Update On Supports For Community Living

Draft

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Program Review and Investigations Committee

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Medicaid gives states the option of developing home and community-based services waiver programs. These programs permit the state to waive certain Medicaid requirements so that some members may reside in the community rather than in more expensive and restrictive institutions.

Supports for Community Living (SCL) is Kentucky's waiver program for individuals with intellectual or developmental disabilities that reduces the use of intermediate care facilities for individuals with such disabilities. It helps the state to comply with the Americans with Disabilities Act and the related Olmstead decision of the US Supreme Court by allowing these individuals to receive services in the least restrictive environment that is economically feasible.

The Department for Medicaid Services has contracted with Navigant Consulting for advice about redesigning its waiver programs and developing new reimbursement rates. Program Review staff will observe and evaluate the rate-setting process if it occurs. This memorandum is a status report covering SCL waiver reimbursement rates through the end of 2017.

In July 2004, SCL reimbursement rates were increased across the board, 10.8 percent on average. With the implementation of a 5.5 percent provider tax, the net increase was approximately 4.7 percent. Since then, some rates have increased, some have remained the same, and others have decreased. Services were significantly restructured twice, meaning that some services were added, removed, or changed in substantial ways.

The average amount spent per SCL member increased more than $20 per month from July 2004 to April 2006, when the first restructuring occurred. From then to September of that year, the monthly average rose 26 percent from $4,886 to $6,173. After reimbursement stabilized that September, the average amount spent per SCL member was relatively flat, increasing an average of $1.70 per month through 2017. The second restructuring was phased in during calendar year 2014, but the spending per member remained approximately the same.

As a result, average provider revenues per member have remained flat since 2006. Analysis of spending on different types of services indicates that providers shifted the types of services they delivered in ways that probably increased their revenues or reduced their costs. For example, after April 2006, residential providers seem to have lowered their daytime staffing cost by referring residents to adult day training services. After 2014, there was a marked increase in billing for employment support services and community access services when those rates went up. Also, claims show a recent shift from provider-operated residences to adult foster care.

According to the Consumer Price Index for all items and urban consumers, the value of a dollar fell to 76 cents between July 2004 and December 2017, reducing the value of payments to providers.

This memorandum could not estimate the net earnings of SCL providers because their costs were not known. However, states are free to set Medicaid rates however they choose and are not required to ensure provider profitability. Federal law simply requires a state to ensure that

"payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" (42 USC sec. 1396a(a)30(A)). It appears from Kentucky's waiver applications that the state has set rates that keep spending within budgeted limits. This is consistent with the stability of monthly spending since 2006.

Update On Supports For Community Living

During the 2017 Regular Session the House passed HCR 100, which called for a review of Supports for Community Living (SCL) reimbursement rates and the SCL provider tax. The Program Review and Investigations Committee authorized a study of the topic.

Medicaid offers states the option of developing home and community-based services (HCBS) waiver programs. These programs permit the state to waive certain Medicaid requirements so that some members may reside in the community rather than in more expensive and restrictive institutions like nursing homes. Kentucky has HCBS waivers for elderly or others with disabilities in need of nursing level of care, individuals with acquired brain injury, and individuals dependent on a ventilator.

SCL is Kentucky's HCBS waiver program for individuals with intellectual or developmental disabilities (IDD) that reduces the use of intermediate care facilities for individuals with IDD.[a] It helps the state to comply with the Americans with Disabilities Act and the related Olmstead decision of the US Supreme Court by allowing individuals with IDD to receive services in the least restrictive environment that is economically feasible.[1]

The Department for Medicaid Services has contracted with Navigant Consulting for advice about redesigning Kentucky's HCBS waiver programs and setting new rates. Department officials have reported that if they decide to set rates, the process should be completed by the end of 2019.[2] Program Review staff will observe and evaluate that process if it occurs.

For the 2018-2020 biennium, the General Assembly appropriated an additional $21,058,000 from the state General Fund and $49,135,600 in matching federal funds for the SCL program (2018 RS HB 200). The budget bill directed the Department for Medicaid Services to use those funds to increase all provider reimbursement rates by 10 percent based on rates in effect at the end of 2017. If the SCL waiver were to be substantially changed, the bill appears to require reimbursement rates under the altered waiver to be at least 10 percent higher than the corresponding rates as of the end of 2017.

