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Program Review

February 2002 **Report No. 02-09**

Legislative Options to Control Rising Developmental Disabilities Costs

at a glance

Fiscal Year 2001-02 appropriations for the Department of Children and Families' Developmental Disabilities Program are $830.3 million. Funding for community services has more than doubled over the past five years to its current level of $677.8 million. The program is serving twice as many clients, providing more services per client, and paying more per unit for those services.

The department is taking some action to control costs. However, further steps could be taken to control costs and manage growth.

The Legislature should consider

- **requiring the department to establish purchasing strategies to improve cost-efficiency and save an estimated $38.7 million;**
- **limiting the number of new clients on the Home and Community-based Services Medicaid Waiver and/or the amount spent per client; and**
- **requiring the department to develop a plan to test the feasibility of implementing a managed care system.**

Purpose

At the Legislature's request, OPPAGA reviewed the Developmental Disabilities Program as part of the Legislative Budget Commission's Zero-Based Budget review of the program. Our examination focused on three issues:

- reasons for the program's rapidly rising costs;
- steps the department is taking to control program costs; and
- legislative options for controlling rising program costs.

Our review focuses on the community portion of the Developmental Disabilities Program because that is where most clients are served and where most growth has occurred.

Background

The Legislature established the program to improve the quality of life of all developmentally disabled persons through the development and implementation of

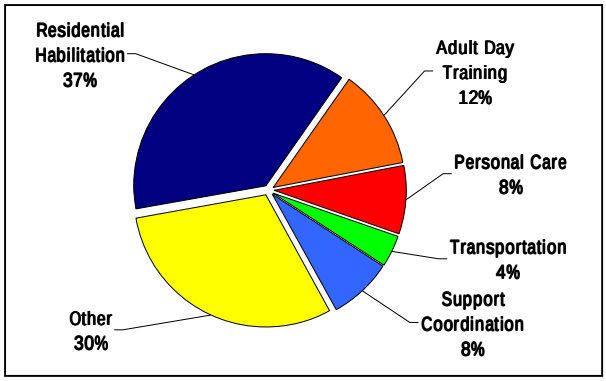
community-based residential placements, services, and treatment. [1]

The Department of Children and Families administers the program and serves clients in both institutions and community settings. Most clients are served in community settings. [2] As of October 2001, the program served 33,139 clients in the community.

Most community clients (25,448) receive services funded through the Home and Community-based Services Medicaid Waiver. [3] The waiver program allows Medicaid reimbursement for services that normally would be reimbursed only if clients were served in an institution. The federal share of Medicaid for Home and Community-Based Services constitutes 55% of the funding for the program while general revenue funds the remaining 45%.

The community program provides a wide range of services (see Appendix A). However, five services account for over two-thirds of program costs (see Exhibit 1). The single most costly community-based service is residential habilitation, a service that helps consumers learn the skills needed for daily living such as personal grooming, food preparation, and household chores. This service accounts for 37% of service costs. Adult day training, which accounts for 12% of program expenditures, helps clients to function more independently. For example, adult day training includes teaching clients age-appropriate social skills that are important for more independent community living. Personal Care Assistance, which makes up 8% of program costs, provides clients with assistance in bathing, dressing, and personal hygiene. Support Coordination helps clients to identify their service needs and to locate service providers. Expenditures for support coordination are 8% of the total. The remaining 30% includes a variety of services such as skilled and private duty nursing, chore and companion services, and speech, physical, respiratory, and occupational therapies.

Exhibit 1
Five Services Account for Over Two-Thirds of Program Expenditures 2000-01



Source: OPPAGA analysis of department data.

Program costs have more than doubled in the past five years; further increases are expected

Legislative appropriations for community-based services to developmentally disabled clients have increased rapidly, growing from $333.2 million in Fiscal Year 1996-97 to $677.8 million in Fiscal Year 2001-02. [4] In its Legislative Budget Request for Fiscal Year 2002-03, the department requested appropriations for community-based services of $732.8 million, or an increase of 8% over the previous fiscal year (see Exhibit 2).

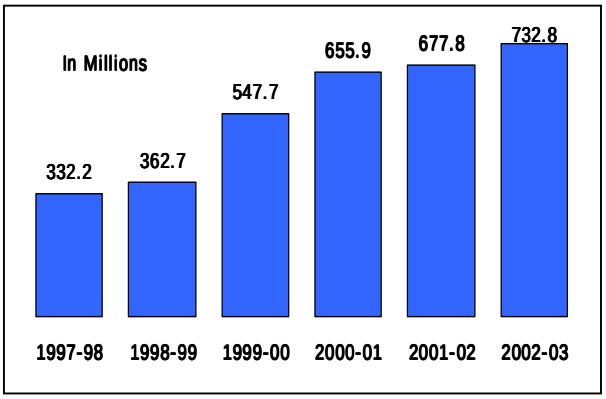
[1] Florida law defines developmental disabilities as life-long handicapping disorders or syndromes attributable to mental retardation, autism, cerebral palsy, spina bifida, and Prader-Willi syndrome.

[2] A total of 3,357 consumers reside in public or private Intermediate Care Facilities and 316 clients reside in other facilities such as psychiatric hospitals or jails or are served through the Mentally Retarded Defendant Program.

[3] The remaining clients who are not Medicaid eligible have received services funded solely through general revenue.

[4] Fiscal Year 2001-02 appropriations are $830.3 million, including $152.5 million for the four state-operated institutions. Funding for the state institutions has remained fairly constant over the past five fiscal years.

Exhibit 2
Funding for Community Services Has More Than Doubled Over the Past Five Years[1]



[1] The community services figures above include approximately $160 million for private Intermediate Care Facilities for the Developmentally Disabled. The figures do not show funding for the four state institutions, an estimated $152.5 million for 2002-03. The department's budget request for 2002-03 requested removal of approximately $258 million in federal Medicaid matching funds that already appear in the Agency for Health Care Administration's budget. The $258 million in federal Medicaid match is included above in the $732 million to be consistent with prior years.

Source: For Fiscal Years 1997-2001, legislative appropriations; for Fiscal Year 2002-03, Developmental Disabilities Legislative Budget Request.

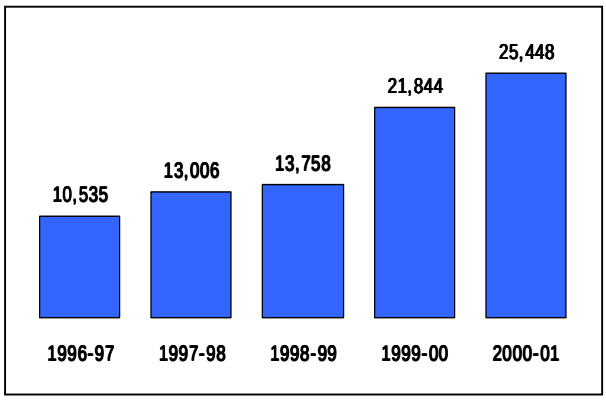
Five factors contribute to rising program costs

Five factors have driven this increased spending over the past five years.

- The program has more than doubled the number of clients served.
- The program has increased the level of services provided to clients.
- Costs for certain key services have increased at very high rates.
- An ineffective needs assessment process means the program is unable to adequately plan for client service needs.
- The program lacks an effective rate setting system.

Program clients have increased. The number of clients enrolled on the Home and Community-based Services Medicaid Waiver has more than doubled over the past five years (See Exhibit 3). The program's caseload grew from 10,535 in Fiscal Year 1996-97 to 25,448 for Fiscal Year 2000-01. The largest increase in clients occurred in Fiscal Year 1999-2000 and corresponds to the large increase in appropriations from Fiscal Year 1998-99 to Fiscal Year 1999-2000.

Exhibit 3
Number of Clients Enrolled on the Medicaid Waiver Has More Than Doubled in the Past Five Years



Source: Department of Children and Families.

This caseload growth will probably continue; the program planned to enroll 6,280 new waiver clients between March and June 2002. However, program officials report they will not be able to enroll as many clients as planned and could not say how many of the 6,280 would be enrolled. Annualizing costs to serve these clients would have cost an additional $100 million in Fiscal Year 2002-03. During Fiscal Year 2002-03 program officials estimated an additional 3,577 new clients would need services.

The rapid rise in the number of consumers served is due in part to lawsuits filed by consumers and other stakeholders against the State of Florida. The courts have interpreted current state and federal law to require the state to reduce waiting lists, which means that the state has to serve more people, thus contributing to the increase in the number of clients served by the program. Despite

increased appropriations intended to eliminate waiting lists, the number of consumers waiting for services could approach 10,000 by 2002-03.

