (Wang et al., 2021). Due to the rapid growth of the elderly with disability and dementia, there is a demand for HCBS long-term care services (Wang et al. 2021).

Medicaid HCBS programs are long-term care (LTC) services whose funding source is primarily the government (Wang et al., 2021). The limitations that hinder the elderly from participating in the HCBS long-term care services include financial pressures, low efficiency, excessive government intervention, and unsatisfied demand within the United States: “The sustainable development of home and community-based LTC for the elderly will be affected if the issues in the supply process are not fully understood” (Wang et al., 2021, p. 1729).

Wang et al. (2021) used content analysis to conduct this research, and stakeholder theory was the theoretical basis. By aggregating data, researchers Wang et al. (2021) identified 13 reasons why the elderly do not participate in the HCBS program:

1. Lack of qualified LTC professionals;
2. Limited service types, low service quality, and unrealized integrated care;
3. Lack of steady profit patterns;
4. Difficulty in obtaining the site and unreasonable site selection;
5. Lack of subdivision of the elderly’s needs;
6. Lack of credibility of the providers;

7. The government;
8. Deficiencies of the LTC system;
9. Lack of incentive policies and legislation for private investors' participation;
10. Difficulty in implementing the policies;
11. Lack of information transmission and guidance to the public;
12. Shortage of home and community support resources; and
13. Inability to adapt to a change due to mindsets.

Results from the study focused on the government using content analysis with news coverage and websites for data collection to understand the issues with the supply of HCBS in long-term care (LTC) (Wang et al., 2021). "There were 70 out of 3294 news reports chosen for the analysis, and 12 problems were identified" (Wang et al., 2021, p. 1737). Research showed that the proper use of LTC services is essential to the quality and survival of 40 million or more elderly with disabilities and the development of LTC services. LTC must ensure high quality and adequate service (Wang et al., 2021). "Identifying issues in the home and community-based LTC for the elderly is critical to LTC's success, as public perceptions can challenge or even undermine the advancement of it" (Wang et al., 2021, p. 1738).

Siegler et al. (2018) reported that community-based support services are designed to assist the elderly population in remaining safely in their homes and to delay nursing home placement. Research showed that 20% of the elderly, 60 years and older, receive community-based services (Seigler et al., 2018). Many were dependent on their primary healthcare providers to refer them for services. According to Siegler et al. (2015) "[C]linicians may have little more than a vague awareness of what is available and which services may benefit their patients" (p. 1). Due to a healthcare change toward more holistic and creative models of care, the goal is for the

community-based staff and clinicians to work toward enabling the elderly client to remain safely in the community and maintain their health (Siegler et al., 2015).

Siegler et al. (2015) conducted a nationwide survey of community-dwelling elderly individuals who were interested in receiving community-based services. The results of the study showed that elderly individuals were not knowledgeable of the range of services provided or how to apply for them (Siegler et al., 2015). Respondents viewed accessible healthcare providers as one of the primary sources for information about community-based support services; however, the participants were less likely to contact the agencies directly (Siegler et al., 2015). The elderly as well as their caregivers responded that they were comfortable discussing social and health issues with their primary health providers, who educate elderly clients or caregivers about community-based support services (Siegler et al., 2015). Also, the elderly individuals or caregivers expected the primary care providers would refer them for support and services when appropriate (Siegler et al., 2015).

Results from the study showed that the primary care provider had little information on community-based support services as well as little knowledge of referral patterns to share with the elderly or caregivers regarding in-home services (Siegler et al., 2015). “One Canadian study published almost 25 years ago found that physicians lacked basic information about these services; almost half (47%) acknowledged that lack of information contributed to their failure to refer patients for CBSS” (Siegler et al., 2015, p. 2). Siegler et al. (2015) noted that “health care providers still lack basic knowledge about the types of services provided by these agencies, which types of patients are eligible to receive them, and how to refer older patients (and/or caregivers) for services when appropriate” (p. 2).

Research Process

Research is the component used to examine the selected research question. “Research is the primary tool used in virtually all areas of science to expand the frontiers of knowledge” (Marczyk et al., 2005, p. 1). “The research process is systematic in that defining the objective, managing the data, and communicating the findings that occur within established frameworks and by existing guidelines. Research is the process of collecting, analyzing, and interpreting data to understand a phenomenon” (Williams, 2007, p. 65). Research is used to assist the researcher in decreasing the problems, enhancing the way to live, and detecting the association among unrelated events (Marczyk et al., 2005). “Research is used for description, explanation, and prediction, all of which make important and valuable contributions to the expansion of what we know and how we live our lives” (Marczyk et al., 2005, p. 1). The main goal is to attempt to answer the research question, gain new knowledge, explain how things work, and improve how things will run with the services (Marczyk et al., 2005).

Research Procedure

The research presented in the study has been conducted using descriptive research. Research within this study has been used to collect and synthesize scholarship on the elderly and disabled in the Medicaid HCBS program and their limitations as well as nonparticipation in long-care services. The following sections discuss in-depth the procedure implementation and the research design used in this study.

Procedure Implementation

The research procedure used in this dissertation is descriptive research. Descriptive research "is used to describe a phenomenon in a real-life setting. Quantifies characteristics of identified individuals, groups, or situations" (Bloomfield & Murray, 2019, p. 28). This researcher assessed Medicaid HCBS and the limitations of the programs in Alabama that affect elderly participation. The intent of using descriptive research is to assist the researcher in examining variables, measuring variable samples systematically, and interpreting and describing variables (Bloomfield & Murray, 2019). A researcher uses descriptive research to gather information on specific phenomena or characteristics of the research topic (Bloomfield & Murray, 2019). It is essential that the methods used to ensure the data gathered are valid and dependable for the research (Bloomfield & Murray, 2019).

Under the quantitative research methodology, the descriptive research design has several methods and instruments most used to collect data: checklists, observations, surveys, interviews, and equipment that assist with measuring physiological variables (Bloomfield & Murray 2019). It is also essential to assure internal validity in research in the calibration, piloted, and standardization (Bloomfield & Murray, 2019). The descriptive research approach assists in examining the proposed research topic as it exists in its present state (Williams, 2007). It will also aid the researcher in identifying the characteristics of the lack of services being observed, as well as the exploration of the correlation between two or more developments related to Medicaid HCBS and the elderly (Williams, 2007).

Research Design

Research design implementation is vital in research (Bloomfield & Murray, 2019). It is essential that the researcher understands the concept of research design and can identify any imperfections in the research study design that might hinder the findings in the reported analysis (Bloomfield & Murray, 2019). Research design is defined as "the blueprint or plan that will be used by researchers to answer a specific research question" (Bloomfield & Murray, 2019, p. 27).

Within this study, the researcher chose a quantitative approach. Quantitative research is defined as a "formal, objective, systematic process used to describe variables, test relationships between them, and examine cause and effect associations between variables" (Bloomfield & Murray, 2019, p. 27). Quantitative research helps to produce numerical data (Bloomfield & Murray, 2019). It also is underpinned by several assumptions; it is informed by post-positivist or positivist criteria (Bloomfield & Murray, 2019). Quantitative research explores ways to identify the answer to the research question by testing the hypotheses by using neutral scientific methods and objectives (Bloomfield & Murray, 2019). Quantitative research is "the process of collecting, analyzing, interpreting, and writing the results of the study" (Williams, 2007, p. 65). In this quantitative research, the population, data set, and location are the elderly who receive Medicaid HCBS in the state of Alabama.

It is helpful to have a comprehensive background for understanding the research methods for the methodology of quantitative research (Queirós, 2017). "Research methods are used for the development of scientific studies, which allow specific analysis according to the methodology employed by the researcher" (p. 383). The most used research method for quantitative research methodology is correlational and surveys (Queirós, 2017). The other methods used in quantitative research consist of survey research, observational studies, and developmental design (Williams,

2007). Other research methods that may be used are quantitative analysis, interviews, and experimental research. The main methods that have been used to collect data for this study are secondary analysis, quantitative analysis, and interviews.

