Mike Randol, Director  
Kansas Department of Health and Environment  
Division of Health Care Finance  
900 SW Jackson Street, Room 900N  
Topeka, KS  66612

Dear Mr. Randol:

In recent months, the Centers for Medicare & Medicaid Services (CMS) has received numerous questions and concerns regarding the changes to the residential billing policy for the Intellectual/Developmentally Disabled (IDD) waiver from Medicaid providers, recipients, advocates, and stakeholders. In May 2016, changes were made to the fee-for-service provider manual for Home- and Community-Based Services (HCBS) Intellectual/Developmentally Disabled. The changes were emailed to stakeholders for comment on June 29, 2016. On September 1, a letter was sent to the Community Developmental Disability Organizations (CDDOs) stating that the new policy had been finalized and all providers billing for residential support services must become compliant with it by October 1.

Payments for all Medicaid services, including those provided through waivers, must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that Medicaid services are available to beneficiaries at least to the extent that those services are available to the general population (Section 1902(a)(30)(A) of the Social Security Act). For 1915(c) waivers, the methodology used to determine the rate for each service covered must be described in Appendix I-2-a of the approved waiver. Details of the rate methodology must include inputs (e.g., wages and benefits, administrative and overhead costs, inflation and cost-of-living factors), productivity assumptions and adjustments (the amount of time spent during an 8-hour day or 40-hour week directly providing services to waiver participants and adjustments to the calculation based on that amount), and other information used to establish the rate. Other information that must be described in Appendix I includes: the entities responsible for rate determination, how public comments are solicited, how payment rates are made available to individuals, and a reference to the capitation rate methodology described in Kansas’ 1115 waiver.

The April 2016 study of Kansas HCBS rates performed by Myers and Stauffer described the development of the rate formula in 1991; it states that this formula continues to be the basis of the current rates. Appendix I of the approved I/DD waiver states, “Under KanCare, the state sets the floor for HCBS service rates which serve as the minimum MCOs are required to pay providers.” However, Appendix I does not describe the information or methods used to establish the rate.

From information provided by stakeholders, CMS understands that the current rate for residential support services was reached by calculating a monthly cost, and dividing that monthly cost by 30
to calculate a daily amount as the “reasonable and customary” rate. Providers billed that daily amount every day in each month, regardless of whether services were directly provided to a resident. With the changes described in the September 1 letter, the same daily rate (the monthly cost divided by 30) is still used, but providers can only bill for days on which a service was directly provided to a resident. In general, CMS agrees that only allowing providers to bill for services rendered is the correct approach. But the rates paid for all Medicaid services must meet the federal requirements stated above, regarding efficiency, economy, and quality of care and sufficiency. Because of the lack of information on the rate setting methodology in Appendix I, CMS cannot determine whether the billing policy change described above constitutes a change to the rate methodology and/or a change to the “reasonable and customary” rate.

The September 1 letter also explained that the MCOs would be requesting documentation from providers to assess the residential support needs of the individuals they serve, and adjusting integrated service plans in accordance with the policy changes. Accordingly, Kansas’ three MCOs released a joint statement on September 20, requesting documentation of each resident’s actual utilization of residential services for the last 90 days and stating that the documentation will be used to adjust the resident’s integrated service plan to reflect historical usage. The statement also noted that MCOs may complete an assessment if needed.

Waiver participants’ plans of care should reflect the waiver and non-waiver services needed to successfully live in the community and avoid institutionalization. We are concerned that the adjustments made to a waiver participant’s ISP may not be appropriate, if that participant’s utilization of residential support during the last 90 days is not indicative of his/her need for ongoing support. We are also concerned, since integrated service plans are being adjusted based on the policy change, that it may represent a change in the amount, duration, and scope of residential support services available through the IDD waiver. Additionally, we have heard from residential support providers that producing the required documentation will be difficult, if not impossible. Please ensure that all waiver participants whose services have been or will be reduced are aware of their right and responsibility to appeal the MCOs’ decisions and request State fair hearings.

Finally, CMS is concerned that the implemented changes have not fully been transparent to waiver providers and participants. To ensure transparency and proper federal approval of rate methodology and/or service changes, CMS requires the state to submit a waiver amendment to implement the changes to the residential billing policy. The rate methodology waiver amendment must be submitted for public comment, as required by 42 CFR 441.304(e) and (f). It must also have a prospective effective date as required by 42 CFR 441.304(d); the rate methodology change should not be implemented prior to the approval of the waiver amendment. Therefore, please halt implementation of the changes until after the waiver amendment has been submitted and approved. Implementation of the rate adjustment change regarding residential support services prior to approval of the waiver amendment may result in compliance action by CMS.
If you have any questions regarding this letter, please contact Michala Walker at (816) 426-5925.

Sincerely,

11/8/2016

Megan K. Buck
Acting Associate Regional Administrator
for Medicaid and Children’s Health Operations

Signed by: Megan K. Buck -A