Clients are receiving more services. The second reason for rising costs is that the program is providing more services to its clients. In recent years the state has increased the units of service provided to clients for some key waiver services including transportation, residential habilitation, and adult day training. Personal Care Assistance shows the largest increase in units of service. The number of clients who received hourly personal care assistance increased from 563 in Fiscal Year 1996-97 to 2,260 in Fiscal Year 2001-02, a 300% increase. Further, the average number of hours of personal care assistance provided to clients increased from 146 hours to 188 hours during this same period (see Appendix B for methodology used in data analysis). [5]

Lawsuits also are partially responsible for increasing the amount of services provided to consumers. Consumers already on the waiver brought suit claiming that they were not receiving services or were receiving insufficient services. Clients argued that they were receiving fewer services than they needed. In August 2001, the state entered into a settlement agreement in Prado-Steiman v. Bush regarding the adequacy of services on the Home and Community based Medicaid waiver. As part of the settlement agreement in Prado, the Developmental Disabilities Program must provide needed services for waiver clients within 90 days. Two similar cases are still pending. [6] Continuing lawsuits over the adequacy of services means continuing pressure from consumers, stakeholders, and the courts to increase spending for developmentally disabled clients.

Service rates have increased. The department is paying higher rates for some services, particularly for residential habilitation and personal care assistance. [7] Exhibit 4 shows that the rates for some services provided by the Developmental Disabilities Program have increased by up to 101% since Fiscal Year 1996-97. By comparison, the state's General Revenue Fund increased 22% during the same period. Monthly residential habilitation rates have risen from $806 to $1,618 per month. Total costs for residential habilitation exceeded $159.8 million in Fiscal Year 2000-01, which was 37% of total costs (see Appendix C for additional information on rate increases for other services).

Ineffective needs assessment adds to costs. The fourth factor that has contributed to rapidly rising program costs is that the program lacks a valid, reliable assessment of client needs. Without an effective assessment process, the department cannot accurately determine what services consumers need and cannot accurately estimate the cost for those services. In prior reports, we identified problems with the department's processes for identifying client needs. [8] We found, for example, that sometimes consumers were receiving services that did not meet their needs and did not help them achieve their goals.

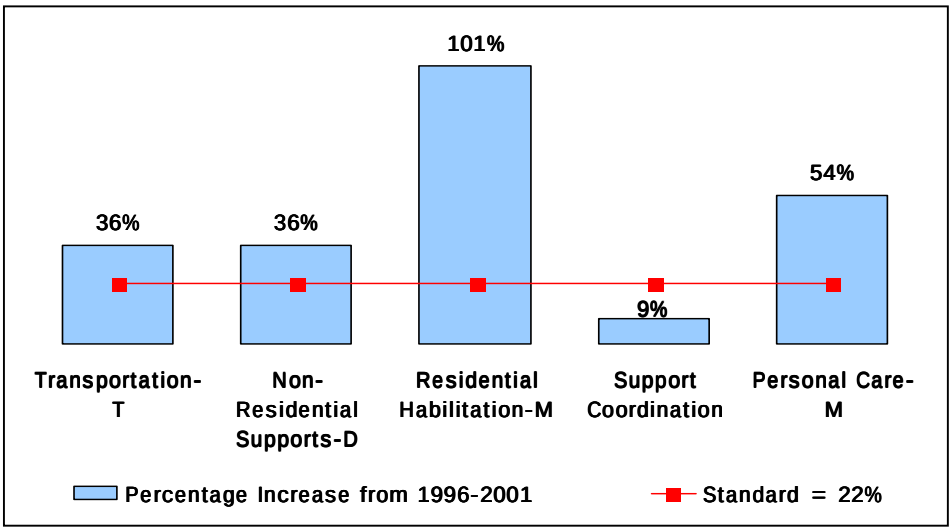
[5] As a result of the three-fold growth in the clients receiving the service and increases in the units of service, costs for personal care assistance (hourly) rose by $8.5 million from Fiscal Year 1996-97 to 2000-01—from $2.5 to $12.9 million.

[6] See Brown v. Bush Case Number 98-673- CIV-FERGUSON; USDC (Southern District) and Murray v. Auslander, Case Number 98-1066-CIV-FERGUSON; USDC (Southern District).

[7] The department purchases most services in hourly increments or days and months. Transportation services are provided in miles, one-way trips, or months of service.

[8] *Performance Review: The Home and Community-Based Services Waiver Systems, Controls Should Be Improved,* Report No. 99-31, February 2000. *Justification Review: Developmental Disabilities Program Florida Department of Children and Families*, Report No. 00-17, November 2000.

Exhibit 4
Personal Care and Residential Habilitation Rates Show Dramatic Increases Since 1996



Source: OPPAGA analysis.

The department uses the Florida Status Tracking Survey (FSTS) as the first step in assessing client needs. However, the instrument was not designed for this purpose. The FSTS was created and initially used to estimate the likelihood that an institutionalized client would be endangered if moved from an institutional setting. The department is now using the FSTS to determine a client's overall level of need.

The problem with FSTS is that it assesses the challenges a person faces because of their disability rather than assessing their need for services. Consequently, the program is unable to control costs based on level of need under the current system.

FSTS emphasizes individual challenges not service needs. FSTS does not assess a person's need for specific services but instead measures an individual's physical, functional, and behavioral challenges. The instrument was designed to assess clients' status and potential risk when moving from an institutional to a community placement. If a client was experiencing difficulty and declining physically or behaviorally, then those changes would show up in the FSTS. However, there may be an important difference between a person's status and their actual need for assistance or services. Two consumers with the same FSTS level could, depending on their personal circumstance, need vastly different levels of services. Take the hypothetical case of two consumers with mild mental retardation. Both consumers have about the same IQ and comparable levels in terms of physical and functional indicators. However, one consumer lives at home with a supportive family, has additional community supports, and desires to work in competitive employment with help and training. The other consumer has no family, no additional supports, and has no desire to train for or participate in competitive employment. The two consumers, while comparable in FSTS levels, differ significantly in their actual need for services.

FSTS cannot be used to establish cost parameters. Because FSTS does not reliably identify clients' need for specific services, it cannot be used to estimate the costs of providing services to clients. The program

currently does not have any other mechanism for assessing client needs, which is a critical problem.[9] However, there are alternative instruments that could be used.

If the state had a reliable method to determine level of need, then the state could establish cost parameters based on level of need. The department could then set a maximum dollar amount for services per client. However, under the current system establishing cost parameters for services is problematic. Expenditures for the average waiver consumer are $20,000, but services for a few consumers with the lowest FSTS scores exceeded $120,000 each in Fiscal Year 2000-01. Further, many clients with the lowest levels of need receive more in services than many clients whose needs are at higher levels. For example, annual expenditures for 3,026 clients with the lowest levels of need (level 1-3) exceeded $15,200 per client in Fiscal Year 2000-01. In contrast, 5,977 consumers (60% of all consumers at level of need 4 and 50% of all consumers at level of need 5) received less than $15,200 each in total services during the same period.[10]

Despite these problems, the department continues to make the Florida Status Tracking Survey (FSTS) the cornerstone of many policies and procedures. For example, the department's new residential habilitation rate is tied to the consumer's FSTS score.

There are alternative assessment instruments and methods for limiting per client spending. For example, the Inventory for Client and Agency Planning (ICAP) is used to assess clients in several states, including Texas, South Dakota, and Wyoming. Texas, a state that serves a comparable number of developmentally disabled consumers, uses the ICAP to assess client needs and limit costs per consumer. For example, Texas has five different levels of need. Clients with the lowest levels of need are capped at the same maximum rate while clients with extensive medical or behavioral needs have higher caps. However, community-based services are capped so that no one whose needs exceed 125% of the institutional rate is eligible. Wyoming has taken ICAP one step further and established individual funding levels based on ICAP scores.

Ineffective rate setting system contributes to rising costs. The fifth factor we identified that has contributed to rapidly increasing program costs is that the department lacks an effective system for establishing provider rates. Specifically, the department has not developed uniform rates for services it purchases from providers, and the rates it pays under the waiver can be substantially higher than the rates it pays for the same services that are provided under the state Medicaid plan.

Ineffective rate setting process results in widely varying provider rates. The department pays widely differing rates for the same services both within and across districts. Exhibit 5 shows the wide range of rates paid for the most frequently provided waiver services.[11] This occurs because the department has not developed a cost system to establish rates and it instead negotiates rates with individual providers. The rates paid to contractors who provide similar services can vary widely depending on factors such as staff negotiating skills and the rates historically paid to organizations. As a

[9] The department's expanded assessment process, the Personal Planning Guide (PPG) includes a revised FSTS assessment that includes screening for vision, hearing, and communication challenges and may improve assessments of clients with high levels of need. However, fundamental concerns regarding the use of FSTS are likely to persist.

[10] This pattern holds true when only waiver-enrolled clients are included in the analysis. There is very little difference in expenditures for non-waiver clients across level of need. It also holds when controlling for age, comparing expenditures for consumers over and under age 18.