In quantitative research methods, data collection methods assist in improving the validity and accuracy of study findings and outcomes (Sadan, 2017). Data collection is very time-consuming and challenging. However, using available records allow significant timesaving and can save money in studying (Xu & Hickman, 2020). Therefore, the researcher must be able to identify the kind of data to be collected as well as the sources from which the data can be collected (Sadan, 2017). The data to be collected and analyzed should be centered on the population and location of the proposed research topic. “The data sources can be either the existing data or the new data” (Sadan, 2017, p. 58). The data comes from the existing records or documents that might be available at the current agency regarding the elderly population 65 and older in the state of Alabama. However, if existing data were unavailable, new data would need to be collected.

New data may be classified as primary and secondary data (Sadan, 2017). Primary data is a form of data collection that a trained data collector or researcher retrieves directly from the participants in the study. It consists of surveys, questionnaires, interviews, biophysicalogical measures, and observations. Secondary data is the collection of data the researcher uses to collect information such as patient records or government databases (Sadan, 2017). Other locations from which that data was collected include the web, journal articles, and statistical reports. One of the administrators with the Alabama Department of Senior Services, which oversees the Medicaid HCBS, conducted interviews.

Quantitative research is essential in primary research to assist with data collection, reporting, and data analysis (Queirós et al., 2017). The research study results address the concerns about the elderly's lack of services funded by Medicaid as well as state and federal funds. Data and active numbers are important in determining the number of people to whom the state can provide services, which may or may not result in placing the elderly on a waiting list. Using the quantitative research methodology assisted in answering the following research questions: How many elderly and disabled participants in the Alabama HCBS program? What are the expenditures spent on participating in the Alabama HCBS programs? What are the waiting list numbers in Alabama? How do Alabama's participation rate and waiting list compare with similar states? What factors, if any, encourage or limit participation in home and community-based services? Furthermore, using the research methods of quantitative analysis as well as secondary analysis assisted this researcher in gathering the needed data for analysis and interpretation of the results of the research.

Medicaid HCBS is not a mandatory program, but it is needed. Research has shown that there are factors impacting the elderly participation rate in the Medicaid HCBS program. Friedman et al. (2019) stated that the misappropriation of claims data toward HCBS impacts the program's growth. The literature reported that the average spending in Alabama was 1 billion dollars, with 26 billion projected for waiver services. On the other hand, the projected spending for the elderly participating in HCBS was $2,5556.51; unduplicated participation was 200, with an average spending of $12,783, per capita of 0.53, and fiscal effort of 0.01. With claims data duplication, the state will not be able to examine effectively HCBS programs' usage.

Sowers et al. (2016) reported that Congress has amended the current laws numerous times to help streamline the elderly's access to the HCBS program. Change in laws can assist in

streamlining Medicaid HCBS programs and assist in addressing the fiscal pressure states with funding the programs. Without adequate finances, HCBS can be impacted, resulting in fewer elderly enrollments (Sowers et al., 2016).

The elderly population is growing; however, there are still reports of unmet needs and assistance being needed for the elderly's daily living (Spetz et al., 2019). Due to this growth, the lack of workers will continue to worsen. Chong et al. (2022) reported that 21% of the elderly report not receiving services from the Medicaid HCBS programs. With reports of the elderly's unmet needs, policymakers must work to address them (Chong et al., 2022). As HCBS programs continue to grow, policymakers' addressing their needs will improve the health and well-being of the elderly requesting in-home services (Chong et al., 2022). Addressing the unmet need will assist in cost reductions and increase HBCS participation rates among the elderly.

Wang and Wu (2018) accessed the HCBS program, elderly participation, and caregivers. In many circumstances, caregivers play a significant role in providing care for the elderly. Many are faced with financial hardships due to out-of-pocket expenditures, unpaid labor, services, access, and employment-related costs. Many caregivers are challenged with compensating for the gaps in the systems in which the elderly population are under their care; 60% of caregivers work to seek ways to accommodate the elderly. Medicaid and out-of-pocket expenses are to ways pay for in-home care services and nursing home care (Wang & Wu, 2018). Two-thirds of long-term care Medicaid spending is for nursing homes, and some states fail to provide enough funding for in-home care. The study assessed the importance of the caregiver's burden associated with the elderly population.

Norman et al. (2018) assessed the Medicaid HCBS programs and the impact of elderly participation rates by focusing on HCBS coordination. The lack of HCBS coordination affects

the elderly needs (Norman et al., 2018). Seventy-four percent of elderly participants have indicated a need for HCBS in the past 12 months. However, due to coordination problems, Norman et al. (2018) have reported that 57% noted coordination was different; 65% stated coordination with cost, and 63% noted coordination with eligibility requirements. Four out of five practices reported difficulties with coordination as well (Norman et al., 2018). Given these issues, more effort must be initiated when coordinating HCBS services to provide for the elderly (Norman et al., 2018).

Medicaid is the primary funding source to fill in the gaps for long-term support services (Watts et al., 2020). Due to increased pressure, state Medicaid programs will face challenges in meeting the growth of the elderly population and the impact of the economic downturn (Watts et al., 2020). The economic downturn will result in limited resources, a reduction in services affecting HCBS, a reduction in HCBS programs, fewer enrollments, and an increase in waiting lists (Watts et al., 2020).

Research has shown that there is still a demand for HCBS long-term care services. The elderly population, aged 65 and older, exceeds 7%. It is estimated that by the year 2050, a share of 2015 would increase by 247%, with the proportion of the elderly population, aged 80 and older, growing faster (Wang et al., 2021). These researchers have reported that 15 significant problems limit the elderly participation rate in HCBS programs (Wang et al., 2021). Wang et al. (2021) have pointed out that, of the 15 problems, financial pressure, low efficiency, excessive government and intervention, and unsatisfied U.S. demands rank among the highest. There will continue to be participation issues if the supply system is not thoroughly understood (Wang et al., 2021).

Sixty percent of elderly patients, aged 60 and older, receive community-based services (Siegler et al., 2015). However, many of the main referral resources that can connect the elderly to the agencies to start the process for services are unaware or have no knowledge of HCBS programs. Many of the elderly are interested in receiving services and feel comfortable speaking with their primary health providers regarding needed services. Most healthcare providers lack knowledge and awareness of service types, how to refer services and eligibility requirements for services. Due to this disconnection, many elderly people are not referred to the programs, which results in no enrollment or participation in the programs (Siegler et al., 2015).

Research has shown that as the elderly population is growing, so is the demand for HCBS programs (Wang et al., 2021). However, the literature shows that impacts are affecting the elderly participation rate in Medicaid HCBS programs. The unmet needs of the elderly population must be addressed, which will assist in the overall costs and elderly participation rates (Chong et al., 2022).

Summary

Within the research process, the researcher gathered information to address the limitations of the elderly individuals in the state of Alabama who do not participate in the Medicaid HCBS long-term care services. The research process also included the research procedure, the implementation procedure, and the research design of the study. The next chapter discusses in detail the collected data, data analysis, findings, and solutions to the problems.

Chapter III: Methodology

This chapter focuses on the research method, population and/or data sample, interview process, data process, and analysis procedure used in obtaining data for this study. The information obtained has assisted in the exploration process and in the description of understanding the participation rate of the elderly and disabled in the Medicaid Home and Community-Based Service (HCBS) waiver programs. The population as well as the data collected during interviews assisted the researcher in better comprehending the enrollment processes and the participation rates of the elderly individuals in the HCBS waiver programs. The data also assisted the researcher in identifying the factors that limit participation. Given the researcher's present career-related experiences with the HCBS waiver programs and future aspirations of becoming an expert in the Medicaid office or the Area Agency on Aging, exploring elderly participation rates is of great interest.

