CHAPTER VI

FEDERAL POLICIES

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During 1989 and 1990, federal Medicaid policies affecting services to persons with developmental disabilities were changed modestly. Congressional action was limited to the approval of minor changes in statutory provisions regarding the HCB waiver program and the addition of a new, limited-scope, optional state plan service called, "community supported living arrangements" services.

Meantime, certain HCFA policies posed additional problems for states in their utilization of the HCB waiver program to meet the needs of people with developmental disabilities. At the same time, HCFA made other proposals aimed at "streamlining" the program.

In this section of the report, we update recent changes in federal Medicaid policies affecting community-based services to people with developmental disabilities. Both Congressional and federal administrative policies are discussed. In addition, we report on the views state officials concerning needed changes in the HCB waiver program.

A. Congressional Activity

Since 1983, there has been growing recognition that federal Medicaid policies affecting services to people with developmental disabilities are in need of reform. The impetus for such reform is that present policies are biased toward the delivery of institutional services when most people with developmental disabilities (and their families) need and want a wide-range of community services that promote "independence, productivity, and integrations" (Gettings and Smith, 1989).

While many observers agree that the HCB waiver program has helped to counterbalance the Medicaid program's "institutional bias", the waiver program's caps on utilization and spending -- as well as the requirement which ties eligibility for HCB waiver services to a person's need for institutionalization" -- reduces the program's utility as a solution to the needs of the nation's citizens with developmental disabilities.

During the 101st Congress (1989 and 1990), renewed efforts were made to enact Senator John Chafee's (R-RI) sweeping Medicaid reform measure (The Medicaid Home and Community Quality Services Act; S. 384). This measure enjoyed wide support by many national organizations and gained a large number of Senator co-sponsors. Chafee's measure would have mandated that each state cover a core set of community services while affording each states the option to cover many other elements of home and community-based services. Eligibility for these services would have been based on an individual's disability rather than the "need for institutionalization." The quid pro quo for this substantial broadening of Medicaid-reimbursable community services would have been to cap federal outlays for large (16 beds or more) ICF/MRs.

The cap, however, drew strong opposition from other interest groups and, ultimately, kept it bottled up in the Senate. The compromises needed to blunt this opposition caught the legislation up in the difficult business of keeping federal outlays within the spending boundaries imposed

by the huge federal budget deficit. While attempts were made in the fall of 1990 to resurrect Chafee's legislation in a different form, the measure did not move forward in the legislative process.

In the House, the debate concerning Medicaid reform centered on Representative Henry Waxman's (D - CA) proposal to give states the option of covering "community habilitation and supportive services" under their Medicaid state plan. In some respects, Waxman's proposal would have given a state the opportunity to exchange the limitations of the HCB waiver program for an open-ended entitlement that included an array of services similar to those states offered under their HCB waiver programs.

Waxman's bill (H.R. 3934), however, would have substantially reordered federal-state responsibilities for program oversight, enacted more detailed requirements governing the ICF/MR program, and affected other policy areas. While Waxman's measure enjoyed support from some groups (principally because -- unlike Chafee's bill – it offered no immediate threat to federal payments for institutional services), other groups were less enthusiastic or expressed outright opposition to Waxman's proposal. Two areas – the legislation's proscriptive quality assurance requirements and protections for state institutional workers – were regarded as very problematic by many groups.

Waxman's bill was included in the House's 1989 budget reconciliation measure, but ultimately was not enacted due to: (a) lack of Senate support; and, (b) the view that the proposal did not comply with the ground rules that the 1989 budget reconciliation bill only include measures directly related to deficit reduction.

Waxman re introduced his measure in 1990 as one of a package of six bills aimed at expanding the Medicaid program. The lack of significant support for Waxman's measure, the unlikelihood that it could be reconciled with Senator Chafee's proposal, and -- most importantly -- impossibility of including any Medicaid expansions that could be accommodated under the 1990 budget accord all lead to representative Waxman's proposal not being included in the 1990 budget reconciliation bill.