[11] It does not appear that the higher rates are necessarily explained by the rural districts being forced to pay higher rates for services. In Exhibit 5, the high transportation rates and high daily residential habilitation rates are in District 9 composed of Palm Beach County.

result of these widely varying rates, providers contend that payments are inequitable.

Exhibit 5
Districts Pay Widely Varying Rates for Key Waiver Services

Service	Range of Average Rates Across Districts
Transportation (trip)	$6.44 to $9.50
Non-Residential Support (day)	$32.33 to $51.10
Non-Residential Support (month)	$154.50 to $796.69
Residential Habilitation (day)	$68.43 to $110.28
Residential Habilitation (month)	$848.59 to $4309.45[1]
Adult Day Training	$28.45 to $44.59
Personal Care Assistance (quarter-hour)	$2.58 to $3.56
Personal Care Assistance (month)	$671.51 to $2,127.78

[1] A small number of clients are serviced at the maximum rate allowed, an average of $9,976.86 per month.

Source: OPPAGA analysis of department data.

To address this problem, the 2000 Legislature provided for a study to establish a uniform rate structure for community-based service providers. The Center for Prevention and Early Intervention Policy conducted the study. The study did propose more uniform rate policies. However, if its recommendations were adopted, costs for services would increase in the first year by $74 million. This would occur because of two problems with the study.

- The study proposes to equalize rates by increasing payments to most providers while not reducing rates for any providers who may be receiving artificially high rates. The department is caught between providers who complain that rates are low and the need to recruit more providers. We feel, however, that simply increasing rates without an analysis of their efficiency or the reasonableness of their profits cannot be justified.
- The study assumes that training for direct care positions will be increased, which increased costs. Department officials said increased training hours were part of a court settlement and were necessary to ensure quality direct care staff.

The department contracted with another consultant to review the rate study.[12] Department and program officials we interviewed said they hope the Legislature will adopt a five-year plan to increase provider rates each year until they reach the levels outlined in the rate study. However, any decision to increase provider rates must be carried out on a rational basis, or else it will only further contribute to rapid growth of program costs.

Waiver pays higher rates. A related problem in the program's rate structure is that although some services are provided under both the waiver and the state plan, the waiver pays higher rates for services, such as personal care assistance. In Fiscal Year 2000-01, the program allowed a maximum personal care assistance rate four times as high as the state plan and paid on average as much as 25% more per hour than the state plan ($12.04 per hour compared to the $9.72). In Fiscal Year 2000-01, the Medicaid waiver provided $12.9 million in personal care assistance to 2,260 consumers. If the program had paid the Medicaid rate for these services, it would have saved $3.53 million.

Maximum allowable waiver rates are set by the Agency for Health Care Administration in consultation with Developmental Disabilities Program officials. Program officials said that the waiver pays higher rates because waiver consumers require more intensive services and because providers will not accept the lower state plan rates. However, currently the department requires consumers who are eligible to receive personal care through the state plan to receive that service under the state plan.

[12] The final rate study report was due to the department on July 30, 2001, but was not yet available for our review during publication of this report.

New department cost control initiatives have merit but may face significant obstacles

The department is taking some steps and has proposed additional actions to control costs, and we believe these steps could result in savings.[13] However, program officials acknowledged that these efforts might be time-consuming and costly to implement, thus reducing any potential cost savings. In addition, advocates have opposed some of these steps because they perceive that they could reduce or deny services to consumers. The primary obstacle to many of the department's proposals is that consumers can demand a hearing before services can be reduced or eliminated.

New prior authorization policy intended to ensure services are appropriate and cost-effective. Effective November 1, 2001, the department required prior authorization for services for new clients and began reviewing services for all consumers. The new policy, according to department officials, will help eliminate inappropriate use of services and better control costs. Department personnel will conduct reviews of all consumers. The department's private contractor will conduct additional reviews for clients whose services do not appear appropriate in terms of intensity, frequency, duration, or cost of service. By November 2002, department officials estimate that they will have assessed and reviewed all services provided to all consumers. Department officials estimate that 5,000 consumers will require additional review by a private contractor because their services exceed clinical or other guidelines.

Prior authorization faces opposition from consumers and stakeholders who are suspicious of the department's efforts to reduce or limit client services. In addition, due process requirements necessary under federal law and regulations, as well as lawsuit settlements, may make implementation of service reductions costly and time-consuming.

Under these due process requirements, customers are entitled to a fair hearing to challenge any department decisions that their services are unnecessary or excessively costly. These hearings are carried out within the Department of Children and Families under contract with a private provider. Because fair hearings involving Developmental Disabilities clients are often complicated, they can last from two hours to two days and estimated costs can range from $250 -$300 per hearing. The Developmental Disabilities Program was reversed in 6% of fair hearings in Fiscal Year 2000-01 and changed its position in another 13% of cases. Thus, the steps necessary to reduce a client's services are potentially time-consuming, costly, and may not result in less cost to the state.

New service directory intended to limit services to those that are medically necessary. The department also intends to reduce costs that result when a client receives a service that is unnecessary. In July 2001, the department implemented a new service directory that outlines the criteria that a client must meet to receive a service, criteria that are based on "medical necessity".[14] New guidelines in the service directory, for example, state that personal care assistance must be medically necessary and is limited to

[13]The department and the Agency for Health Care Administration have been working to establish a new quality assurance process for the Developmental Disabilities Program. Program officials hope the new system will ensure that consumers are receiving quality services that help them achieve their goals. Once the new system is in place, it may help identify providers who are not providing quality services. However, the new quality assurance process is directed at improving quality rather than controlling costs.

[14]Medical necessity requires, for example, that services must be necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. Services must be individualized, specific and consistent with symptoms or confirmed diagnosis. They must be provided in a manner consistent with generally accepted professional medical standards. For the complete definition see 59G-1.010(166), *Florida Administrative Code*.

four hours per day for most consumers. Department officials reported that some consumers were receiving and using personal care inappropriately. For example, some families receive personal care assistance in the after school hours that amounts to after school care rather than personal care.

Department officials could not tell us how many consumers are affected by the new personal care policy or the total cost savings that might result from the change. However, because of stakeholder concerns and at the request of the Governor's Office, the department has delayed changes in personal care usage for after school until Fiscal Year 2002-03.

Department proposals may result in additional cost savings. In its Legislative Budget Request for Fiscal Year 2002-03, the department proposed additional steps to control costs. Some of these proposals face obstacles similar to current efforts. Some changes may enable consumers to seek an administrative hearing through the Department of Administrative Hearings, potentially more costly and time-consuming than a departmental fair hearing. Specifically, the department proposes to take the actions discussed below.

- Change eligibility by limiting services to only those clients who are Medicaid eligible, thereby reducing general revenue funding. The change in eligibility would potentially affect 2,300 consumers and could result in a cost savings of $18.9 million. However, any effort to reduce a consumer's services may require an administrative hearing.
- Limit community funding to no more than current Intermediate Care Facility for the Developmentally Disabled (ICF/DD) reimbursement rates.[15] This proposal could result in a net savings of $5.7 million. However, any cost savings may be offset by expenditures and time necessary to fully implement the proposal. The department will have to assess whether these consumers can be safely served in the community at reduced rates or find an ICF/DD bed for that person. Department officials report that currently there are not enough ICF/DD beds available for these consumers and that increasing institutional beds is counter to the program's policy of community-based services.
- Allow support coordination as an "optional" waiver service. The department estimates that if 10% of consumers chose this option, there would be a cost savings of $1.4 million. This proposal should face limited obstacles if consumers are allowed to choose alternative services and could possibly be more widely implemented.
- Pay for contract management and oversight via a new "surcharge" on each contract. To reduce costs and still ensure adequate oversight of its contracts, the agency has proposed a contract surcharge that will fund a department-wide initiative involving 300 DCF employees. Each provider would be required to pay a fee, based on the amount of reimbursements per their contract. If implemented, the proposal could produce an estimated cost transfer of $19.8 million.[16] The contract surcharge would require legislation to grant DCF authority to implement the proposal. This proposal could face opposition from providers who would see the surcharge as reducing the value of their contracts.

[15] An ICF/DD is an Intermediate Care Facility for the Developmentally Disabled. Operated by private providers, they receive an institutional reimbursement per day that covers all services provided to the resident.

[16] The potential $19.8 million dollars is not a savings to the Developmental Disabilities Program but rather across the whole agency.

While the department's various initiatives have merit and may result in some cost savings, further steps are needed to control rapidly rising costs. As a result, we recommend that the Legislature consider additional strategies that might help control rising costs in the short term and restructure service delivery to bring about long-term changes in the program.

Strategies the Legislature Should Consider

Controlling costs will require some major structural reforms in the Developmental Disabilities Program that will require time to implement. We identified short-term and long-term options to consider. All of the options below will require legislative intervention if they are to be successful. These options fall into three broad categories. The Legislature could

- require the department and waiver support coordinators to use purchasing strategies that improve cost-efficiency, which could save an estimated $38.7 million;
- place caps on the program by limiting the number of clients on the wavier and/or the amount spent per client; and
- require the department to design and implement a plan to convert the current fee-for-service system to a capitated system of care for developmentally disabled clients based upon their levels of need.