Research Method

This study used the quantitative research method. The quantitative method is the most appropriate for this research study because it utilizes the three parts associated with research: 1) the forms of data collection, 2) the interpretation that the researchers propose for the study, and 3) analysis (Abutabenjeh & Jaradat, 2018). To obtain the research results, the researcher asked close-ended questions and utilized data analysis and interpretation (Abutabenjeh & Jaradat, 2018).

The research methods for quantitative research are used to study a large population, such as this study's elderly (Troy, 2021). Quantitative research methods are techniques that use a unique approach to address research questions, establish an appropriate research methodology,

and draw findings and conclusions (Troy, 2021). The research methods used in this study consisted of secondary data analysis, statistical analysis, and interviews.

Population and Data Sample

The population for this study was limited to the state of Alabama and individuals who are considered elderly and disabled. The qualified elderly and disabled are defined as those who meet nursing home levels of care. Interviews were guided by the Chief Administrator of the Home Community-Based Services program with the Alabama Department of Senior Services, the Deputy Director of the Division of Aging, Adult, and Behavioral Health Services of Arkansas, and the Elderly and Disabled Request for Information Administration of the Mississippi Division of Medicaid.

Interview Process

The goal of the interview was to gather information from government officials that assist with the HCBS elderly and disabled program in the state of Alabama. interviews were used for the quantitative research method protocol. Standardized interviews are the question-and-answer alternatives, provided to the interviewee rather than the interviewee completing a survey on his or her own (Sheppard, 2020). The standardized interview questions were closed-ended. The aim of the standardized interview questions and answer alternatives is to pose them in the same way, to every interviewee (Sheppard, 2020). This technique helps to minimize the researcher's effect and to change the way the interviewer presents the questions and answer options to the interviewee. (Sheppard, 2020). Data collection for standardized interviews is quite common by telephone and has been expanded to mobile phone or internet use. The interviews in this research guide the data collection process for the demographic areas chosen for research.

In standardized interviews, each interview was conducted via telephone and the Internet. The protocol for the standardized interviews consisted of the researcher selecting individuals who work with the elderly population in home and community-based service programs within the state of Alabama, as well as two other similar demographic states-- Mississippi and Arkansas. The researcher administered a total of three interviews, with five questions.

Data Processing

Data processing includes collecting data with the instruments used for organizing. Within the data collection process, the researcher meticulously selected five interview questions to ask key professionals who had relationships in departments within the HCBS programs in this study's key states. The researcher retrieved answers from each interviewee, which assists in guiding the research. This strategy also assists in the researcher's understanding of how the elderly participation rate may affect the number of persons being serviced in the HCBS programs.

Continuing in the data processing, the researcher orchestrated the collection, consolidation, and analysis of the data. In performing this step, the researcher used specific instruments in this portion of the data processing. The instruments used in this study included interviews, secondary analysis, and statistical analysis. As previously indicated, the elderly and disabled populations are the target populations, and the main state is Alabama. The two demographic states that were compared to Alabama are Mississippi and Arkansas. The focus of this study is the participation rate of the elderly and disabled population in the Medicaid HCBS programs.

The quantitative research method generates results by using interviewee responses to assist with data collection as well as the information gathered from secondary and statistical data.

This method is significant to this research because it helps determine if the elderly and disabled participation rate affects the number of persons being served in the HCBS programs in Alabama. It is important to research the issue as well as to compare it with similar demographic states, which are Mississippi and Arkansas. Data were accrued using Medicaid's state summary index report (Watts et al., 2020). Tables were used to illustrate the data collected and organized.

Analysis Procedure

The researcher utilized the data analysis procedure to assist in organizing, transforming, and showing the collected data to determine the effects the elderly and disabled participation rates may have on the Medicaid HCBS program. The researcher used quantitative descriptive analysis to obtain a summarization of the state HCBS programs. The researcher conducted interviews focused on the participation rate, expenditures, waiting list, eligible population, and any factors that could limit the elderly and disabled participation in the HCBS.

The researcher used secondary data from the latest Medicaid HCBS 50-state survey, which was retrieved from the state level (Watts et al., 2020). The researcher used statistical data to retrieve, collect, and analyze data from each state's annual and statistical reports for the fiscal years being researched. The data were analyzed to include the number of participants, the number on the waiting list, annual funding, and participation rate for the target population-- the elderly and disabled individuals in the state of Alabama. The two demographic states that are compared to the state of Alabama are Mississippi and Arkansas. From the collected data, there is a predictive analysis of the effects that the elderly and disabled participation rate has on the Medicaid HCBS programs.

Variables Used in the Study

In this study, there are dependent, independent, and moderating variables. The independent variable used is the HCBS program. The dependent variable used is the participation rate. The moderating variables are acknowledged as the demographic areas, which are Alabama, Mississippi, and Arkansas. The variables are displayed in Table 1.

Table 1

Variables Used in the Study

Independent Variables	HCBS Programs
Dependent Variables	Participation Rate
Moderate Variables	Alabama
	Mississippi
	Arkansas

As shown in Table 1, variables are used in collecting and analyzing data to explore the participation rate with the HCBS elderly and disabled programs. The independent variables include the HCBS programs, while the dependent variables indicate the participation rate. The moderate variables include the states in which the HCBS programs were studied—Alabama, Mississippi, and Arkansas.

Reliability and Validity

Reliability and validity are used to help enhance the quality of quantitative research (Heale & Twycross, 2015). According to Heale and Twycross (2015), reliability is the precision of the instrument. Reliability ensures that the research method is consistent and has the same results in repeated situations, as well as in similar circumstances (Heale & Tywcross, 2015). According to Taherdoost (2016), reliability is focused on the extent of the measurement that provides consistent and stable results. The examination of Alabama's Medicaid Home and Community-Based Service (HCBS) program identifies the factors that positively and negatively impact the participation rate. This study also recommends strategies for improving elderly and disabled individuals' participation rates.

Validity "is defined as the extent to which a concept is accurately measured in a quantitative study" (Heale & Twycross, 2015, p. 66). Validity describes the data that has been collected and covers the area that is being studied (Taherdoost, 2016). In this study, the validity's purpose is to determine what is projected to be measured (Taherdoost, 2016). The reports that assist with the validity were derived from the relevant and nationwide literature review related to the elderly participation rates in the Medicaid HCBS programs. For research to possess a value of quality, the mechanisms or instruments utilized must be valid and reliable. The states determine the validity of the Medicaid HCBS programs with the approach-- the numerator being the participants and the denominator being the eligible individuals.

For this study, the researcher used secondary data, journal articles, interviews, and statistical reports to collect information to explore the elderly and disabled participation rate in the Medicaid HCBS waiver programs. Each of these mechanisms' reliability and validity has

been demonstrated as valid and consistent in the implementation of exploring the elderly and disabled participation rate in the HCBS programs.

Summary

The quantitative research method was the most appropriate methodology used for this study. The quantitative research method's purpose is to assist the researcher with analyses, data collection, and interpretation of data. This study's target population was elderly and disabled, and the quantitative research method was used to study these large populations.

Within the methodology process, the researcher has provided an overview of the chapter and the specifics regarding research methods in studying the elderly and disabled participation rate of the HCBS programs. The methodology section has also included the population and data sample, interview process, data processing, variables used in the study, and reliability and validity. Chapter IV analyzes the data and presents the findings.

Chapter IV: Findings

This chapter presents the study's results from the data collected, after IRB approval. An overview of the chapter includes an analysis of the data and a presentation of findings. The findings are described in detail and are presented as tables and figures. Following the findings are the interviews that were performed during this study. The chapter concludes with a summary of the study's findings.