In large part, then, the 101st Congress continued to struggle without success in resolving the "gridlock" (Gettings and Smith, 1989) that has stymied reform of federal Medicaid policies affecting services to people with developmental disabilities since 1983. This gridlock involves: (a) the fiscal consequences of broadening Medicaid coverage of community-based developmental disabilities services; (b) achieving an acceptable balance between federal and state roles and responsibilities in the delivery and oversight of such services; and, (c) deciding what, if any measures, are needed to alter Medicaid policies governing the financing of large public and private ICF/MRs. During the 101st Congress, solution to these thorny questions remained as elusive as ever.

In 1990, however, Congress did take a step which ultimately might have important long-term consequences for federal Medicaid policies affecting services to people with developmental disabilities. In the Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508; OBRA-90), Congress

established a new optional Medicaid state plan coverage for persons with mental retardation and other related conditions entitled, "community supported living arrangements" (CSLA) services. Under this new authority:

> Two-eight states will be selected to permit add CSLA services to their Medicaid state plans following an evolution of applications submitted by interested states, in accordance with criteria promulgated by the Secretary of Health and Human Services;
>
> Federal outlays for such services are to be limited to $100 million over the five-year period 1991-95;
>
> CSLA services include the provision of services and supports (e.g., personal care, habilitation, assistive technology) to individuals with developmental disabilities who live in their own homes (e.g., an apartment) or with their families;
>
> These services can be furnished to Medicaid-eligible individuals whether they would qualify for institutional services;
>
> States offering these services must initiate a multi-faceted quality assurance system;
>
> Federal oversight of CSLA services will focus on assuring that certain "minimum protections" are being observed. [N.B., See Smith (1990) for a more detailed description of the provisions of this legislation.]

While the CSLA option is very limited in scope (by 1995, for example, the dollars available will be sufficient to support only about 2,000 - 4,000 consumers and families, nation-wide), the legislation nonetheless contains important provisions:

> The most significant change is the decoupling of eligibility for Medicaid long term care services from the "need for institutionalization" test which governs eligibility for the HCB waiver program. Under the CSLA option, services and supports can be furnished without determining that a person's disabilities are so severe that they warrant a restrictive institutional placement.
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> Second, CSLA services are intended to be provided in integrated living arrangements or to people with developmental disabilities who live with their families. In other words, the delivery of these services are not linked to the use of specialized facilities for people with developmental disabilities -- an inescapable feature of the ICF/MR program.
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> Third, the legislation does not use "active treatment" as an organizing programmatic framework for the delivery of CSLA services. Instead, each person's service plan is to be based on the services and supports the particular individual

needs to achieve greater "independence, productivity, and integration."

Fourth, the legislation recognizes the need to assure the quality of CSLA services but leaves it largely to the states to develop quality assurance systems that will address the various components of an effective system.

In short, the 1990 CSLA legislation responds to many -- but not all --of the defects in current federal Medicaid policies that have lead to a growing dissonance between federal policies and contemporary directions in serving people with developmental disabilities.

A good many of the key provisions of the CSLA authority were strongly influenced by the success several states have had in using their HCB waiver programs to promote supported living and home-based services for persons with developmental disabilities (Smith, 1990). While it is too early to tell whether Congress will be inclined in future years to expand the coverage of CSLA services, there is little doubt that the policy directions contained in this legislation constitute the seeds of a fundamental restructuring of federal Medicaid policies affecting services to people with developmental disabilities.

With regard to the HCB waiver program itself, the 101st Congress considered a wide array of measures aimed at improving the program's effectiveness or resolving nagging state-federal policy issues; but, ultimately, Congress approved only minor changes in federal statutes governing the waiver program.

NASMRPD and other organizations advanced various "technical and corrective" amendments aimed at solving various problems. Among the proposals they offered were:

Remove the restriction in federal law that limits the provision of prevocational and supported employment services under the HCB waiver program only to participants who previously had been institutionalized and, hence, allow such services to be offered to all waiver program participants.