Develop purchasing strategies to increase cost-efficiency

One of the more immediate options available to the Legislature is to develop purchasing strategies to increase cost-efficiency. Currently, where available, consumers may choose from any enrolled provider. Under this proposed option, consumers should have choice in the range of services that help them meet their needs, but they may not have the choice of buying services from the most expensive provider. Using purchasing practices that result in acquiring more cost-efficient services could significantly increase the number of clients who can be served under the program. However, these practices are likely to be problematic for many providers who might be forced to offer services at a more competitive rate or see the number of clients decline.

We identified three approaches that could make purchasing more cost-effective. First, limiting waiver reimbursement rates to those in the state Medicaid plan could save an estimated $3.9 million. Second, limiting the department's discretion in purchasing decisions could save an estimated $34.8 million. Finally, developing more competitive purchasing strategies at the district or county level could result in additional cost savings.

Limit reimbursement rates to those in state Medicaid plan. One approach for using more cost-efficient purchasing practices is to limit the Medicaid reimbursement rate for developmental services to those permitted under the Florida Medicaid plan. Under the current Home and Community-based Services Medicaid Waiver, the department makes a number of clients eligible for Medicaid services and also provides a higher reimbursement rate for these services.

Both the state Medicaid plan and the Home and Community-based Services Medicaid Waiver, provide common services such as private duty nursing and personal care assistance. However, the Medicaid waiver reimburses for these services at a higher rate. For example, the waiver allows for one-quarter hour as much as the state plan pays for a whole hour ($9.27 per quarter hour on the waiver compared to $9.70 per hour under the state Medicaid plan). If the waiver rate for personal care had been capped at the rate for comparable services under the Medicaid

state plan, the cost of these services would have been about $9,391,687, or about $3,538,325 (38%) less than what the program actually paid. Smaller cost savings would be realized for nursing and therapy services where total expenditures are lower and rate differences are smaller. Medicaid waiver rates for nursing are 40% higher than state plan rates but only 3% higher for therapy services (speech, occupational, and physical therapy). However, the total estimated cost savings for requiring state plan rates for waiver services is $3.9 million (see Appendix D).

One drawback to requiring the waiver to pay state Medicaid plan rates is that this decision might reduce the availability of providers because some would choose not to provide services at the lower rate. However, waiver clients who are eligible for personal care under the state plan are required to receive services under the state plan, paid for at the lower state plan rates. Consumers who are eligible for personal care only through the waiver receive services paid at the higher waiver rate.

Purchase bulk services. Another approach for increasing cost-efficiency when purchasing services is to require the department to purchase services in bulk. Many developmental services can be purchased in different increments of service, such as by the day or month (e.g., personal care assistance and non-residential support services) or by the mile, trip, or month (e.g., transportation). Others are billed at a single rate (e.g., adult day training has a daily rate only and waiver support coordination a monthly rate). Purchasing services at daily rates when the service will be needed for long periods of time costs considerably more than purchasing the services at a monthly rate.

For example, the average rate for residential habilitation (the most expensive program service) was $93 per day in Fiscal Year 2000-01, and the average consumer received 197 days of service for the year (about 17 days per month). However, many clients received more than 17 days of service per month and often received service every day. In fact, 93% of daily residential habilitation expenditures went to pay client invoices that exceeded 17 days of service, and the total cost for these invoices was $140.1 million. Based upon our analysis of department data, we estimated the department would have saved $34.8 million if it had contracted for monthly rather than daily services for these clients.

The Legislature should statutorily mandate that, to the extent possible, the department should purchase services in bulk. Whenever a client's need for services is such that it would be more economical to purchase services in bulk (e.g., by the month rather than the day), statute should direct the department to make the cost-effective decision.

Department officials said that one drawback to bulk purchasing is that Medicaid will not reimburse for days that a client did not actually receive services. However, AHCA officials said it was feasible to cap daily rates not to exceed a monthly maximum. In addition, the state could even raise average monthly rates slightly and still produce a cost savings over purchasing services at daily rates.

Develop competitive purchasing practices. Another approach available to the Legislature for purchasing more cost-efficient services is to require the department to develop a competitive bidding system to take advantage of the state's purchasing power when obtaining developmental services. Under this approach, depending upon how the process is structured, districts would issue an invitation to bid for each type of service provided. District offices could develop more cost-effective rates for services by contracting with providers who submit the lowest and best bids.

Department officials expressed some concerns about competitive purchasing strategies and said that an invitation to bid process might further reduce the number of providers in a given area thereby reducing access to needed services, especially in rural areas. Program officials also expressed concern that reducing providers would reduce consumer choice.

Legislate limitations on the number of clients served and on the amount spent per client

A second strategy available to the Legislature to control the growth in program costs is to legislate limits on the number of clients served and/or the amount that can be spent per client. Over the past few years, the state's policy has been to expand the use of the Home and Community-based Services Medicaid Waiver. Likewise, in response to various lawsuits, the state has made more services available to clients on the waiver. However, federal policy permits the states to limit both the number of clients served on the waiver and the amount of services that can be provided to them.

Limit number of clients because the waiver is not an entitlement. The state could control rising costs by placing a limit on the number of clients served. Historically, the department has limited the number of clients on the waiver by limiting the number of waiver slots available under the wavier.

The Home and Community-based Services Medicaid Waiver is not an entitlement and therefore the Legislature might consider setting a maximum number of new consumers that can be served with each new appropriation of funds. For example, Medicaid rules would allow the Legislature to stipulate that up to a certain number of new consumers could be served, depending on the availability of funds. Because of their deficit, the department now has an estimated waiting list of 6,280 consumers to be served in the order they applied for services. [17]

Legislatively limiting the maximum number of consumers who could be added to the waiver would prevent the department from enrolling more consumers than expected, which increases costs. This option would reduce the department's flexibility to decide how many clients will be served and will require legislative action each time the cap is to be increased. Currently, the only cap that exists is on the number of waiver slots approved by the federal government. However, the department could increase the number of waiver slots by submitting a request to the federal government. Placing caps on enrollment could lead to waiting lists, which the use of the waiver was intended to reduce. Thus, while this is an effective control on program costs, it may be a last resort in the event the department is not able to reduce the growth.

If a cap were enacted, it could be based on the average cost per consumer on the waiver ($20,000). Thus, if the Legislature decided to increase funding by $20 million, the department could enroll an additional 1,000 clients.

Program officials expressed two concerns related to this option. First, they noted that customers must be phased in to service throughout the year, which would need to be taken into account in funding allocations. Program officials also expressed concern that limits on waiver growth could negatively affect the settlement agreements in some of their lawsuits.

Limit per client spending. Another way to better control the growth in program costs is to limit the total cost of services that individual clients can receive. This method involves placing a hard cap on the amount of

[17] Current figures show a $10 million deficit for the Developmental Disabilities program.

services.[18] Using a hard limit on services involves setting a maximum dollar amount on the benefits an individual may receive. Individuals who need services and supports beyond the hard cap would not be eligible for home and community-based services. The department's legislative budget request for 2002-03 proposes a hard cap on individual services at the current institutional reimbursement rate. However, this cap would only affect about 360 of the program's 25,448 waiver clients and already faces organized opposition from stakeholders.

The main problem with using hard caps is that some individuals who need services beyond the caps may be denied services. When the clients are denied services, they may turn to institutional services to meet their needs. Hard caps set closer to the institutional rate, as the department proposes, should enable the wavier to meet the needs of more individuals. However, as we noted earlier, hard caps face a number of obstacles.

We believe that services could be capped according to the consumer's level of need once the problems with the assessment process are fixed. A more flexible type of per-client spending limit would include an exception policy (a soft cap) and might result in fewer obstacles. A soft cap allows more flexibility; for example, it would allow exceptions for one-time equipment purchases or home renovations. The Legislature should require the program to review annualized expenditures for consumers at a certain rate based on their level of need.[19] For example, a consumer with the lowest need for services could be capped at the average cost for all consumers at that level of need, with the exception of a total one-time expenditure for home renovations. According to AHCA officials, any type of spending cap would require an amendment to the current waiver. Either type of cap would also have to allow changes in spending if the consumer's needs increased significantly.

The Legislature could further soften the effect of using hard caps by providing for approval of plans of care that exceed the hard caps. The Legislature could require the department to develop separate waivers tailored to specific levels of need.

Using multiple waivers could enable the department to better defend legal challenges. Some have interpreted the Supreme Court's Olmstead decision to mean that consumers must have equal access to services, meaning that groups within the client population cannot be denied services that are available to the rest of the group.[20] However, Medicaid rules make it possible for a state to fashion separate waiver programs based on client's level of need and tailor services more narrowly and control costs more effectively. For example, a waiver that serves only clients with limited or minimal needs would be serving a population by definition that needed only periodic or intermittent services.