This quantitative study aimed to examine Alabama's Medicaid Home and Community-Based Service (HCBS) program and the elderly and disabled individuals' participation rates for 2017 through 2020. The study was guided by the following research questions:

1. How, many elderly and disabled participants are in the Alabama HCBS program?
2. What are the expenditures spent on participating in the Alabama HCBS programs?
3. What are the waiting list numbers in Alabama?
4. How do Alabama's participation rate and waiting list compare with similar states?
5. What factors, if any, encourage or limit participation in home and community-based services?

This study identified the factors that positively and negatively impact the elderly and disabled participation rates in HCBS programs. The study reported comparative participation rates among states demographically similar to Alabama and its HCBS elderly and disabled waiver program. The two states compared to Alabama were Mississippi and Arkansas.

Analysis of the Data

In analyzing the collected data, the researcher reviewed the number of participants, waiting list number, annual funding, eligible population, and participation rate. The researcher collected information from the primary state, Alabama, and similar states--Arkansas and

Mississippi. The data collected from the individual state were guided by the five research questions and the social and person-centered theory theoretical framework. The central research question was based on exploring the elderly and disabled participation rate in the Medicaid HCBS programs and identifying limitations that might impact participation. The collected data addressed how each state used the HCBS programs and displays the participation and expenditures for HCBS programs, comparison of the programs, and enhancements of the programs. Lastly, the researcher followed up with quantitative interviews with governmental officials regarding any changes or updates within the HCBS programs in their respective states.

Quantitative Findings for Each State

Alabama HCBS Data

Table 2 shows the answers to research questions 1-3 regarding the number of elderly and disabled participants in the Alabama HCBS program for the fiscal years reviewed.

Table 2

Elderly and Disabled Participants in Alabama by Years Reviewed

Fiscal Year	# Alabama Participants	# Waiting List	Annual Funding	Eligible	Participation Rate
2017	7449	4194	$79,000,000	9355	.796%

(continued)

2018	7578	7793	$86,000,000	9355	.810%
2019	8225	0	$104,000,000	9355	.879%
2020	8580	0	$116,000,000	9355	.917%

As shown in Table 2, there was an increase in participation, annual funding, and waiting list participants in Alabama. In the fiscal year 2019, the waiting list was eliminated. Figures 1-3 show Alabama's participation, waiting list, and expenditures.

Figure 1

Alabama Participation Numbers

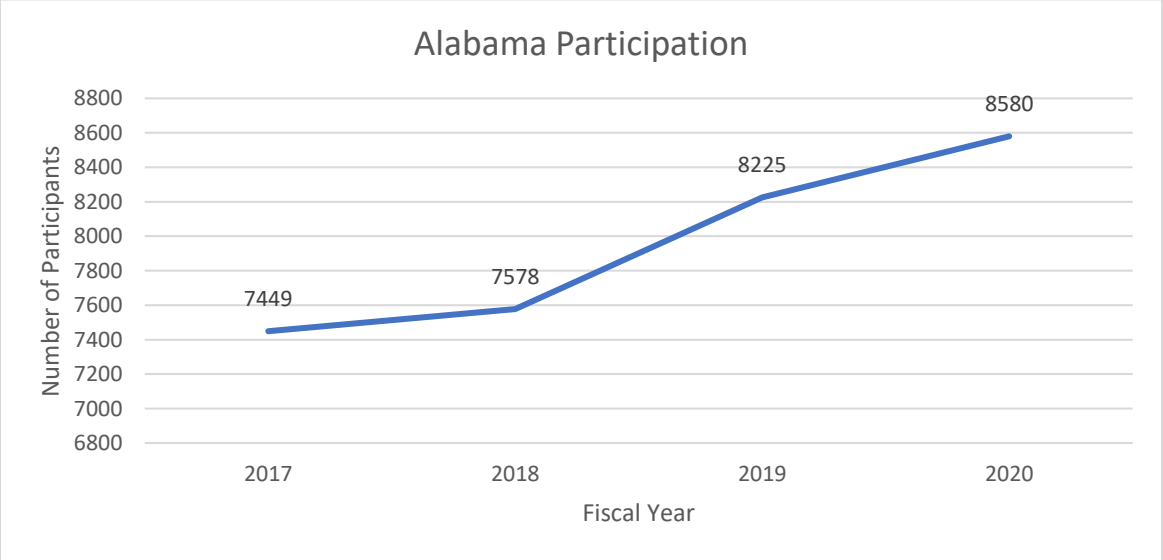


Figure 2

Alabama Waiting List Numbers

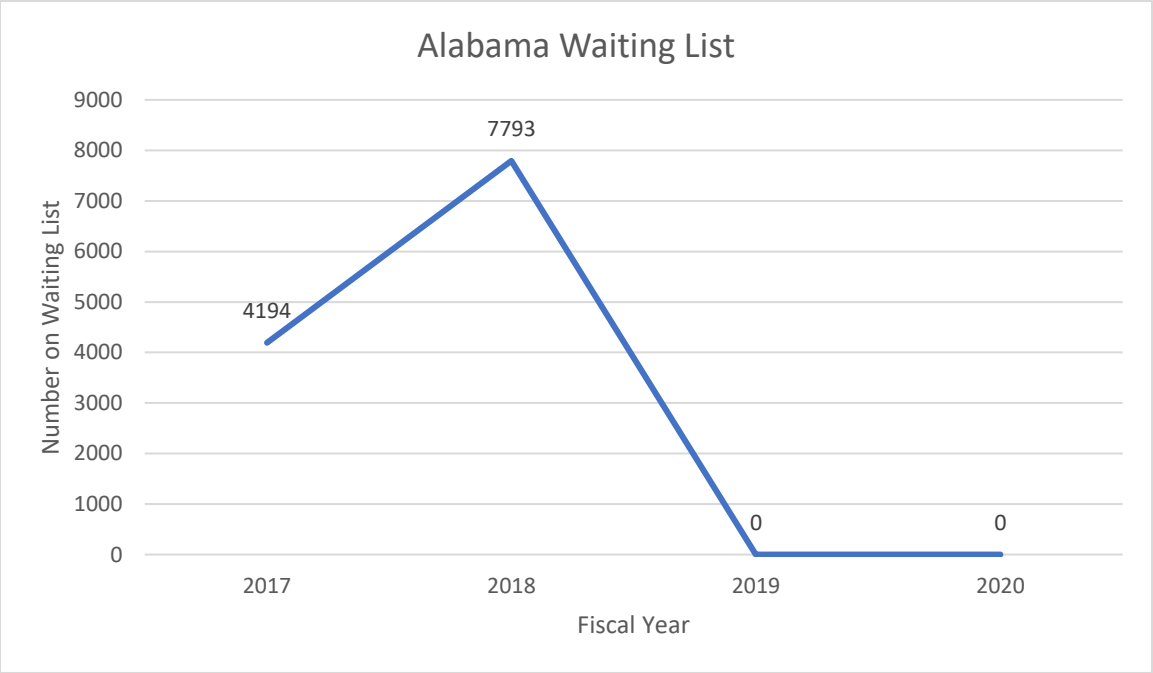
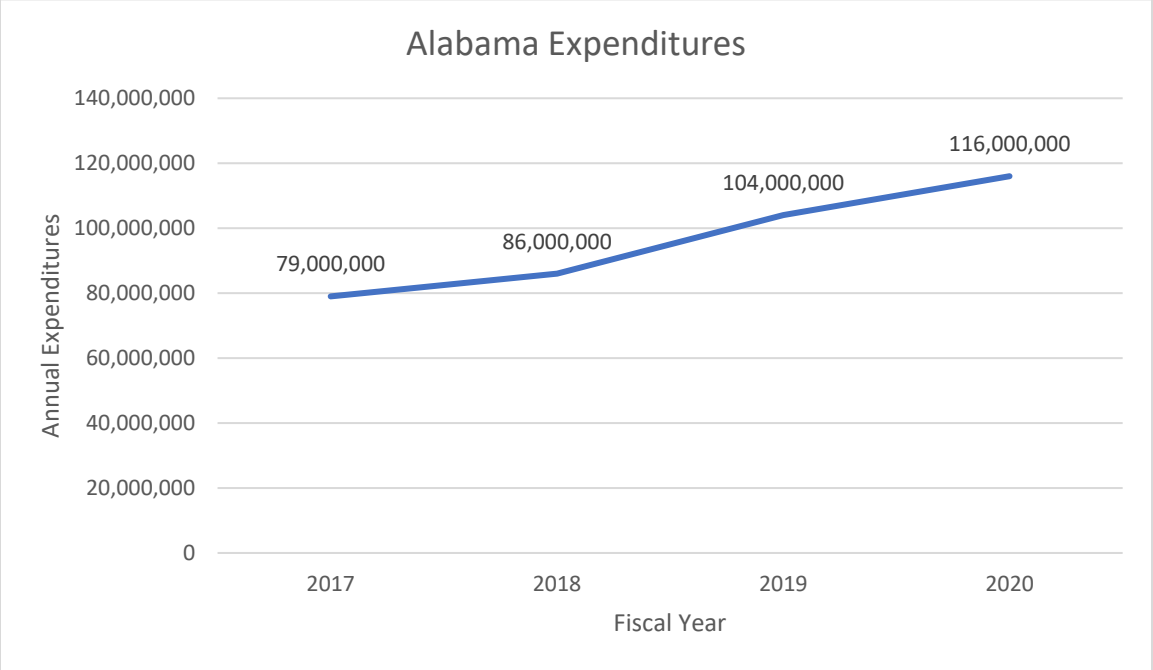