Include definitions of vocational and supported employment services in federal statutes applicable to both the HCB waiver and ICF/MR programs in order to establish a clearer set of Medicaid policies that affirm the value of the vocationally oriented services;

Resolve the multitude of problems that have arisen sur-rounding "freedom of choice", "factoring", and provider agreements since 1988 (see additional discussion of these issues below);

Permit states to offer HCB waiver services to certain persons with developmental disabilities who have been denied admission to nursing facilities under the PASARR provisions of OBRA-87; and,

Correct certain technical issues regarding the HCB waiver program's cost-effectiveness test as well as administrative restrictions that HCFA had imposed on certain services.

These proposals gained some measure of support in both the House and Senate during 1989. Several amendments were included in the House's budget reconciliation measure and parallel provisions were approved by the Senate Finance Committee when it reported out budget reconciliation legislation covering programs under its jurisdiction. Ultimately, however, most of these proposals were not included in the final 1989 budget reconciliation act since they were deemed not be germane to deficit reduction, the test agreed to by the Bush Administration and Congressional leaders during last minute negotiations over the contents of the 1989 budget reconciliation act.

During 1990, renewed efforts were made to secure passage of Medicaid technical and corrective amendments that had been close to adoption in 1989. The drawn-out negotiations to forge a five-year budget accord to contain the federal deficit focused Congressional attention on the broad outlines of federal domestic policy, leaving little or no opportunity for House and Senate consideration of specific Medicaid measures.

The 1990 budget reconciliation bill ultimately included a few relatively minor measures affecting the HCB waiver program. In particular:

Congress countermanded HCFA's administrative policy that limited the provision of respite care services to no more than 30 days per participant during any single year.

Congress instructed the Secretary of the Health and Human Services to recognize the effects of the OBRA-87 PASARR legislation on ICF/MR utilization in determining whether a state's HCB waiver program was cost-effective.

In addition, Congress prohibited HCFA from negatively adjusting a state's "cold beds" whenever an ICF/MR was decertified. The aim of this measure was to allow a state the option of employing its HCB waiver program to meet the needs of residents of a decertified ICF/MR facility.

Finally, Congress made it clear that room and board payment for live-in care givers of HCB waiver participants could be treated as eligible costs for purposes of federal financial participation. HCFA had disallowed FFP for such payments in Oregon's HCB waiver program for elderly and physically handicapped persons, arguing that the prohibition against Medicaid reimbursement for "room and board" costs was applicable not only to the recipient's expenses but also those incurred by live-in caregivers.

Left unaddressed, however, were other critical concerns that had gained support in 1989.

With the potential exception of the new CSLA authority, over the past two years Congress has been unable to address critical issues in federal Medicaid policies affecting services to people with developmental disabilities and enacted only minor changes in policies affecting the HCB waiver program.

As a consequence, the HCB waiver program remains the principal Medicaid financing option that states can employ to help pay for a wide-range of community-based services to people with developmental disabilities. While the program continues to grow rapidly, its fundamental limitations remain in place.

B. HCFA Policy Developments

HCFA's policies concerning the HCB waiver program continued to evolve during 1989 and 1990. In addition, in late 1990, the Agency outlined its views on how the HCB waiver program might be integrated into the "mainstream" of the Medicaid program.

1. Administrative Policy Issues

During the past two years, HCFA drew into sharper focus its long-standing position that the HCB waiver authority does not relieve a state of the obligation to operate its HCB waiver program in compliance with basic Medicaid statutory provisions. On the other hand, the Agency announced -- and seemed to adhere to – a policy of attempting to work out issues that could snag Agency approval of state waiver proposals.