Although using multiple waivers may help to meet federal conditions under Olmstead, it

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[18] Gary Smith, Janet O'Keeffe, Letty Carpenter, Pamela Doty, Gavin Kennedy, Brian Burwell, Robert Mollica, and Loretta Williams. "Creating Comprehensive Cost-Effective Systems: System Design Issues" in *Understanding Medicaid Home and Community Services: A Primer* (Washington, D.C.: George Washington University, Center for Health Policy Research, 2000), http://aspe.hhs.gov/daltcp/reports/primer.htm,, November 2001.

[19] The department implemented a high-cost review policy in October 1999 that called for reviews of high-cost consumers. We found that the department approved virtually all the high cost plans that were submitted. While they have instituted an additional review by a private contractor, we believe legislative action is necessary to ensure that caps are followed.

[20] U.S. Supreme Court, *Olmstead vs. L.C.*, Decision No. 98-536. Argued April 21, 1999–Decided June 22, 1999. Washington, D.C. The essence of the Olmstead decision is that "States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities…."

could increase the complexity of the program administration. Program officials expressed concern about the length of time needed for approval of additional waivers. In addition, appropriate waiver enrollment would depend upon defensible decisions about clients' disabilities and service needs. As previously discussed, the problems associated with the department's needs assessment process would diminish the feasibility of this option.

Managed care offers the potential for limiting costs and controlling growth

Another option available to the Legislature is to create a capitated system for care of the developmentally disabled. Capitated systems, better known as managed care, are being used in Florida and other states for adult and children's Medicaid medical services and behavioral health care. A few states also have applied managed care principles to developmental disabilities services.

In a capitated system, a managed care organization receives a monthly payment for each member enrolled in its system. The managed care organization in return is responsible for delivering all the services needed by enrollees as specified in its contract. The managed care organization also assumes financial risk should the cost of services exceed the capitated payment. Financial risk is the incentive that moves a managed care system to greater efficiency.

There are several reasons why Florida should consider developing a managed care system for developmental disabilities services. In the early 1980s, Florida turned to a managed care system for Medicaid medical services to better control the growth of expenditures. While Florida has not used a managed care system for the developmentally disabled, other states have turned to such a system to increase program efficiency. For example, Arizona and Michigan program officials cite efficiencies generated in their programs that allow more service delivery per fixed dollar cost than conventional Medicaid models.

To implement a managed care system for the developmentally disabled**,** there are several obstacles the state must overcome. First, a managed care system would require a new Medicaid waiver. In addition, a new managed care waiver would require that all consumers must be served; that is, there can be no waiting lists. There are also a number of implementation issues related to the development of a managed care system. A managed care system requires reliable cost data about clients and their services. The department's data collection system is inadequate to the needs of a managed care system at this time. Furthermore, managed care organizations must be identified and qualified. These organizations could be either private or public sector agencies, such as local associations of retarded citizens, current Medicaid acute health providers, or the department's district offices.

Michigan has determined that a minimum Medicaid eligible population of 20,000 is necessary to set up a local capitated payment base. Initially, they determined their capitated rates based on historical data and assumed partial financial risk along with providers during transition while perfecting their data. Eventually, Michigan will shift all financial risk to their managed care organizations. Similar design considerations would be necessary for Florida.

We believe that a pilot project similar to Michigan's could be implemented in a district during Fiscal Year 2003-04. The selected district should have sufficient Medicaid-eligible clients, not just developmentally disabled clients, to enable the state to set a realistic capitation rate. The selected district should also have a suitable number of potential candidates for the role of a managed care organization. Based on Michigan's experience, we believe a minimum of three years to evaluate design concepts and

prepare for statewide implementation may be necessary. We also anticipate that a complete transition to a managed care system would take up to five years, based on our review of Michigan's program.

Conclusions and Recommendations

The Developmental Disabilities Program's costs have doubled in the last five years. With 25,448 waiver clients, Florida is serving twice as many clients than just a few years ago, providing more services per client, and paying more per unit for those services. Rising program costs are exacerbated by what has become a highly litigious environment, by an ineffective client needs assessment process, and by an inadequate method for establishing provider payment rates. The department has proposed some measures to control costs that could result in cost savings of up to $46 million. However, these proposals face significant obstacles that may reduce their effectiveness. In addition to the department-initiated proposals, we believe that the Legislature should consider other options.

To further control program costs the Legislature should take action in four areas.

Establishing more cost-effective purchasing strategies

To increase the efficiency and effectiveness of the department's process for purchasing program services, we recommend that the Legislature direct the department to take the actions discussed below.

- Limit reimbursement rates to those in the state Medicaid plan. Under the current Home and Community-based Services Medicaid Waiver the department makes a number of clients eligible for Medicaid services and also provides a higher reimbursement rate for these services. The Legislature should amend s. 393.066, *Florida Statutes*, to require state plan rates for Medicaid waiver services. We estimated cost savings of $3.9 million if the department implemented this recommendation. [21]
- Purchase services in bulk, to the greatest extent possible. It would be much more economical for the department to purchase services in bulk; we estimated cost savings of $34.8 million annually if the department implemented this recommendation. To mandate bulk purchasing, the Legislature should amend s. 393.066, *Florida Statutes*.
- Develop competitive bidding practices to take advantage of the state's purchasing power. A competitive Invitation to Bid process would result in more cost-effective purchasing decisions. The Legislature should amend s. 393.066, *Florida Statutes,* to require districts to use providers who would provide quality services at competitive rates.

Setting limits on new clients served and per client spending

Although federal policy permits Florida to limit the number of clients served on the Home and Community-based Services Medicaid Waiver and the amount of services provided to them, the state's policy in recent years has been to expand the use of the waiver and to reduce program waiting lists. To better control the growth of the Medicaid waiver, we recommend that the Legislature take the actions discussed below.

- Establish a cap, in proviso, on the number of new clients that could be

[21] While some providers might refuse to provide services at the lower rate, our analysis of personal care expenditures shows that more than half hourly expenditures in Fiscal Year 2000-01 were for services in more urban areas where providers should be more plentiful. That is, 56% of hourly personal care services were provided in District 11 (Dade, Monroe), District 5 (Pasco and Pinellas), District 6 (Hillsborough, Manatee), and District 1 (Escambia, Walton, Okaloosa, and Santa Rosa).

served with each year's appropriation based on available funding. The Legislature should specify that new funding would be used to serve up to a certain number of new consumers, based on appropriations. The department would continue to serve clients already receiving services and must be able to pay for the increasing needs of existing clients before enrolling new clients. The exact limit on the number of new clients that would be served would depend on the amount of the appropriation.

- Require the department to explore ways to develop a system to cap per-client spending based on level of need, and develop a plan for limiting per-client spending. The department should report its results to the Legislature no later than November 1, 2002. Based on the department's plan, the Legislature could establish cost parameters based on client level of need for the 2003-04 fiscal year.

Implementing better needs assessment process

One of the primary impediments to the department's ability to set cost parameters based on level of need is the lack of an effective needs assessment process. To resolve the problems with the current assessment process, we recommend that the Legislature

- amend s. 393.065, *Florida Statutes*, to require the department to adopt more effective methods for assessing client needs. A better assessment process would allow the department to plan for future growth of the program. In order for the Legislature to successfully limit per-client spending, either through hard or soft caps, the Legislature must resolve long-standing problems with the assessment process.

Developing pilot project to test feasibility of establishing managed care system

We recommend that the Legislature

- direct the department to develop a plan to implement a managed care pilot project in one of the 15 service districts to begin no later than Fiscal Year 2003-04. The pilot should be established in a district with an appropriately large number of Medicaid waiver consumers to test the feasibility of statewide implementation. To ensure the validity of evaluation results, the department should test the reliability of data collected for the project.

Agency Response

The Secretary of the Department of Children and Families provided a written response to our preliminary and tentative findings and recommendations. While the Secretary generally agreed with many of our findings and recommendations, her letter expressed concern with several of our conclusions. For example, the Secretary's letter raised issues relative to the program's process for determining clients' need for services. The Secretary indicated that the department is working to improve its assessment process to ensure client needs are met.

In addition, the Secretary questioned our potential cost savings estimate of $34.8 million if the department were to implement a bulk purchasing strategy for certain services. However, our cost savings estimate is conservative because our analysis excluded data that appeared to be unreliable. Because the department's data contained significant errors, we corrected for invoices with obvious mistakes. For example, we excluded from our analysis of Fiscal Year 2000-01 monthly invoices those invoices that were paid at daily rates or for daily units of service. The Department of Children and Families written response is printed herein on page 21.