This memorandum is a status report while awaiting the department's decision on setting new reimbursement rates. It covers the SCL waiver through the end of 2017.

[a] Intermediate care facilities are institutions that "provide services for all age groups on a twenty-four (24) hour basis, seven (7) days a week, in an establishment with permanent facilities including resident beds for persons whose mental or physical condition requires developmental nursing services along with a planned program of active treatment. The facility provides special programs as indicated by individual care plans to maximize the resident's mental, physical, and social development …" (902 KAR 20:086 sec. 2). Examples are Oakwood and Hazelwood.

General Description

SCL provides supported residences such as group homes, staffed residences, and residential family care. It also provides in-home and community-based support services such as personal care, behavioral supports, supported employment, and supported community access. The waiver program is administered by the Department for Behavioral Health, Developmental and Intellectual Disabilities in conjunction with the Department for Medicaid Services.

Medicaid HCBS waivers must be renewed at least every 5 years. In 2013, the Department for Medicaid Services received approval for a renewed SCL waiver with significant changes in covered services. The new services were implemented in 2014 with a year of overlap as members transitioned to the new waiver. The department refers to the waiver prior to 2014 as SCL1 and the modified waiver as SCL2.

Services under SCL are usually provided through provider agencies. These may be for-profit or nonprofit entities that employ direct care workers and other professional staff and offer personal assistance, case management, therapy, and other services. They must first apply to the Department for Behavioral Health, Developmental and Intellectual Disabilities and then enroll as Medicaid providers. In addition, SCL members may choose to hire their own care workers and be reimbursed through the participant-directed services program, previously called the consumer-directed option.

Inflation

The value of reimbursement to SCL providers has declined since July 2004, the date of the last across-the-board rate increase. The Consumer Price Index indicates that the value of a dollar in July 2004 fell to 76 cents by December 2017. The value of a medical care dollar fell even more, but it was not clear that medical care was the proper category for SCL services. In this memorandum, figures displaying dollar amounts include a gray line that shows constant July 2004 dollars calculated using the seasonally adjusted Consumer Price Index for all items and for all urban consumers.[3]

Overall SCL Spending

Figures A to C show spending on all SCL services. Most of the spending is for services provided by SCL provider agencies. However, the figures also include services performed under the consumer-directed option, which began in 2007, and participant-directed services that replaced the consumer-directed option under SCL2. Other included services that are not relevant to provider rates are home and vehicle modifications and one-time assistance payments.

The later discussion of provider rates, including Figures D to J, excludes consumer-directed, participant-directed, and other payments that are not relevant to provider revenues.

Program Review staff thoroughly examined the service changes described in regulations and in policy documents from the Department for Behavioral Health, Developmental and Intellectual Disabilities in order to place comparable services into groups. The table in the Appendix lists the services included in each group, showing when a service name or definition was in effect from July 2004 to December 2017.

In April 2006, possibly in response to settlements with the US Department of Justice and in the *Michelle P. v. Birdwhistell* case, the cabinet expected an increase in the number of individuals with IDD receiving services in the community.[b] Emergency amendments to 907 KAR 1:145 and 1:155 restructured services and included significant rate increases for group homes and residential family care, bringing them closer to the rate for staffed residences. At the same time, the rates for direct personal services were reduced. Other rates remained nearly the same. The amendments also removed a limit of three SCL members in a group home to allow up to eight. The stated purpose was "to accommodate individuals who may be displaced from an intermediate care facility" and to align reimbursement more closely with provider costs (32 Ky.R. 2002, eff. April 4, 2006).

In 2014, SCL2 also restructured services. Rates for most types of services were reduced, but rates for supported employment and residential family care increased significantly. Exceptional payments, the additional amounts paid on behalf of some members whose needs exceeded the usual requirements of a given service, seemed to offset some of the reductions, especially for direct personal services and staffed residences. SCL1 services and rates remained in effect for current SCL members until they transitioned to SCL2 on their birthdays during calendar year 2014.