The most significant issues raised by HCFA regarding state HCB waiver programs serving persons with developmental disabilities concerned instances in which state statutes dictate particular service delivery structures that HCFA believes are not consistent with basic Medicaid statutory provisions. More specifically, in reviewing state waiver requests, HCFA has begun to seek assurances that they comply with the following federal statutory requirements:

> Recipient Freedom of Choice (Section 1902(a)(23) of the Social Security Act). Federal law mandates that Medicaid recipients be given the freedom to select which qualified provider will furnish Medicaid-reimbursable services to him or her. In some cases, states have run afoul of this requirement, generally in cases where state statutes specify that certain services be furnished only by governmental or quasi-governmental agencies. The service that has proven to be most problematic in this regard is case management, since many states require that case management services be furnished either by state agency personnel or case managers who work for a county or regional MR/DD authority. In such cases, a "single point of entry" system is used to assure the consistent delivery of case management and related services.

The difficulties this policy poses are illustrated by how this problem arose within the context of Minnesota's proposed HCB waiver program for nursing facility recipients with developmental disabilities. In Minnesota, case management services must be furnished by county employees under the "single point of entry" model. When the State applied to HCFA for a special "OBRA waiver" to serve former nursing facility residents with developmental disabilities, Minnesota already had in operation a long-standing HCB waiver program serving people with developmental disabilities in which case management services were furnished exclusively by county human services agency case managers.

HCFA informed Minnesota that its reliance on those case managers violated the provisions of Section 1902(a)(23) of the Act. In order to secure approval of its OBRA waiver request, Minnesota agreed to delete case management as an HCB waiver service. Instead, Medicaid reimbursement for such services is being obtained as a Title XIX administrative cost (albeit at a slightly lower rate of federal reimbursement). Claimed as an administrative expense, case management services are not subject to freedom of choice requirements. Nor are they subject to such requirements when a state opts, instead, to cover such services as a Medicaid state plan service under the provision of Section 1915(g) of the Social Security Act. While Minnesota continues to offer case management services under its longer standing HCB waiver program, it was forced to adopt a different arrangement for its OBRA waiver program.

In this area (and, in other instances, as well), the freedom of choice requirement can place a state in the position of having to comply with a federal statutory provision that is at variance with more fundamental state laws aimed at regulating the types of services and providers that may deliver services.

Broadly speaking, Medicaid[1]s freedom of choice requirement conflicts with the view that community developmental disabilities services should be accessed via a single point of entry and that the providers of such services should be limited to entities designated by state and local MR/DD authorities.

Factoring of Payments (Section 1902(a)(32) of the Social Security Act). Federal law provides that a state must make Medicaid payments directly to the provider agency which furnished the services. When, instead, payments are made to an intermediate agency,

such an arrangement is deemed to be "factoring", which is prohibited under the provisions of Section 1902(a)(32).

The aim of the federal prohibition against factoring Medicaid payments is to prevent questionable arrangements that result in the trafficking of Medicaid claims. Under factoring arrangements, an intermediary makes claims for reimbursement and discounts the dollars that are ultimately paid to the provider agency.

Under the HCB waiver program, the "factoring" problem has arisen with increasing frequency, particularly in MR/DD waiver programs. Typically, such problems arise when state statute specify that a substate agency be directly involved in contracting for developmental disabilities services with vendor agencies within a designated geographic catchment area. Such agencies write contracts with local vendors, pay these provider agencies, and, in turn, are reimbursed by a state agency. Such arrangements are intended to decentralize program management to the local level.

The factoring problem also arises whenever a state designates a provider agency to be principally responsible for arranging for some services to be furnished to a program participant. Such a provider, for example, may have responsibility for furnishing daytime and/or residential services but may, in turn, be required to arrange for (via a subcontract) more specialized services such as physical therapy.

Since such arrangements result in an "intermediary" agency becoming involved in the contracting/billing/payment process, HCFA believes that the statutory prohibition against factoring is violated.