Appendix A

List of Medicaid Home and Community-Based Waiver Services

Home and Community-Based Services	
Adult Day Training	Physical Therapy and Assessment
Adult Dental Services	Private Duty Nursing
Behavior Analysis and Assessment Services	Psychological Assessment
Behavioral Assistant Services	Residential Habilitation
Chore Services	Residential Nursing Services
Companion Services	Respiratory Therapy and Assessment
Consumable Medical Supplies	Respite Care
Dietitian Services	Skilled Nursing
Durable Medical Equipment	Special Medical Home Care
Environmental Accessibility Adaptations	Specialized Mental Health Services
Homemaker Services	Speech Therapy Assessment
In-Home Support	Support Coordination
Medication Review	Supported Employment Services
Non-Residential Support Services	Supported Living Coaching
Occupational Therapy and Assessment	Therapeutic Massage and Assessment
Personal Care Assistance	Transportation
Personal Emergency Response System	

Source: Department of Children and Families.

Appendix B

Data Analysis of Developmental Disabilities Expenditure Data

In our analysis of the program's expenditure data, we were interested in rates paid per unit of service and the number of units provided to consumers annually across the most used community-based services. We analyzed Developmental Disabilities Program expenditure data for Fiscal Year 1996-97 through Fiscal Year 2000-01 and found substantial error in the rate per unit and units of service data. For example, we found that 37% of invoices for monthly non-residential habilitation had values of greater than 1, although one month is the most that can be invoiced at a time. We found instances in which daily rates were reported as monthly rates or hourly rates were reported as daily or monthly rates.

Program officials acknowledged data errors and indicated that because of these problems they only assess average client expenditures--total expenditures by service code (regardless of how many different units the service is provided) divided by the number of unduplicated clients. As a result, the department cannot accurately assess how many units of service a client received or what the average rate was for the different units of service.

To estimate average rates for the most used community services, we first eliminated invoices with obvious errors. For the services that could be invoiced in days or months, we eliminated invoices below the 25th percentile for monthly rates and above the 75th percentile for daily rates. Our decision was based on two assumptions. First, the monthly rates below the 25th percentile were too low for a monthly rate and probably were daily rates miscoded as monthly rates. Second, the daily rates above the 75th percentile were too high for a daily rate and probably were monthly rates miscoded as daily rates.

For units of service, we report the median unit of service instead of the average. Program officials indicated that our methodology reasonably compensated for errors.

Appendix C

Average Rate Increases for Selected Waiver Services, 1996-2001

Service	Average Rates		
	Fiscal Year 1996-97	Fiscal Year 2000-01	Percentage Increase
Transportation (trip)	5.93	7.99	35
Transportation (month)	159.58	201.31	26
Non-Residential Supports (daily)	32.34	40.81	26
Residential Habilitation (daily)	47.91	93.21	94
Residential Habilitation (monthly)	805.64	1617.55	101
Adult Day Training (daily)	29.00	34.88	20
Personal Care (quarter-hour)	2.36	3.01	28
Personal Care (monthly)	705.18	1102.39	56

[1]See Appendix B for a discussion of the steps taken to adjust for outliers in the department's data.

Source: OPPAGA analysis.

Appendix D

Potential Cost Savings if Rates for Waiver Services Were Limited to State Plan Rates

Service	Waiver Expenditures			
	Total Fiscal Year 2000-01	Amount Paid at Rates Above State Plan	Percentage of Total	Estimated Cost Savings
Personal Care	$12,930,012	$8,625,976	67%	$3,538,325
Private Duty Nursing	$2,110,979	$767,126	36%	$146,606
Skilled Nursing (RN)	$610,209	$335,190	55%	$91,172
Skilled Nursing (LPN)	$1,189,121	$833,165	70%	$140,488
Speech Therapy	$1,095,158	$651,084	59%	$19,719
Occupational Therapy	$424,405	$180,048	42%	$5,453
Physical Therapy	$1,252,082	$612,114	49%	$18,538
Total	**$19,611,966**	**$12,004,703**	**61%**	**$3,960,301**

[1] Personal Care and nursing services are billed hourly under the state Medicaid plan but by the quarter hour under the waiver. For the sake of comparison, the rates here show hourly rates for personal care and nursing. Therapy services for both the waiver and the state plan are billed by the quarter hour.

Source: OPPAGA analysis.

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John W. Turcotte, OPPAGA Director

FLORIDA DEPARTMENT OF
CHILDREN
& FAMILIES

Jeb Bush
Governor

Kathleen A. Kearney
Secretary

January 25, 2002

John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
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Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

Thank you for giving the Department of Children and Families the opportunity to review and respond to the draft report **"Legislative Options to Control Rising Developmental Disabilities Costs."** The report has been reviewed by staff of the Department and the following comments and corrections are offered.

Page 3,

"This caseload growth will probably continue; the program planned to enroll 6,280 new waiver clients between March and June 2002. However, program officials . . . could not say how many of the 6,280 would be enrolled."

Response:. The 6,280 is a planning number based on estimated statewide growth, but does not represent identified individuals who are waiting for services.

Page 3,

"The rapid rise in the number of consumers served is due in part to lawsuits filed by consumers and other stakeholders against the State of Florida."

Page 4,

"Lawsuits are partially responsible for increasing the amount of services provided to consumers."

Response: As a point of clarification, the rapid rise in the number of consumers served is due to the leadership of this administration and the Legislature, and more specifically, their actions to increase appropriations over multiple years.

The increase in the amount of services provided to consumers is related to two issues, in part: (1) the increased appropriations recommended by the Governor and approved by the Legislature, which made it possible to appropriately increase the amount of services provided to consumers; and (2) the fact that the State of Florida is obligated to provide all covered DS Waiver services that are needed by the individuals participating on the DS Waiver.

Unfortunately, the OPPAGA report does not provide sufficient detail about existing litigation and federal law to understand the very real constraints placed on the Department in administering the Developmental Disabilities program. Generally, the lawsuits in which the Department is involved address certain legal requirements regarding the delivery of Medicaid services to individuals with developmental disabilities. Further, directives from the Centers for Medicare and Medicaid Services ("CMS" - formerly the Healthcare Financing Administration (HCFA)) have further clarified the Department's responsibilities in delivering Medicaid services to individuals with developmental disabilities. Accordingly, certain of the recommendations made by OPPAGA are not feasible given the existing litigation and federal law.

At the appropriate time, the Department is prepared to discuss the interrelationship of the different lawsuits and the federal law with the members of the Legislature and their staff.

Page 4,

"The second reason for rising costs is that the program is providing more services to its clients."

Response: The State is obligated to provide all medically necessary Waiver services to each client who participates on the Waiver. This is not just a requirement of the *Prado-Steiman* agreement, but is also a requirement of federal law. This is clearly stated in *Olmstead* Update No. 4. To comply with federal law, the Department directed Waiver Support Coordinators to conduct assessments to determine which consumers have had unmet needs, and to determine how those needs could be met. Some of the unmet needs identified during this process were previously known to the Department.. However, the Department has, consistent with federal law, ensured that all of the needs are met - to the extent that those needs can be met by medically necessary, covered Waiver services.

When Florida is viewed in comparison to the other states in the nation, the increase in funding for community-based services for individuals with developmental disabilities is relatively modest. As of August 2000, data generated by the Agency for Health Care Administration (AHCA) reflected that Florida was spending on average $12,047 per capita for DS Waiver services. This information is contained in an annual report, which was previously submitted to CMS. For Fiscal Year 2000-2001, the average per capita cost for persons on the DS Waiver was at least $16,021, according to data generated by AHCA.[1] The average per capita DS Waiver expenditure in Florida for Fiscal Year 1999-2000 (the most current period for which data is available) corresponded to a ranking of 32nd out of 50 states, for fiscal effort in spending for DS Waiver services. *See* David Braddock, et al., "The State of the States in Developmental Disabilities: 2000 Study Summary." Florida's national fiscal rating as of 1997-1998, was 48th of 50 states.[2] While Florida's ranking, in terms of fiscal effort may rise slightly as a result of increased average per capita expenditures for the DS Waiver in 2000-2001, the increase in national ranking will, at best, put Florida only slightly below or at the midrange among the states.

It should be noted that Florida's difficulties in litigation were related to inadequate funding for persons with developmental disabilities. In view of the above-mentioned directives from CMS and the inadequacies in prior funding levels, a rise in per client expenditures was foreseeable and expected.

Page 5,

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[1]/This amount is based on claims received up to August 2001, for Fiscal Year 2000-2001. The amount is likely to increase somewhat, but a current figure for that fiscal year is not yet available. Providers have up to one (1) year to submit claims for Medicaid services. Because of this lag time in submission of claims, AHCA does not report the per capita DS Waiver expenditures for Fiscal Year 1999-2000 until later in Fiscal Year 2001-2002. The Department cannot substantiate the $20,000 average per capita cost reported by OPPAGA.

[2]/*See* David Braddock, et al., The State of the States in Developmental Disabilities (5th ed.).