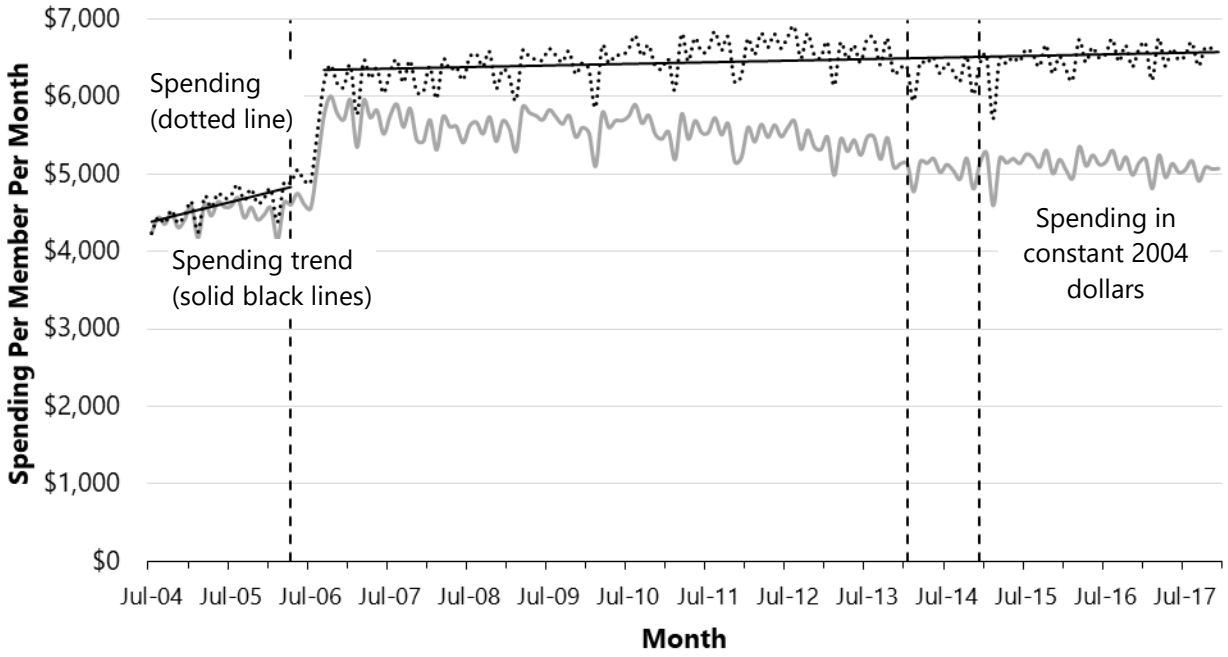
The Department for Medicaid Services provided claims data for each SCL service for each month from July 2004 to December 2017. The data included the number of units of the service and the dollar amount paid for the month. Program Review staff calculated average rates for each month by dividing the number of units of that group of services into the total dollars paid for that group of services. The spending included "intensity" or "exceptional" payments that sometimes caused the calculated average rate for a service to exceed the upper limit listed in regulation.

Spending And Participation Trends

Health insurers often report their spending per member per month. Looking at SCL as a whole, Figure A demonstrates that spending per member increased significantly after the service array changed in April 2006, from $4,886 in April to $6,173 in September, an increase of 26 percent. It remained nearly flat since then with a slight decline during SCL2. Before April 2006, average spending per member increased more than $20 per month, but after September 2006, average spending increased approximately $1.70 per month.

[b] The Department of Justice found that Kentucky's intermediate care facilities housed individuals who could have lived in the community. The *Michelle P.* lawsuit alleged that the state's use of intermediate care facilities rather than providing supportive services in individuals' homes violated the Americans with Disabilities Act and the US Supreme Court's *Olmstead* decision.