The longest running problem in this regard concerns California's HCB waiver program, where the "factoring" issue has held up the renewal of the State's MR/DD waiver program since August, 1988. In California, State statute mandates that 21 nonprofit regional centers contract for all services funded by the State of California. These regional centers are responsible for organizing, planning, and arranging for services on behalf of persons with developmental disabilities within designated geographic catchment areas. HCB waiver dollars are used to reimburse regional centers for outlays that they already have made. In the view of HCFA officials, California's statutes lead to an unreconcilable issue. So long as these statutes are in effect, the State will be in violation of Section 1902(a)(32) and, hence, HCFA cannot approve the

State's HCB waiver renewal application. Instead, California's previously approved program (which included the arrangement that HCFA now regards as violating federal law) has been subject to repeated three-month "extensions". The most direct effect of this situation has been to block California's plans to substantially expand its program to serve a larger number of program participants.

In the California case (as in other instances where HCFA has alleged a violation of the prohibition against factoring), there has been no allegation that current state policies and practices result in any diversion of Medicaid payments from the actual provider of service. Indeed, HCFA officials have admitted that the arrangements that they have been found to be in violation represent technical rather than substantive deviations from the underlying intent of Section 1902(a)(32). In some cases, HCFA officials have acknowledged that the arrangements in question might be more efficient contracting/billing structures than more conventional relationships between Medicaid vendors and the State's Medicaid agency. However, Agency officials do not believe that they have the authority to waive Section 1902(a)(32) regardless of evidence that a State's policies comply with the substantial aims of current federal law.

As a result of this issue, states (frequently with the assistance of HCFA) have gerry-rigged payment/contracting mechanisms that result in technical compliance with Section 1902(a)(32) through the use of exceptions included within the law and HCFA regulations. One option is to designate the intermediary agency as a "billing agent". Another approach relies on a provision which permits provider agencies to voluntarily assign Medicaid payments due them to a governmental agency. While use of such arrangements has helped resolve factoring problems in some state waiver programs (e.g., Pennsylvania and Tennessee), they also have added yet another layer of administrative complication to the program.

Moreover, such technical solutions leave unresolved the more deep-seated issue: the rigidity of federal Medicaid law and its ramifications for state laws and policies governing the organization and delivery of community services to people with developmental disabilities.

Provider Agreements (Section 1902(a)(27) of the Social Security Act. Medicaid law specifies that there must be an agreement between the single state Medicaid agency and each provider of Medicaid services. Again,

in recent years, this requirement has posed problems for some state HCB waiver programs. These problems parallel in some ways the issues surrounding factoring of Medicaid payments, but they also are an outgrowth of the role played by state MR/DD authorities in managing HCB waiver programs.

In such cases, while contracts or provider agreements have been established between a state's Medicaid agency and the state MR/DD authority or between the MR/DD authority and substate agencies, direct provider agreements may not exist between all service providers and the State Medicaid agency.

Even though the web of agreements a state has established may bind a provider agency contractually to the state Medicaid agency, HCFA nonetheless believes that Section 1902(a)(27) mandates that the provider agency and the state Medi-caid agency maintain a distinct, direct provider agreement.

Again, HCFA's position in this regard stems not from substantive problems with current arrangements (e.g., the failure to assure that the provider will comply with all applicable federal/state policies) but rather from technical non-compliance.

States have developed gerry-rigged solutions to this problem. One approach has been to redraw provider agreements between the state's MR/DD agency and HCB waiver pro-viders as three-way agreements to which the state Medicaid agency also is a party. While such agreements resolve the underlying compliance issue, they also can complicate program administration.

In each of these areas, states have encountered problems with HCFA due to differences in state statutes and federal Medicaid laws. HCFA, by adopting the position that it has little or no authority to grant exceptions to problematic provisions of the Act, has placed states in the position of making significant policy changes in order to secure approval or renewal of an HCB waiver program.

These issues are all the more frustrating for states because they largely involve technical rather than substantive violations of federal law. HCFA, for its part, has expressed discomfort regarding these problems but has advanced no solutions which would permit states to continue existing administrative practices sanctioned under state laws. Congressional solutions to these issues have proven elusive, particularly due to their technical complexity and potential effects on other elements of the Medicaid program.