Response: The FSTS is only one component of the current needs assessment process. It is intended to provide one source of information about client needs, and must be coupled with good support planning. Given its present use, the FSTS in conjunction with the support planning should provide an adequate needs assessment for each individual enrolled on the DS Waiver.

Staffing constraints have generally precluded the complete assessment prior to enrollment on the DS Waiver. While the so-called long-form FSTS may be done[3], because of these staffing constraints, only the "short form" of support planning is typically completed. Accordingly, a more thorough assessment of need by the Waiver Support Coordinator occurs through the full support planning process.

Research has been conducted by the Department concerning the application of the Florida Status Tracking Survey Version 4.2 (FSTS). For the past four years, this research has been designed to help support coordinators and other practitioners assemble information for determining needs as well as responsive supports and services. The FSTS was developed from best practices in several states in order to provide access to diagnostic, demographic, assessment and personal information about people being served. Since its original development, the FSTS has been expanded and improved based upon experience in using the instrument and recommendations of experts in the field.

A workgroup headed by AHCA, with Department involvement, is looking at ways to improve front-end assessment of clients with developmental disabilities. The scope of their work will include a review of the FSTS instrument, as well as other options available to maximize the effectiveness of the needs assessment process.

Page 5,

"The FSTS was created and initially used to estimate the likelihood that an institutionalized client would be endangered if moved from an institutional setting."

The original version of the FSTS was designed to assess the needs of various individuals, including those who were transitioning from institutions. It was specifically designed as

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[3]/The long-form version of the FSTS provides more comprehensive information about the needs of individuals with developmental disabilities.

an indicator of physical, behavioral and functional issues in order to provide necessary supports and services.

Initially, the FSTS was developed with a sound research foundation and this foundation has been expanded based upon practical application. This research included:

1. An advisory workgroup of experts designed the FSTS using tools and experiences developed and applied in other states.
2. A national expert review team assessed the FSTS and made recommendations for improvements that became departmental guides for improvement. This team based their recommendations on experiences using other instruments including the Inventory for Client and Agency Planning (ICAP). (These recommended changes were incorporated in the FSTS contained within the web-based electronic version, which has not yet been implemented).
3. Analysis that resulted in the correct classification of 90% of the individuals residing in an ICF/DD using a level of need score of 3-5 as determinants of ICF/DD placement.
4. Two studies conducted by the Department that have found moderate reliability rate for the instrument. The level of reliability could likely be improved by more stringent training and possible reliability checks for individuals administering the instrument.

Page 6,

"FSTS can not be used to establish cost parameters."

Response: The FSTS has not been the sole determinant of service cost, but was a contributing factor in establishing cost parameters. Level of need and corresponding costs must be determined by a combination of factors, including the person's individual characteristics, their living and working environment, access to natural supports, and other factors that are unique to their circumstances, community and state.

A recent telephone survey of ten states that have used other instruments for support and service planning linked to cost models found that none of the states used the standardized instruments alone. They each required additional information on cost-related factors such as:

- Residential setting
- Individual's characteristics such as age, disability level

- Per capital income of local area (more competition for workers)
- Daytime setting (meaningful day activity)
- Funding source

Clearly, additional research is needed prior to selecting another assessment tool or refining the FSTS. This research could include multiple regression analyses to determine factors that are unique to Florida's costs for supports and services. As indicated previously, the Department and AHCA have developed a collaborative work group for researching additional design and implementation issues.

Page 6,

"There are alternative assessment instruments and methods for limiting per client spending."

Response: Caution should be used in the decision-making process regarding this issue. The use of an assessment tool expressly for the purpose of **limiting** the allowed expenditures for persons within the DS Waiver to their level of need could require a new waiver(s) which has historically been very difficult to obtain.

If the purpose of moving clients to the new waiver was simply to provide fewer services than are available on the current DS Waiver, then the application would likely be scrutinized carefully by CMS. To the extent that individuals already participating on the DS Waiver would be (1) required to transition to the new Waiver, and (2) adversely impacted (i.e., receive fewer services) as a result of the transition, the approval process for the new waiver would be more complicated and protracted. This might even result in a denial of the application for the new waiver. (See *Olmstead* Update No. 4).

Therefore, any recommendation by the Legislature regarding the establishment of new waivers should direct the Department and AHCA to explore alternative service mechanisms, but should not assume savings until CMS actually approves the alternative. Historically, legislative reductions in the funding to the Medicaid services delivery system without prior approval from CMS have resulted in litigation. For example, see *Cramer v. Bush*.

Copies of the FSTS have been sent to researchers involved with cost analysis in other states. They have indicated that the FSTS has most of the significant elements that have been included in other instruments such as the ICAP and should serve the same function if other descriptive factors are added for the overall analysis of rates.

While alternative assessment instruments are available, the FSTS had several factors that supported its initial deployment in Florida. First, the advisory team recommended that Florida develop its own instrument to enable maximum versatility and tailored applications. Second, the FSTS was designed to focus on health and safety needs. (Other tools examined, such as the ICAP, do not assess health or medical concerns.) And third, there are no expensive ongoing costs for access to the instrument, its use and maintenance.

The Department and AHCA work group will further review this issue.

Page 6,

"The fifth factor we identified that has contributed to rapidly increasing program costs is that the Department lacks an effective system for establishing provider rates."

Response: During Fiscal Year 2000-01 the Department contracted with the Florida State University Center for Early Intervention and Prevention Policy to conduct a rate study for Developmental Disabilities services. This study concluded with a report provided to the Legislature in January 2001. The study was not addressed during the 2001 Legislative session. A second study of residential rates is currently being conducted under contract with Maximus.

Page 7,

"The Department pays widely differing rates for the same services both within and across districts."

Response: Historically, each service district/region of the Department has negotiated its own rates. Many of these rates were negotiated years ago and are lower than rates for new providers. The Department is presently working with AHCA to establish a rate system that is equitable and reasonable.

Page 7,

The narrative states that the Department officials interviewed "hope the Legislature will adopt a 5-year plan to increase provider rates."

Response: The Department has not yet asked the Legislature to adopt any rate plans. We have analyzed rate studies and are considering a variety of implementation approaches.

The Department is currently working with AHCA to determine the proper course for recommendations to the Legislature.

Page 8,
"A related problem in the program's rate structure is that although some services are provided under both the waiver and the state plan, the waiver pays higher rates for services, such as personal care assistance."

Response: Presently some rates paid for Waiver services may exceed those paid for Medicaid State Plan services. The Department will address this issue as it works with AHCA on issues related to the administration of the Developmental Disabilities Waiver. However, as discussed further below, an across-the-board decision to limit waiver rates to Medicaid State Plan rates in every instance will likely result in problems with provider access.

Page 8,
The narrative states that program officials acknowledged that (cost containment) "efforts might be time-consuming and costly to implement, thus reducing any potential cost savings. . . The primary obstacle to many of the Department's proposals is that consumers can demand a hearing before services can be reduced or eliminated."

Response: The Department is very optimistic about the cost control initiatives recently implemented (prior service authorization and the revised Waiver Services Directory) and believes these strategies will ensure that only allowable medically necessary services are provided to consumers in the Medicaid Waiver Program.

Further, the Department would not characterize due process as an "obstacle" to implementation of the Department's cost-control initiatives.[4] Due process provided through a fair hearing is a fundamental requirement under federal law, to provide protections when individuals have been adversely affected with respect to Medicaid services. Even though there is significant staff time and a cost when providing due process for those individuals who have their Medicaid Waiver services denied, reduced,

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[4]/If due process was fairly considered to be an "obstacle" to the Department's cost-saving measures, then it would likely be an obstacle to some of the measures recommended in the draft report at issue as well. To the extent that individuals are adversely impacted by their removal from an existing waiver, or their service levels are reduced due to cost controls within the waiver, due process protections would still have to be provided.

suspended or terminated, these governmental costs do not exceed the benefit anticipated by the initiatives implemented by the Department. Additionally, the provision of due process ensures fair determinations regarding Medicaid Waiver services, and this is a societal benefit.

The Department anticipates a net reduction in overall cost after applying the appropriate medical necessity requirements to all DS Waiver service requests, as well as assuring compliance with the conditions of the Waiver approval.[5] As with any program, the Department will continue to monitor these initiatives to ensure the most efficient, effective method of providing services.

Page 11,

"One approach for using more cost-efficient purchasing practices is to limit the Medicaid reimbursement rate for developmental services to those permitted under the Florida Medicaid plan."

Response: While the Department recognizes this as a reasonable cost containment measure, it is not feasible in all situations. While only nursing, personal care assistance and therapy services are mentioned in the narrative portion relating to this recommendation (see draft report, pg. 11), the recommendation invites a broad based Legislative directive to limit *all DS Waiver rates* to Medicaid State Plan rates, wherever applicable. For some services, the waiver coverage may require higher payment rates to ensure adequate provider capacity. Specifically, dentists have reluctantly enrolled as Medicaid waiver providers. In other instances, some geographical regions have had difficulty recruiting certain provider types (particularly therapies), and the higher Waiver rates have enabled the districts to attract adequate numbers of providers to ensure appropriate access to Waiver services. The program must have sufficient flexibility to ensure that adequate providers are available, to comply with the statewideness requirements of the Medicaid statutes and regulations.