Figure 3



Interview with the Alabama Assistant Commissioner

In the conversation with the Assistant Commissioner, we learned the current number of participants is 9,563. Alabama's wait list has been eliminated, and now has a referral list. With the referral list, the Area Agency on Aging has added the ADRC process that assists the elderly and disabled population with enrollment. Due to the ability to have slots, there is no waitlist and all qualified clients are taken through the ADRC process. If there is a delay, it is due to no staff and provider issues. Each Area Agency on Aging was given funding to add more staff to assist with the HCBS program. The additional staff included the ADRC department to help perform intake assessments, along with the initial assessment team to help perform enrollments. This would help expedite enrollment for the HCBS programs.

Alabama now has a person-centered program where the individual has personal staffing. Alabama is contracted with 13 Area Agency on Aging that provide waiver services to the elderly and disabled individuals that are enrolled in the HCBS program. The Area Agencies on Aging are equipped to hire the staff needed to perform more initial assessments for the enrollment process and to recruit providers for their programs.

With the services that HCBS programs offer, if there is a delay in the enrollment process and the individual is on the referral list, the ADRC staff performs an assessment and accesses in-house programs as well as local communities to assist the individual until the initial enrollment is done. The program's growth depends on funds. LTSS funds are federally matching money that is provided by CMS to help provide additional services and serve more clients depending on the funds. LTSS focuses on federal-level HCBS services that help people to stay at home while having the funds to finance the program. This fiscal year, expecting to get 3,000 additional slots

to be able to serve more individuals. Additional funding from CMS enhances our ability to strengthen the HCBS program.

Mississippi HCBS Data

The data showed an increase in participation, waiting list, and annual funding in FY 2017-2019, and a decrease in participation in FY 2020. Table 3 shows the participation and expenditures for the Mississippi HCBS Elderly and Disabled program, while Figures 4-6 show the same and include the waiting list information.

Table 3

Participation and Expenditures for Mississippi's HCBS Elderly and Disabled Program

Fiscal Year	# Mississippi Participants	# Waiting List	Annual Funding	Eligible	Participation Rate
2017	16,247	8,800	$67,747,884	21,000	.773%
2018	16,444	8,534	$77,129,672	21,500	.764%
2019	16,845	9,268	$75,743,998	21,500	.783%
2020	16,803	12,059	$76,266,846	21,600	.777%