Besides these complex policy issue, HCFA's administrative policies remained largely unchanged throughout 1989 and 1990. The Agency

continued to enforce the "cold bed" rule, although apparently not as stringently as in the past (even though HCFA's decisions concerning the approval of increased HCB waiver spending and utilization levels remain subject to review by the President's Office of Management and Budget). Typically, states are finding that HCFA appears to be willing to approve annual increases in the number of HCB waiver participants that fall within the 6-9% range, although, even in such cases, a state must present a convincing "cold bed" justification. Waiver amendments to increase the number of people served in order to accommodate "deinstitutionalization" goals have been readily approved by HCFA. Moreover, states typically have encountered little difficulty in gaining HCFA's approval to adjust per capita HCB waiver estimates upward, so long as costs remain below average ICF/MR payment levels.

Following the announcement of the creation of HCFA's new Medicaid Bureau in March, 1990, Agency officials also indicated that they would attempt to improve its relationship with the states. They said HCFA would become more flexible and responsive to the states' concerns. In addition, the Agency would step up the pace of issuing new regulations to implement Congressional changes in Medicaid statutes.

While relationship's between HCFA and the states regarding the HCB waiver program seem to have improved since the creation of the Medicaid Bureau, it still remains to be seen whether HCFA will attempt to resolve a number of long-standing issues that have affected the program. For example, HCFA remains well behind in amending present HCB waiver program regulations to reflect statutory changes enacted by Congress as long ago as 1986. Moreover, states still are frequently caught in the middle between conflicting or inconsistent advice or rulings coming from HCFA's central and the Agency's regional offices. Finally, it remains to be seen whether HCFA will propose or support changes in administrative policies that would allow states to operate their programs more efficiently.

Streamlined Waiver Format

Late in 1990, the staff of HCFA's Medicaid Bureau circulated a draft of "streamlined" format for states to use in preparing HCB waiver requests and renewal applications. While this streamlined format had not been officially issued at the time this report was being drafted, preliminary drafts indicate that the new format will assist states in preparing new and renewal waiver requests.

HCFA's format provides a state with standard phrasing of the various assurances it must make, suggested service definitions, and a somewhat clearer format for constructing cost estimates. In some instances, the format permits a state to avoid the submission of certain materials that HCFA typically has required states to include with their requests in the past (e.g., copies of state laws and regulations governing particular types of services).

HCFA's suggested format streamlines the submission process by standardizing the organization of waiver requests, allowing states to select certain options by simply checking boxes, and agreeing to accept pre-phrased statements of assurances. The format, however, does not represent an effort on HCFA's part to simplify the overall framework of federal requirements within which the HCB waiver program operates. In essence, the new format regularizes what has become over the past nine-years a successively more complicated amalgam of requirements that a state must meet.

3. HCB Waiver as a State Plan Service

Perhaps the most significant HCB waiver policy development involving HCFA during 1990 was the Agency proposal to amend federal statutes in order to give states the option of converting their HCB waiver programs to state plan status. This proposal was incorporated in the Department of Health and Human Services package of proposals for inclusion in President Bush's FY 1991-92 budget. While at the time this report was being prepared, it remained unclear whether the proposal would be included in Bush's request to Congress, the proposal provides an indication of HCFA's views regarding the best means of integrating the waiver program into the "mainstream" of Medicaid policy and practice.

Under HCFA's proposal, a state would be given the option of converting its HCB waiver program(s) to state plan status at the point it becomes due for renewal, provided that the state has demonstrated a satisfactory capability of managing waiver programs to date. Should a state choose to make such a conversion, it would:

- Be required to consolidate all waiver programs serving a single level of care (e.g., persons meeting ICF/MR level of care criteria) into a single program;

- Agree to continue to adhere to all statutory and regulatory assurances and to report program spending and utilization data in the format required by HCFA; and

- Regulate future program utilization and spending under a formula included in HCFA's proposal.