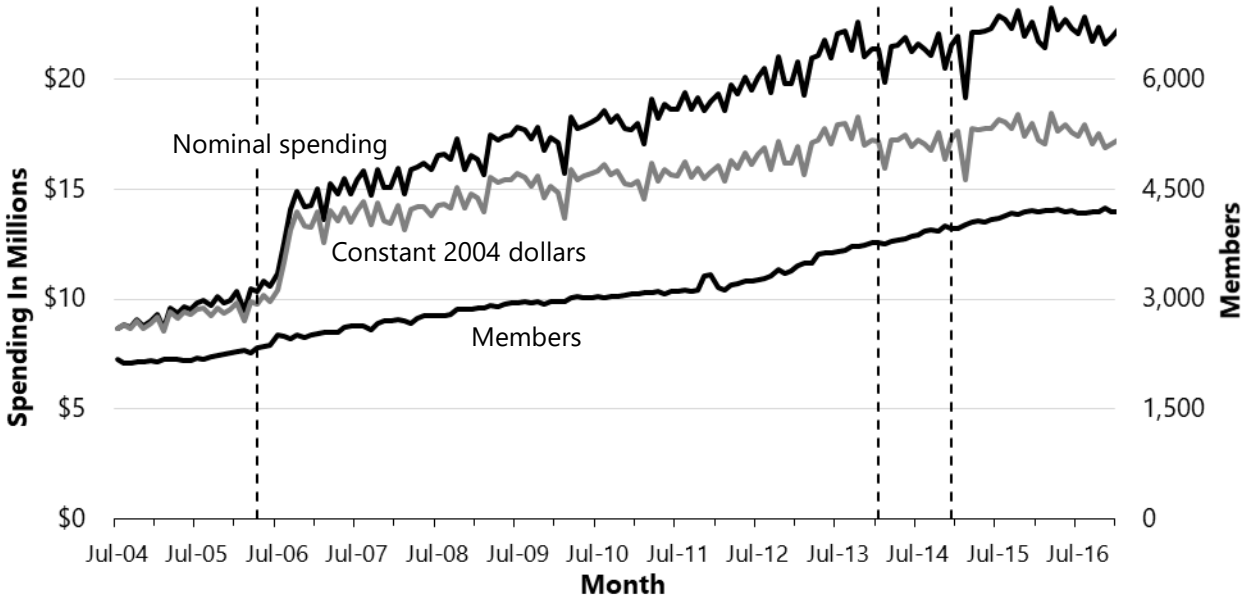
Figure A
Monthly Spending Per Member, All SCL Services
Nominal And Constant 2004 Dollars
July 2004 To December 2017



Note: Spending includes consumer- and participant-directed services, and members include those receiving such services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014. Linear trends lines cover July 2004 to April 2006 and September 2006 to December 2017.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Figure B shows the total dollars spent on SCL services and the number of members. Consistent with stable spending per member since September 2006, the dollars spent have kept pace with the number of members, which nearly doubled since 2004. Figure B covers 2004 to 2016 because claims may be submitted up to a year after the service, so 2017 data were not complete. Even so, 2017 average rates and percentages can be computed from existing claims data and are shown in other figures.

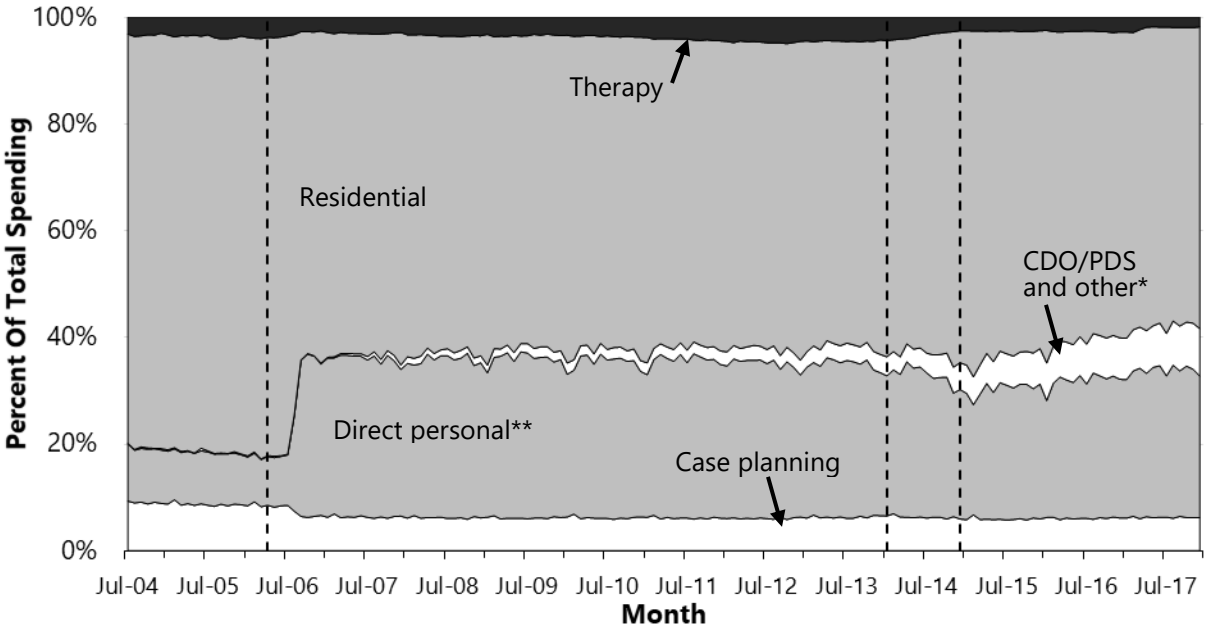
Figure B
Spending On All SCL Services And Number Of Members
Nominal And Constant 2004 Dollars
July 2004 To December 2016