Figure 4

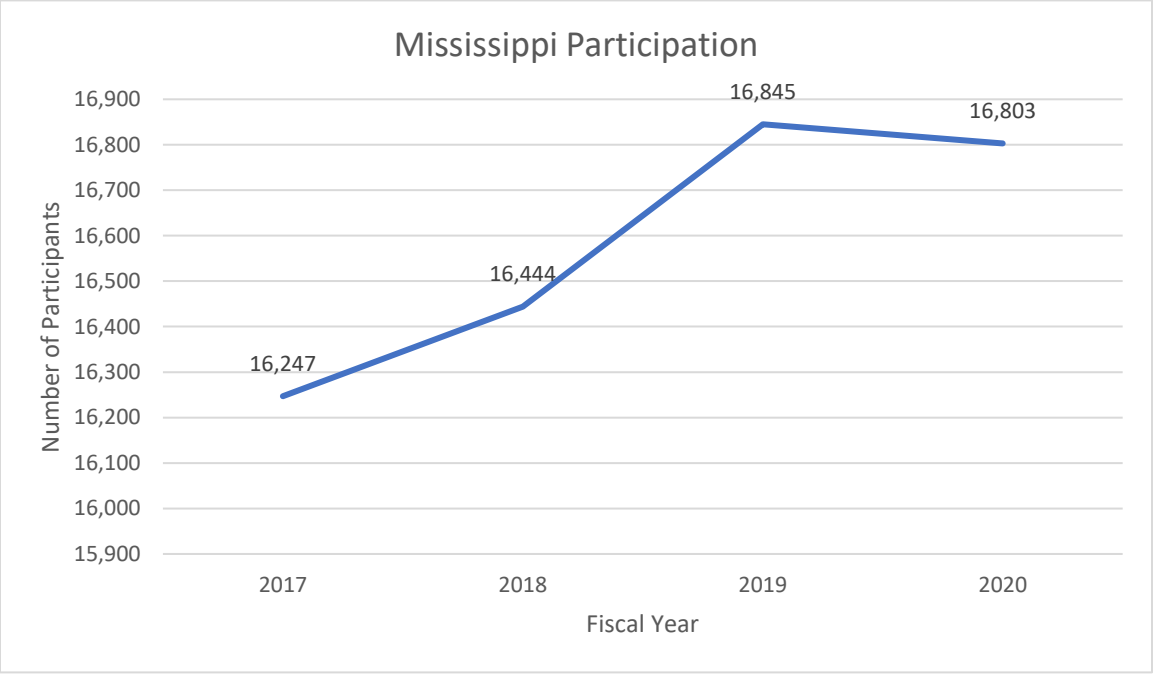


Figure 5

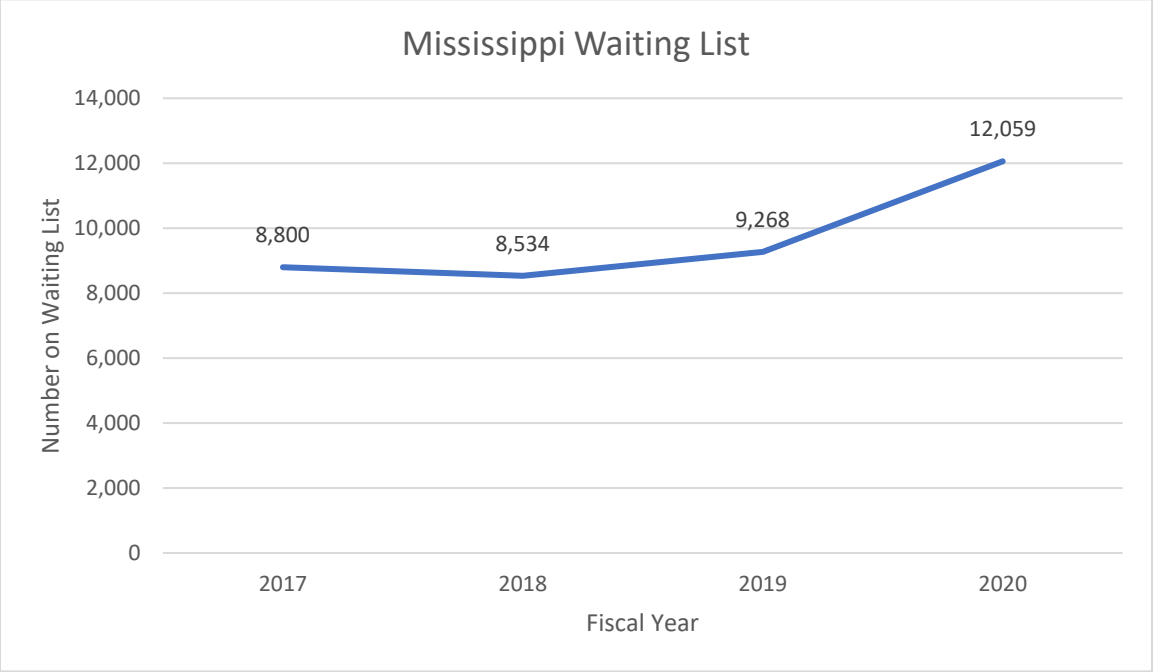
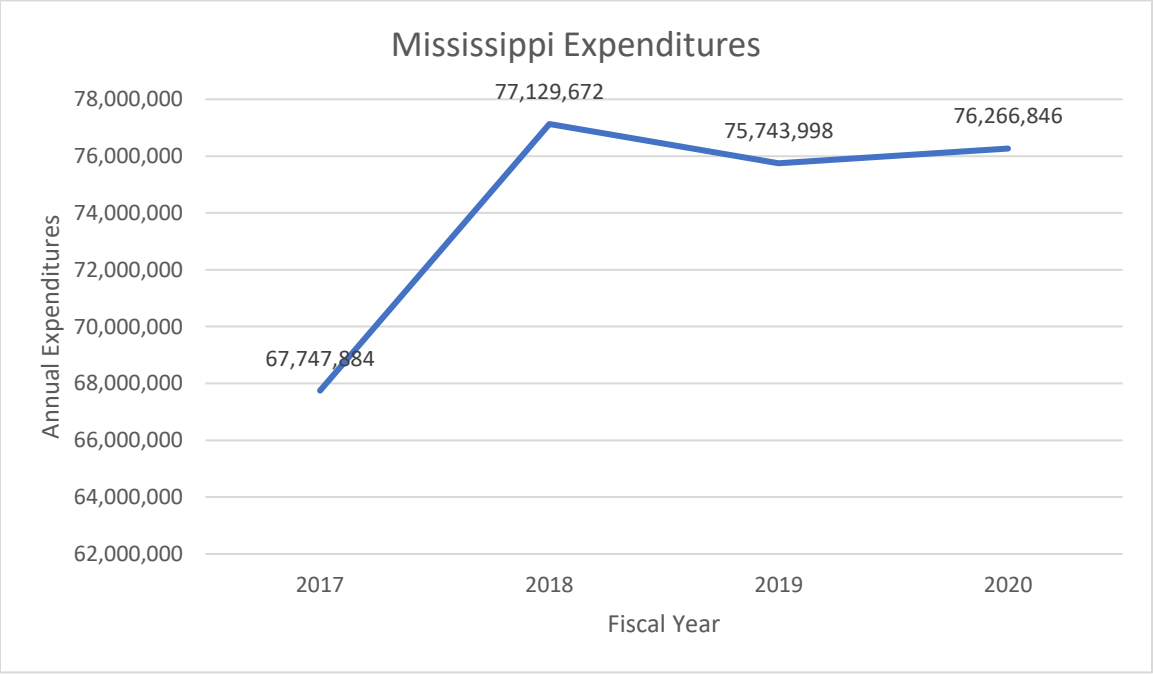


Figure 6



Interview with the Mississippi Division of Medicaid HCBS Request for Information Administration

In the conversation with the Mississippi Division of Medicaid HCBS, we learned the current number of participants is 17,774. Due to slot availability and provider capacity, statewide, Mississippi has 7,841 people on its waiting list. The estimated wait time is 16.3 months. All services on the Elderly and Disabled (E & D) Waiver are being provided to enroll participants according to their person-centered plan of services and support. Mississippi is contracted with approved state providers of waiver services to the elderly and disabled individuals that are enrolled in the HCBS program. Currently, people are served from the wait list in the date order in which they were added to the list. There have not been any structural changes to the Elderly and Disabled Waiver, however, workforce shortages have affected

provider capacity and ultimately waiver slot and service utilization. It is anticipated that public notice of changes will be made on March 1, 2023.

Arkansas HCBS Data

The data showed an increase in the waiting list and annual funding from FY 2017 through FY 2019. Participation increased slightly and decreased for the remainder of the fiscal year. The waiting list continued to increase as the annual funding decreased. After the figures, a summary of the interview with the Deputy Director of the Arkansas Division of Aging, Adult, and Behavioral Health (with assistance from the Division Director and Assistant Division Director) is presented. See Table 4 and Figures 7-9.

Table 4

Participation and Expenditures for Arkansas HCBS Elderly and Disabled Program

Fiscal Year	# Arkansas Participants	# Waiting List	Annual Funding	Eligible	Participation Rate
2017	9,995	2,834	$116,305,406	11, 350	.880%
2018	10,548	3,103	$126,546,296	11,350	.929%
2019	9,788	3,305	$127,495,175	11,350	.862%
2020	8,630	3,325	$94,774,969	11,350	.760%