With regard to the final feature of HCFA's proposal, a state desirous of converting its HCB waiver program(s) to state plan status would have to agree to the following limits on program utilization and expenditures:

- The number of program participants could increase by a rate no greater than the rate of growth in the state's general population; and,

- Per capita spending would have to be held to the rate of change in the medical consumer price index.

In both instances, these formula-based caps on program utilization and spending would be based on the levels approved by HCFA for the final year of the state's currently approved waiver program.

Once a state converted its HCB waiver program to Medicaid state plan status, it would no longer be required to submit renewal applications and engage in the frequently frustrating process of negotiating utilization and spending caps with HCFA. HCFA officials view this change as an especially positive feature of the proposal.

HCFA's proposal, however, would not be particularly attractive to most states. Capping growth in program participation at the rate of general population change would mean that the programs of all but a few states would stagnate. States in which population growth is minimal or which have declining populations obviously would find the proposal unattractive.

In addition, by basing future growth on currently approved caseloads, HCFA's proposal would lock in the existing wide disparities among the states in the number of people with developmental disabilities who participate in the HCB waiver services. Finally, the proposal appears to have no provisions to accommodate caseload increases resulting from further deinstitutionalization initiatives (i.e., either placing people out of ICF/MRs or nursing facilities). Presumably such initiatives would have to be accommodated within the formula-based utilization limits proposed by HCFA.

While most states probably could accept HCFA's proposal to link per capita spending to the medical consumer price index, not all could. Again, by basing future increases in per capita spending on presently approved costs, HCFA's proposal would freeze the present disparities among the states in per capita program spending into place. Here again, the present range of average per capita costs vary widely from state to state.

In advocating for this change in federal policy, HCFA officials point out that the waiver program has proven to be extremely cost-effective. At the same time, it is ironic that the Agency's proposal would tightly cap future growth in the number of program participants and, hence, increase pressure on states to turn to more costly institutional alternatives.

HCFA's proposal is offered as a state option. States rejecting conversion to state plan status could continue to negotiate with HCFA during the waiver renewal process if they so elected. Again, given the restrictiveness of the conversion proposal, however, few states would be likely to exercise this option.

Furthermore, the proposal suggests that HCFA regards the waiver program as an aberration in "mainstream" federal Medicaid policy. Converting the HCB waiver program to state plan status would cure the aberration while reducing HCFA's workload considerably. The

proposal, however, includes no steps to improve the overall effectiveness and efficiency of the waiver program; nor does it reflect proactive policies on the part of the Agency to emphasize community-based alternatives to institutional care.

Conclusion. The past two years have seen HCFA and the states achieve some measure of accommodation regarding the HCB waiver program. While HCFA's policymaking and interpretation continue to pose certain problems for states, negotiations surrounding state waiver requests are proceeding more expeditiously and issues are being worked out more readily. HCFA's streamlined submission format will ease some of the tasks associated with submitting new and renewal HCB waiver requests.

At the same time, HCFA continues to show no particular interest in promoting home and community-based service options as alternatives to institutional care. Throughout most of the Reagan Administration and the first two years of the Bush Administration, the Agency has regarded the HCB waiver program as less an opportunity to promote more cost-effective alternatives than an aberration in the Medicaid program that needs to be contained. This reflects the apparent unwillingness of Agency officials to develop coherent strategies for the delivery of long-term care services under the Medicaid program.

C. State Views

As part of its 1990 HCB waiver survey, NASMRPD asked state HCB waiver program managers to express their opinions regarding possible changes that might be made in federal policies affecting the waiver program. Managers from 26 states responded to this survey element.