Note: Spending includes consumer- and participant-directed services, and members include those receiving such services. Data for 2017 are not shown because claims are often submitted after a delay, so data for 2017 will not be complete until the end of 2018. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

The percentage of funds spent on different SCL services has changed since 2004. Figure C shows that the most significant changes occurred after the April 2006 restructuring, when adult day services, a type of direct personal service, were first authorized. Even though most direct service rates were reduced, the rapid adoption of adult day services caused spending for that group to more than double as a percentage of overall spending. This dramatic increase in one area made percentage spending in other areas smaller even when raw dollar spending went up. While it is not apparent from the figure, the percentage spent on group homes, a type of residential service, also rose, and the total spent on residential care increased.

Figure C
Percentage Of Spending On All Types Of Service
July 2004 To December 2017



Note: Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
*SCL provider agencies do not provide consumer-directed option (CDO) services, which began in Jan. 2007, or participant-directed services (PDS), which replaced CDO in 2014. Other services not related to provider rates are included here, such as home and vehicle modifications.
**Direct personal services in this figure include employment services.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Provider Tax

Medicaid provider taxes are attractive to providers and states because they are a mechanism for converting Medicaid funds—70 percent or more of which are already federal dollars in Kentucky—into state funds that can be reused to match more federal dollars. In 2004, Kentucky levied a tax of 5.5 percent on intermediate care facilities for individuals with IDD and on SCL providers (KRS 142.363). From 2004 to 2016, the SCL provider tax collected $153.6 million, of which approximately $107.5 million was originally federal funding. This was used to match an estimated additional $408.7 million federal funds, for an approximate total of $562.3 million.[c] [4]

Reimbursement Rates

The bill that levied the provider tax required that a portion of the revenues be used to increase reimbursement rates for intermediate care facilities and SCL providers. In response, all SCL

[c] The estimate was based on historical federal medical assistance percentages but did not take into account some small variations due to the difference between the federal and state fiscal years and potentially due to the Medicaid expansion. If the latter is relevant, the federal fund estimates would have to be increased.

rates were increased by approximately 10.8 percent in July 2004. Accounting for the 5.5 percent provider tax, the net increase was approximately 4.7 percent.[d]

There has been no across-the-board increase since 2004. Rates for some services have gone up, some remain the same, and others have gone down. Figure A indicates that payments to providers per SCL member per month have remained nearly the same since September 2006. Without information about provider costs, however, it is impossible to tell from the spending data whether there has been an increase or decrease in net provider earnings.

It was difficult to trace rate changes because the covered services themselves sometimes changed, so Program Review staff assigned similar services to groups that were consistent from 2004 to 2017. Average payments for service groups were calculated from the actual payments reported in claims data. The averages may be more or less than the upper rate limits allowed in regulation because groups comprise services having different limits and because they include supplemental payments for exceptional needs.[e]

Table 1 shows the average payment for each service group in 2004 and the average in 2017 in nominal and constant July 2004 dollars. The latter amount shows the effect of inflation on payments. Average reimbursement for three service groups (case planning, direct personal, and therapy) declined in nominal dollars. Reimbursement for staffed residences went up slightly in nominal dollars but fell in constant dollars. Reimbursement rose in both nominal and constant dollars for employment services, group homes, and residential family care.

Table 1
Average Payments For Types Of SCL Service
July 2004 And December 2017
Nominal And Constant 2004 Dollars

		Average Payment		
			Dec. 2017	
Type Of Service	**Unit**	**July 2004**	**Nominal**	**Constant 2004**
Residential—Group Home	Day	$65.51	$128.11	$97.72
Residential—Staffed Residence	Day	169.23	176.00	134.25
Residential—Residential Family Care	Day	64.24	140.63	107.27
Direct Personal	¼ hour	3.47	2.79	2.13
Case Planning	Month	362.86	318.24	242.75
Therapy	¼ hour	26.32	22.49	17.15
Employment	¼ hour	5.48	10.25	7.82

Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

The black lines in Figures D to J show the average dollar amount paid per unit of service for the indicated type of service each month. The gray lines are the same average value adjusted to constant July 2004 dollars. The shaded areas show the overall amount spent for that type of

[d] The net increase was only 4.7 percent because the provider tax was applied to the 10.8 percent increase as well as to the base amount.
[e] Department for Medicaid Services officials reported that providers usually bill at the upper limit.

service as a percentage of the total spent on SCL services each month. Table 2 summarizes the percentage of total spending for each type of service in July 2004 and December 2017.