Figure 7

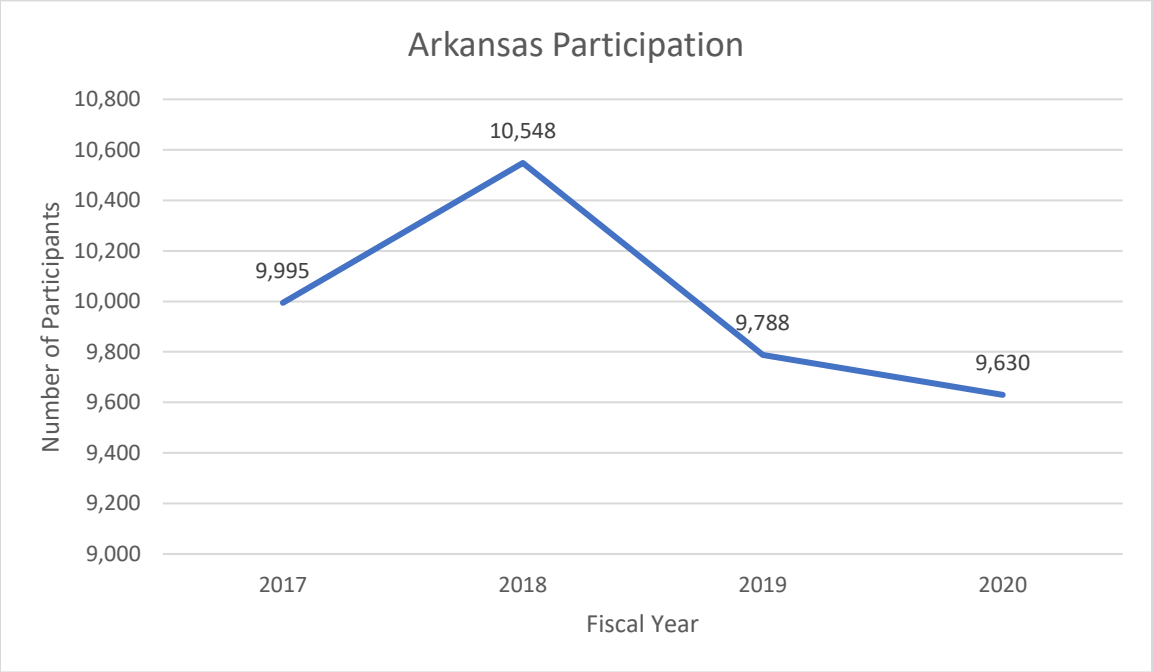


Figure 8

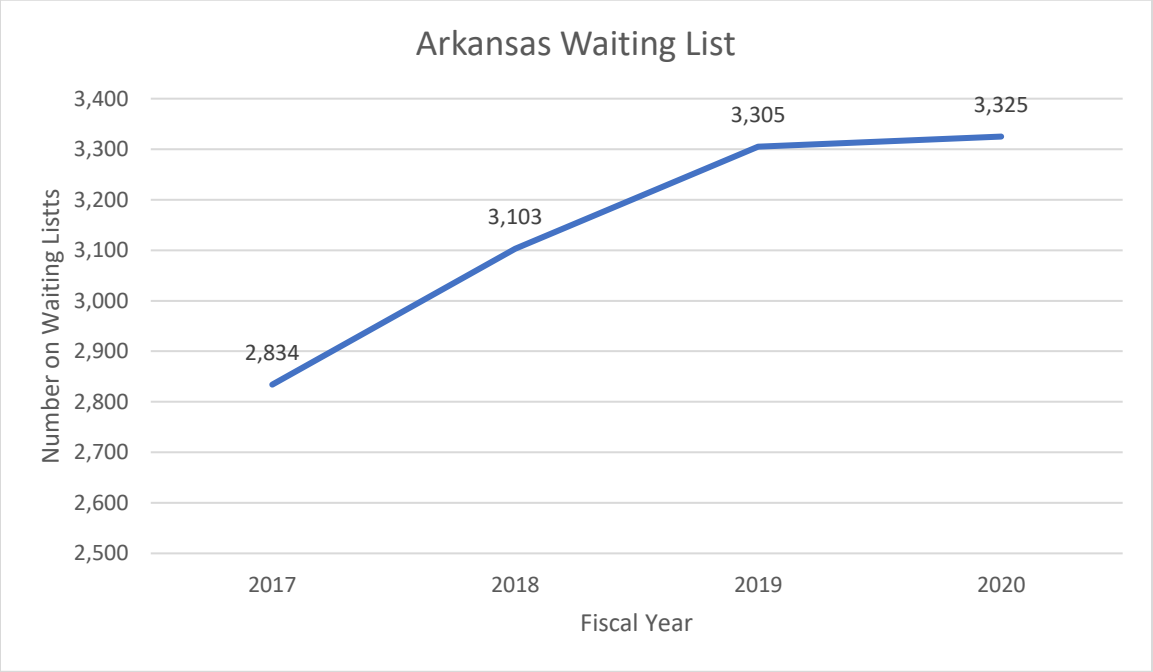
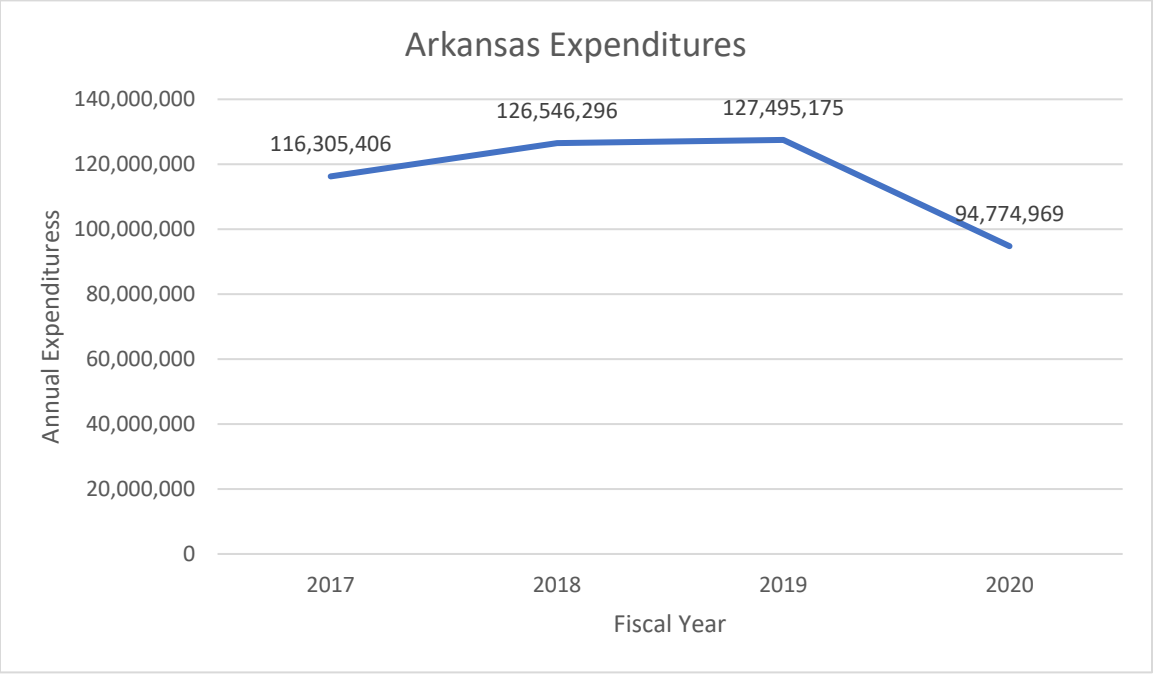


Figure 9



Interview with the Deputy Director of the Arkansas Division of Aging, Adult, and Behavioral Health

In the conversation with the Deputy Director of Arkansas, the researcher learned the current participation number is 9,749 under the two waivers. In Arkansas, the HCBS program does not have anyone on its waiting list. Services are provided based on a Person-Centered Service Plan (PCSP) created by a registered nurse (RN) in coordination with the client, family, and or guardian to meet the needs of the individual. We are not aware that there are services that are not currently being provided based on the developed plan of care. However, if there are instances in which we are made aware of a lack of services, the client or targeted case manager may notify the RN and the RN will assist the client with changing providers and updating the PCSP. We are contracted with approved state providers that provide waiver services to the elderly and disabled individuals that are enrolled in the HCBS program.

To date, there is no waiting list. Below their anticipated participation cap, rates are adjusted yearly, slots are increased each year, and work to avoid a waiting list. The agency anticipates an increase in the usage of the program, an increase in rate growth with all their waiver programs, and maintenance where they are. They do not anticipate a reduction in the program.

Comparative Analyses of the Data

The data showed that Alabama had an increase in participation in all four FYs. Mississippi showed an increase in FY 2017-2019 and a decrease in 2020. Arkansas showed an increase in FY 2017 and a decrease in 2019 and 2020. Table 5 shows this increase.

Table 5

Increase in Participation: Alabama, Mississippi, Arkansas

Fiscal Year	Alabama	Mississippi	Arkansas
2017	7449	16,247	9,995
2018	7578	16,444	10,548
2019	8225	16,845	9,788
2020	8,580	16,803	8,630

The data showed that Alabama had an increase in expenditure in all four FYs. Whereas, Mississippi had an increase in FY 2018, a decrease in FY 2019, and an increase in FY 2020. Data showed Arkansas had an increase in 2018 and 2019 and a decrease in 2020. See Table 6.

Table 6

Expenditures: Alabama Mississippi, Arkansas

Fiscal Year	Alabama	Mississippi	Arkansas
2017	79,000,000	67,747,884	116,305,406
2018	86,000,000	77,129,672	126,546,296
2019	104,000,000	75,743,998	127,495,175.
2020	116,000,000	76,266,846	94,774,969

The data showed that Alabama had an increase in the waiting list, and the waiting list was eliminated in 2019. Mississippi and Arkansas showed an increase in the waiting list in the FYs 2017 through 2020 and an increase in participation. See Tables 7 and 8.