Nearly all (80%) of these managers identified two changes in federal policy as being particularly important:

Eliminate/Replace Cold the Bed Rule. Nearly all program managers pointed to so-called "cold bed" rule as being the most objectionable feature of the HCB waiver program. State managers viewed the rule as substantially foreshortening the capacity of their states to respond to the needs of people with developmental disabilities. They pointed out that negotiations with HCFA surrounding the number of program participants under "cold bed" rule were extremely frustrating. The rule requires them, they said, to compile information about plans to construct new facilities or convert existing group homes that bear little relationship to their states' real future plans. The rule disadvantages states that have adopted progressive policies stressing "non-facility" based programs and is regarded by many state officials as simply a waste of time and energy that could better be devoted to other more profitable pursuits (e.g., making waiver policies and practices more compatible with contemporary directions in serving people with developmental disabilities).

The message from state waiver program managers is that the time is long overdue to end the "cold bed" rule in favor of some different approach that recognizes the maturation of the HCB waiver program as a primary community service financing option, rather than as a secondary alternative to ICF/MR funding. Several survey respondents, for example, advocated for converting the HCB waiver program to state plan status or for the adoption of broader-based Medicaid reform strategies.

Follow-up discussions with several program managers revealed considerable disappointment with HCFA's proposed legislation to convert the waiver program to state plan status. While states agree that periodic negotiations around waiver renewal requests are frustrating, freezing programs at their current levels is not regarded as an acceptable quid pro quo for state plan status.

Supported Employment/Prevocational Services. All survey respondents called for the elimination of the present restriction on payment for prevocational and supported employment services to previously institutionalized persons. They regard this restriction as discriminatory. Several state waiver coordinators pointed out that the restriction works against the best interests of program participants by creating disincentives to work for people not eligible for these options.

Other issues also drew comment from state program managers, These included:

Federal Reporting. Several managers expressed considerable frustration with HCFA's waiver reporting requirements, as contained in the Agency's so-called "HCFA 372" report. Some managers complained that the costs of data systems (and state worker time) needed to prepare this report is disproportionate to its value. The HCFA 372 is viewed by most state managers as having no utility in their management of the HCB waiver program, despite the costliness of its preparation. While this report's stated purpose is to tell HCFA whether or not a state is managing it waiver program within federally approved spending and utilization levels, many state managers question whether the detailed information required holds any utility for HCFA (or other federal policymakers).

Several managers complained of what they regarded as the excessive intrusiveness by HCFA central office and regional office personnel. They questioned the wisdom of (and HCFA's authority) to conduct detailed reviews of state policies and practices, as well as the Agency's apparent nearly endless capacity to find additional nuances in what states may or may not do under a HCB waiver program.

Serious levels of frustration also were expressed concerning inconsistent interpretations and points of view among HCFA central office personnel, regional Medicaid administrative offices and HCFA auditors. States frequently complain that they are told by regional staff that a requirement must be interpreted in a fashion that is different than interpretations in other regions or at the national level. Some survey respondents even complained that they are being asked to serve many different federal masters, not all of whom work within the same organizational units.

In other cases, some program managers expressed frustration with HCFA's enforcement of "freedom of choice," "factoring" and "provider agreement" requirements. While most agreed that solutions to the problems identified by HCFA usually could be worked out, they objected to the Agency's being unwilling or unable to deem a state's current service delivery arrangements as adequate, given the overall aims of federal law, or work out more flexible arrangements.

In most states, frustrations with HCFA's administration of the waiver program is not particularly deep-seated. But, increasingly state program managers do not feel the Agency has any particular aims in mind regarding the program -- other than to enforce regulations or other requirements that serve no beneficial purpose.

D. Conclusion

On the whole, federal Medicaid policies affecting the HCB waiver program in particular and services to people with developmental disabilities underwent little change during 1989 and 1990. Congress was unprepared and unable to make fundamental changes in existing federal statutes that govern the provision of long term care services to persons with developmental disabilities. HCFA, for its part, appeared to improve the timeliness with which it deals with state HCB waiver requests but instituted no measures to address some of the programs underlying policy and administrative problems. Meanwhile, on the whole, states have continued to move forward in expanding their MR/DD HCB waiver programs in spite of the lack of movement in reforming fundamental federal policies affecting community-based services.