Table 2
Percentage Of Total Spending For Types Of SCL Service
July 2004 And December 2017

	Percentage Of Total Spending	
Type Of Service	**July 2004**	**Dec. 2017**
Residential—Group Home	0.45%	2.01%
Residential—Staffed Residence	71.45	44.79
Residential—Residential Family Care	6.39	24.64
Direct Personal	9.34	21.43
Case Planning	8.74	5.17
Therapy	2.93	1.47
Employment	0.70	0.50

Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

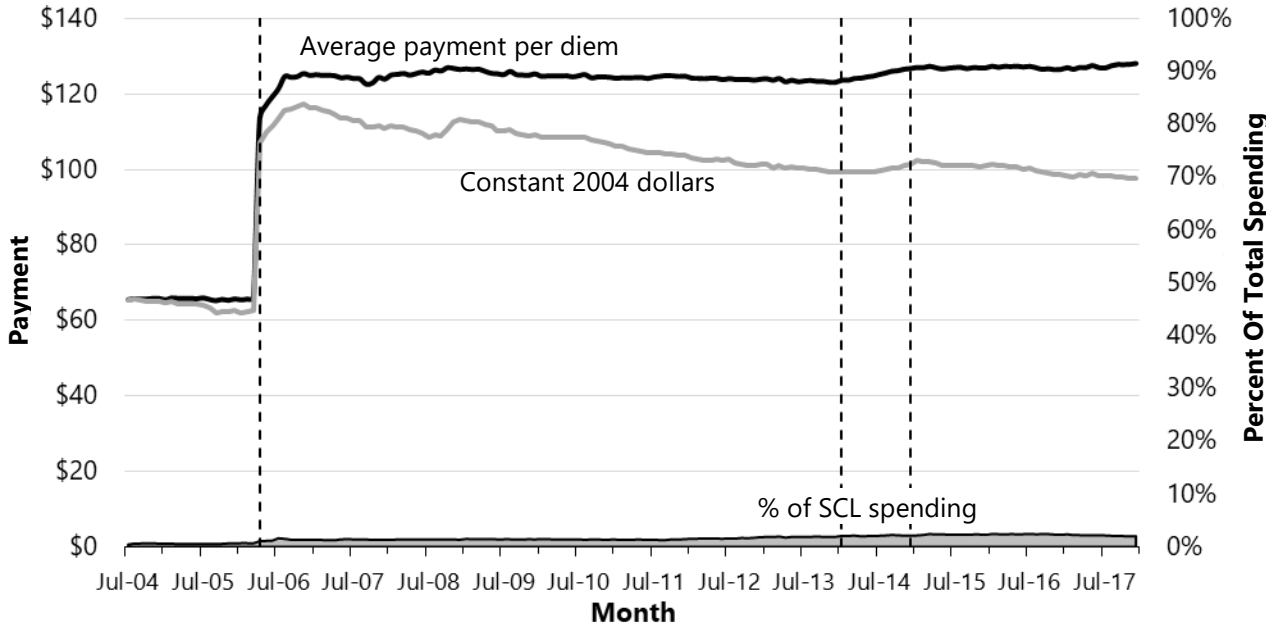
Residential Reimbursement

To comply with the Americans with Disabilities Act, states must allow as many individuals with IDD as feasible to move from intermediate care facilities into the community. Residential services in the community are less restrictive than in the facilities, but the residents do not own or control the operation of their residences. The following sections describe three levels of residential services.

Group Homes. Group homes are small residential facilities with four to eight residents who may be SCL members or others with IDD (902 KAR 20:078, 907 KAR 12:010). These facilities have paid staff on duty at least 19 hours per day and are the most restrictive setting that is considered to be community based.