Table 7

Waiting List: Alabama Mississippi, Arkansas

Fiscal Year	Alabama	Mississippi	Arkansas
2017	4194	8,800	2,834
2018	7793	8,534	3,103
2019	0	9,268	3,305
2020	0	12,059	3,325

The data showed that Alabama had an increase in the waiting list, and the waiting list was eliminated in 2019. Mississippi and Arkansas showed an increase in the waiting list in the FYs 2017 through 2020 and an increase in participation.

Table 8

Participation Rate: Alabama Mississippi, Arkansas

Fiscal Year	Alabama	Mississippi	Arkansas
2017	80%	77%	88%
2018	81%	76%	93%
2019	88%	78%	86%
2020	92%	78%	76%

The data showed Alabama's average participation for the HCBS elderly and disabled programs was 7,958. From 2017 to 2020, there was a 1,131 increase in participation in Alabama's HCBS elderly and disabled program. Alabama had an average participation rate of 85%, with an increase in annual funding at the end of the fiscal year 2020. Alabama no longer has a waiting list., starting in fiscal 2019 to the present.

In contrast, Mississippi's average participation for the HCBS elderly and disabled programs was 16,585, more than double that of Alabama. Mississippi reported an increase of 556 in participation in the HCBS elderly and disabled program for the fiscal years of 2017-2020. Mississippi's average participation rate was 77% and ended with an increase in funds at the end of the fiscal year 2020.

Arkansas's average participation for the HCBS elderly and disabled programs was 9,740. Arkansas reported an increase of 553 in participation for the fiscal year 2017-2018. For the fiscal years 2018-2020, Arkansas reported a 1,918 decrease in participation. Arkansas had an average participation rate of 86%, with a decrease in annual funds for the end of the fiscal year 2020.

When examining the waiting list in all three states, the researcher found that each showed an increase. During the fiscal years 2019 and 2020, Arkansas's participation decreased. The participation rate for all three states averaged 70%-90% for all four fiscal years. Out of the three states, Alabama no longer has a waiting list. The elderly and disabled are on a referral list where they are being screened for all services within the agencies during the HCBS enrollment process.

Research showed factors that limit participation in HCBS elderly and disabled programs**.** According to the Assistant Commissioner of the Alabama HCBS programs, more funding could assist with the growth of the program. Also, there is a delay in individuals receiving services due to a lack of staff and providers. The Area Agency on Aging has a new Person-Centered Plan, but if there is a lack of funds and available slots participation is still limited. According to Chong (2022), the unmet of the elderly population will assist in cost reductions and increase HCBS participation rates. Also, inadequate finances will cause fewer enrollments in HCBS programs (Sowers et al., 2016).

Summary

This study examined the participation rates of the elderly and disabled individuals in Alabama's Home and Community-Based Service (HCBS) program. When looking at the factors that impacted the participation rate of the elderly and disabled HCBS programs, research showed that funding can increase participation and reduce the waiting list. Participation is directly related to funding, availability of staff, contracted direct services providers, and person-centered services.

This study showed how the participation rate in the elderly and disabled HCBS has been impacted in Alabama compared the data to two demographically states, Arkansas, and Mississippi. The participation ranged from 7,449 to 16,845 for all three states. The expenditures

ranged from 67,747,884 to 127,495,175 for all three states, The waiting list ranged from 2,834 to 12,059 for all three states with Alabama's waiting list eliminated in FY 2019. The participation rate ranged from 76% to 93% for all three states.

Within the findings process, the researchers have provided an overview of the chapter, an analysis of the data, and a presentation of findings using figures, tables, and interviews in exploring the elderly and disabled individual participation rate in the State of Alabama HCBS programs. This section has also included a comparative analysis of data and factors that limit participation in the HCBS elderly and disabled program. Chapter V is the final stage of the research process and concludes the research.

Chapter V: Conclusion

This study examined Alabama's Home and Community-Based Service (HCBS) programs and the elderly and disabled participation rate. This research focused on Alabama's HCBS elderly and disabled program as well as its two similar demographical states, Arkansas and Mississippi. This chapter includes an overview, conclusions, and recommendations for future research. Prior research identified the elderly and disabled HCBS programs' cost reductions, inadequate finances, lack of workers, caregiver burdens, compensating gaps in the systems, lack of HCBS coordination, and the economic downturn as factors impacting the participation rate (Chong et al., 2022; Sowers et al., 2016; Spetz et al.; 2019, Wang and Wu 2018; Norman et al.; Watts et al., 2020). Current research identified that the elderly and disabled HCBS programs are impacted by available funds, staff, and direct service providers.

The researcher used quantitative research to explore the HCBS participation rate in Alabama and to compare the similar demographic states Arkansas and Mississippi. The focus of the study centered on elderly and disabled populations during the fiscal years 2017 through 2020. As previously noted, funding is a major factor when trying to increase participation in the HCBS programs in all three states. After collecting and analyzing the data for the four fiscal years, the researcher showed that state funding can increase participation and reduce the waiting list in the HCBS programs. The researcher also concluded that HCBS participation is directly related to the availability of the state's funding, staffing, direct service providers, and person-centered care. While the State has provided Alabama with additional funding to add more staff to assist with expediting enrollment processes, there remains a lack of hiring and retaining staff and direct service providers. As a result, the elderly and disabled may still experience delays in receiving services.

Recommendations

There are several recommendations for the participation rate in the elderly and disabled HCBS programs in Alabama. Research shows that the HCBS program participation is not mandatory; it is a program that provides the elderly and disabled population with HCBS benefits (MACPAC, 2020). Many federal and state policies have suggested rebalancing HCBS programs that will move the spending of Medicaid long-term care services and support away from institutional services and toward HCBS programs (MACPAC, 2020). In other words, more home care services are needed for the elderly and disabled, instead of funneling the resources to institutions. The rebalancing of spending to the elderly and disabled programs will assist with the increase in enrollment as well as the participation rate of the HCBS programs.

Additionally, more marketing is needed to ensure that the masses of eligible elderly and disabled are aware of HCBS programs. Given that the HCBS services consist of nonmedical and medical transportation, assistive technology, respite care, in-home nursing, wheelchairs, and meals (McLean et al., 2020), having more elderly and disabled participants partake of these resources will positively impact HCBS programs' participation rates and their overall health and well-being. As McLean et al. (2020) stated, "Through these services and supports, HCBS helps to ensure that people with disabilities are fully integrated into community life, rather than living in costly, isolated, and segregated institutions" (p. 685). Such services will allow this population to remain in the comforts of their homes, thus avoiding costly institutional care.

This researcher also recommends person-centered care; that is, providing a worker to offer nonmedical services for elderly and disabled participants. Alabama, Mississippi, and Arkansas increased the number of elderly and disabled participants this fiscal year due to person-centered care. Despite this increase, there are still concerns about funding and staffing clients for

the HCBS programs. If the HCBS programs include person-centered care and existing enrollment processes, the states should experience an increase in participation as well as in reduction in the waiting list.

Summary

This quantitative research study assisted with the exploration of the participation rate of the elderly and disabled individuals in HCBS programs. Using figures, tables, and interviews, the researcher explored the participation of the elderly and disabled individuals who receive services through the HCBS programs in Alabama. The theoretical framework was centered around the social theory and the person-centered theory that focused on the elderly and disabled individuals functioning in their communities while receiving in-home services. This study assists in identifying the limitations in participation rates in the Medicaid HCBS elderly and disabled programs in Alabama. Further, this study identified the participation rates, waiting lists, annual funding, and participation rates as limiting elderly and disabled participation in Alabama. This study provided information to consider on the participation rate in Alabama and in similar states regarding the HCBS elderly and disabled program, which would assist with funding the HCBS waiver programs.

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