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[5]/Both the prior service authorization initiative and the 2001 Services Directory provide specific guidance regarding medical necessity determinations. The goal of both initiatives is to ensure that only those medically necessary covered DS Waiver services are provided to clients enrolled on the DS Waiver.

Page 11,

"Another approach for increasing cost-efficiency when purchasing services is to require the Department to purchase services in bulk."

Response: This section suggests the purchase of services in larger increments such as month versus days, is more cost effective. Due to the lack of a uniform rate structure, many monthly versus daily rates have no correlation; therefore, it is impossible to determine whether there is any savings potential through a bulk purchasing mandate. The Department plans to implement a rate structure during the next fiscal year that would establish uniform units of measure or increments for the purchase of services. This would eliminate a local option to purchase services in a different mode that is ultimately more costly to the state.

This report suggests that $34.8 million could be saved if the Department purchased Residential Habilitation by the month, rather than by the day, based on an average utilization of 17 service days per month. Since residential habilitation is a daily service, it is calculated to accommodate absences from residential facilities. Federal Medicaid waiver guidelines allow states to factor in absent days to ensure that the bed is held for the recipient. The strategy recommended by OPPAGA suggests that for individuals residing in group homes the state could limit its payment to 17 days per month and save $34.8 million. While this may be true, it is unlikely that providers would render residential care for residents on the14 days per month where there would be no payment from the state.

Page 12,
"Another approach available to the Legislature for purchasing more cost-efficient services is to require the Department to develop a competitive bidding system to take advantage of the state's purchasing power when obtaining developmental services."

Response: Use of purchasing strategies described in the report may require different waivers. Any Legislative proposal that might require modification to the existing Waiver or that would require additional waivers should be reviewed by AHCA in advance to determine feasibility and to ensure that federal requirements are not violated.

Page 12,

"The state could control rising costs by placing a limit on the number of clients served."

Response: Florida has limited the numbers of persons who have been enrolled on the DS Waiver according to appropriations each year, which is an option specifically provided for in the Code of Federal Regulations, and referenced in the DS Waiver application approved by CMS. Each year AHCA sends a letter to CMS for Medicare and Medicaid establishing the maximum number of clients it believes the Department can serve based on the Legislative appropriation for that fiscal year.

Pages 13 & 14,

"Another way to better control the growth in program costs is to limit the total cost of services that individual clients can receive."

Response: The current approved Home and Community Based Services (HCBS) waiver allows the state to cap the spending limit at the ICF/DD level either at the individual or aggregate level for waiver recipients. Using any other method to cap individual expenditures would likely require a different waiver than currently approved.

Additionally, if individuals cannot obtain adequate HCBS waiver services (because of cost restrictions), then eligible individuals may choose ICF/DD services. The capacity for ICF/DDs is not sufficient to sustain any significant increased demand, unless the Legislature decides to build more ICF/DDs. Accordingly, this might result in the imposition of additional requirements on the State, by modification of the final order in *Does,* with the possibility that plaintiffs might ultimately be successful in obtaining contempt sanctions.

The report suggests the possibility of developing multiple waivers. Any plan which calls for new waivers or amendment of the existing waiver to limit expenditures by level of need should be carefully scrutinized, in light of *Olmstead* Update No. 4. To the extent that the application (whether for a new waiver or an amended waiver) adversely affects persons already receiving waiver services, the application is likely to be subjected to rigorous scrutiny and the Department will be required to demonstrate how it will avoid the anticipated adverse impact.

The Department and AHCA are exploring alternative methods of service delivery. Any alternative methods that require new waivers will be presented to the Legislature prior to any changes in the current system.

Page 14,
"Another option available to the Legislature is to create a capitated system for care of the developmentally disabled."

Response: The managed care option would require a new waiver. The transition to a managed care system can only occur after CMS approves this option.

Conclusions and Recommendations:

Many of the Department's comments provided throughout the response to the report pertain to OPPAGA's conclusions and recommendations. For the sake of brevity those comments are not reiterated in the following responses.

Establishing more cost effective purchasing strategies

- *Limit reimbursement rates to those in the state Medicaid plan*

Response: The Department agrees rates for waiver services should be addressed and when feasible should be established in line with the Medicaid plan rate for the same service. However, it is necessary for the Department to retain the flexibility to utilize different rates, when necessary to ensure provider access. In those instances where the services are not the same as the Medicaid State Plan, the Department is pursuing a statewide rate structure designed to provide adequate rates for all services provided under the DS/HCBS Waiver. Additionally, ensuring that sufficient provider capacity is available to meet the identified needs is essential. The Department and AHCA are working together to design and implement such a rate structure for next fiscal year.

- *Purchase services in bulk to the greatest extent possible*

Response: The Department agrees that the statewide rate structure that is being designed must include the most economically feasible and most efficient rate unit for the service. However, the purported savings of $34.8 million is questionable because: a) the data used to estimate the savings is flawed, and b) the rates used to arrive at the projected savings may not represent identical services (both in amount and scope). As to the latter concern, residential habilitation rates factor in a certain number of days when the individual will be away from the facility and the bed will be vacant. While the Department is working with AHCA to establish a uniform way to set residential habilitation rates, different districts may negotiate a residential habilitation rate which factors in a different number of absences per month. For example, one district may base its rate on the assumption that a

person will be on the premises for 345 days out of the year. Another district may base its rate on the assumption that a person will be at the facility for 333 days per year. Accordingly, the unit cost, for purposes of calculating a projected savings, must be adjusted with the specific information about vacancies included - to get to a true per unit cost. It does not appear that this adjustment was made in OPPAGA's calculations.

Additionally, residential habilitation rates may include different bundles of services. This also must be factored in so that like services are compared to like services. The rate structure designed by the Department and AHCA will accommodate those differences and identify rates that are for comparable services.

- *Develop competitive bidding practices to take advantage of the state's purchasing power*

Response: Use of this option will likely require a waiver amendment or a new waiver to allow this type of purchasing strategy to be implemented. Accordingly, AHCA should be consulted regarding any specific Legislative proposals to implement this recommendation in order to assess the feasibility and provide guidance as to the period of time needed for implementation.

Setting limits on new clients served and per client spending

- *Establish a cap in proviso on the number of new clients that could be served with each year's appropriation based on available funding*

Response: The Department agrees with this recommendation. The Department respectfully recommends that the funding and cap provide for continued expansion of the DS Waiver.

- *Require the Department to explore ways to develop a system to cap per client spending based on level of need and develop a plan for limiting per client spending*

Response: The Department is willing to explore various options. Implementation of a new system (with modifications to allow the system to provide adequate predictors of cost in Florida) would likely require additional funding. It would be problematic if the requirement to explore new approaches was associated with a mandated reduction in funding - particularly in view of the fact that AHCA and the Department may need to seek approval of a new waiver(s) to implement such a system redesign.

Implementing better needs assessment process

- *Amend § 393.065, Florida Statutes, to require the Department to adopt more effective methods for assessing client needs*

Response: The Department and AHCA are working on improvements to the current needs assessment process in order to coordinate its use with implementing a rate structure. However, the Department does not agree that a change to the Statute is necessary to implement such improvements.

Developing pilot project to test feasibility of establishing managed care system

- *Direct the Department to develop a plan to implement a managed care pilot project in one of the 15 service districts to begin no later than Fiscal Year 2003-2004.*

Response: This recommendation will require additional waiver authority that may take longer than the time frame designated in this recommendation.

Once again, thank you for the opportunity to respond to this report. If you have any questions or need additional clarification, please contact Dr. Sam Navarro, Assistant Secretary for Programs (921-8533) or Amy Baker, Chief Financial Officer (488-6062).

Very truly yours,

Kathleen A. Kearney

Kathleen A. Kearney
Secretary

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2000

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website **at http://www.hcfa.gov/medicaid/olmstead/olmshome.htm**.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

Attachment 4-A "Allowable Limits and State Options in HCBS waivers"
Attachment 4-B "EPSDT and HCBS waivers"

State Medicaid Director – 2

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
National Association of State Medicaid Directors

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
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Director, State Community Care Programs
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Attachment 4-A
Subject: Allowable Limits and State Options in HCBS Waivers
Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

3. ***Access to Services Within a Waiver***: May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

4. ***Sufficiency of Amount, Duration, and Scope of Services***: What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

5. ***Amendments that Lower the Potential Number of Participants***:May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statues, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

> The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the

State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of

care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The

issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional

restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

***Avoiding or Minimizing Adverse Effects on Current Participants*:** Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.

- The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.

- The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B
Subject: EPSDT and HCBS Waivers
Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and

risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.

- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the

full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.