In April 2006, the cabinet promulgated an emergency amendment to 907 KAR 1:155 that nearly doubled the daily reimbursement rate for an SCL member in a group home from $66.50 to $126.35. Figure D reflects the rate increase but also shows that spending on group homes has been a small portion of total SCL spending, which makes the increase in percentage difficult to detect in the figure. The spending increased from 0.4 percent in 2004 to 2.5 percent in 2016, declining to 2.0 percent by the end of 2017.

Figure D
SCL Average Payment And Percentage Of SCL Spending
Group Homes Per Diem
July 2004 to December 2017



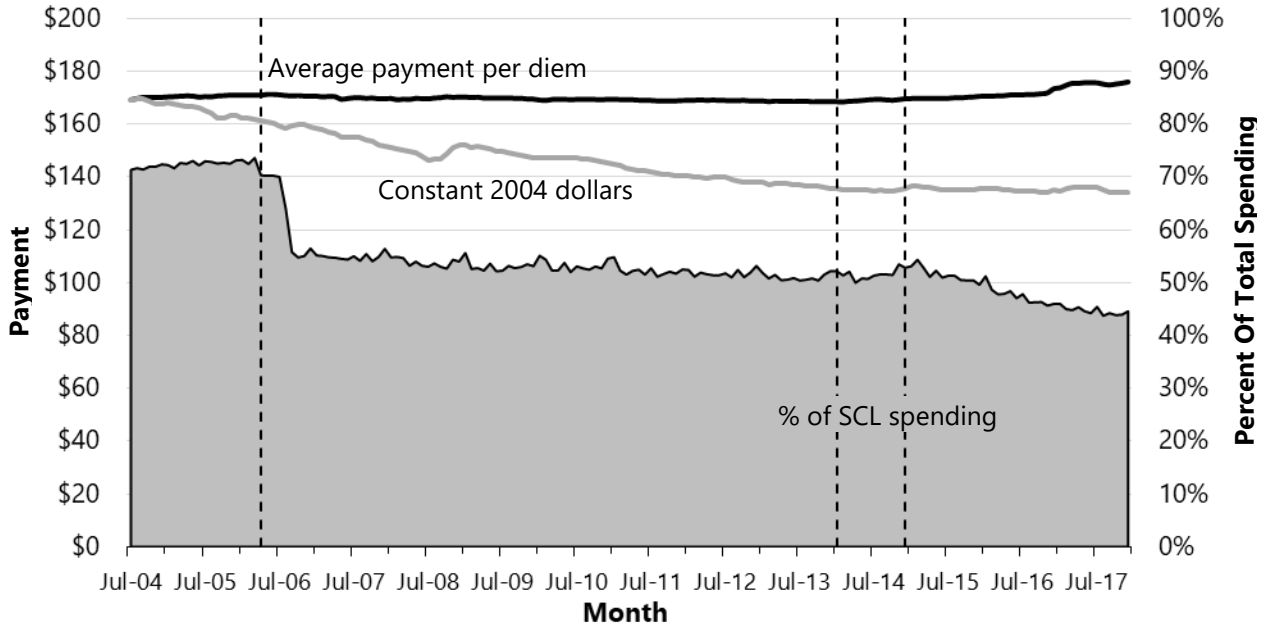
Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Staffed Residences. A staffed residence is a house owned or leased by an SCL provider that has no more than three SCL members and that has paid staff supervision for at least 19 hours per day. Compared with a group home, it is less like a residential facility and more like a shared household. Figure E shows that until December 2015, staffed residences accounted for more than half of all SCL spending.

The per diem upper limit under SCL1 for staffed residences of $168.46 was significantly higher than the limit for group homes but was constant from 2004 to 2014. Under SCL2, the limit increased slightly to $172.46. The figure shows that average reimbursement increased further after 2016 as the amount of exceptional payments grew significantly.

The number of days billed remained the same after April 2006 even though the percentage of total SCL spending for staffed residences showed a sharp drop due to the large increase in SCL spending for direct personal services. The number of days actually increased until mid-2015, when it began the decline reflected in the figure.

Figure E
SCL Average Payment And Percentage Of SCL Spending
Staffed Residences Per Diem
July 2004 to December 2017



Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Residential Family Care. SCL1 covered two nearly identical service settings in which a family agreed to include from one to three SCL members in their home. In SCL2, these were merged into the "Residential Level II" service with two rate levels depending on the amount of supervision required.

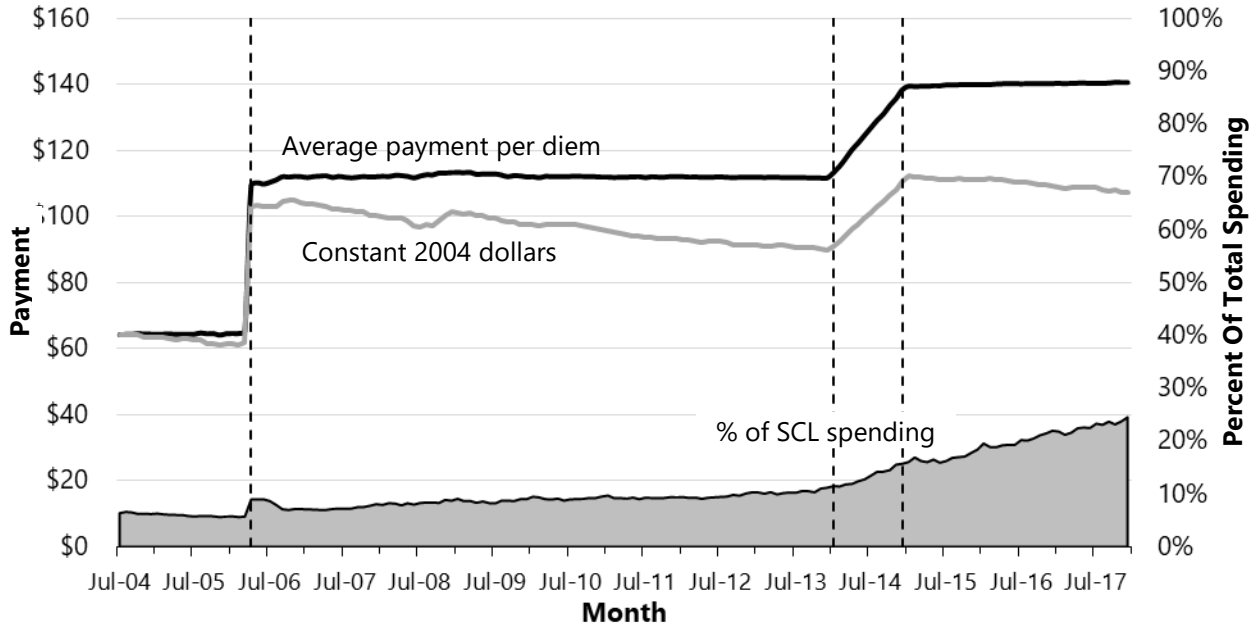
According to the SCL website, families providing residential care do so under contract with SCL provider agencies rather than directly as SCL providers. At the time of this writing, it was not known how much of the reimbursement was retained by the provider agencies and how much was passed on to the families, so it is impossible to know how much revenue SCL providers received. The significant amount of SCL spending on these services, however, seemed to justify mentioning them.

The rate limit under SCL1 nearly doubled in April 2006 to $112.49 and then was constant until 2014. Under SCL2, the two rate levels were $79.00 and $141.69, the midpoint of which is slightly lower than the SCL1 rate. Figure F shows the effect of the 2006 rate increase and the increase in average payments between 2014 and 2015 that occurred because more than 99 percent of Residential Level II providers billed at the higher level.

The residential family care portion of SCL spending increased mostly because of the increase in days billed in this setting. The number of days grew from approximately 23,000 in 2014 to 44,000 in 2017. Information from SCL providers indicated that many of them, especially

community mental health centers, had shifted their emphasis from staffed residences to residential family care. This might have been due to staff turnover and costs in the former. Families could afford to provide supervision and intervention within the SCL per diem even after the SCL providers retained their administrative fees.

Figure F
SCL Average Payment And Percentage Of SCL Spending
Residential Family Care Per Diem*
July 2004 to December 2017



Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
*It appears that most families participating in these services contract with provider agencies that receive a portion of the reimbursement and remit the remainder to the families. Some families participate independently and receive the entire reimbursement. These services are not included in the service table in the Appendix.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Direct Personal Services Reimbursement

Under the Americans with Disabilities Act, living in one's own or one's own family's home is the least restrictive living arrangement. Direct services support individuals in those settings. Certain direct services—community access and day training—are also available to SCL members in the residential settings described earlier. Direct services comprise services provided to members by direct service professionals, both individually and in small groups, and in residences, group meeting spaces, and the community at large. Services billed as employment supports are discussed separately.

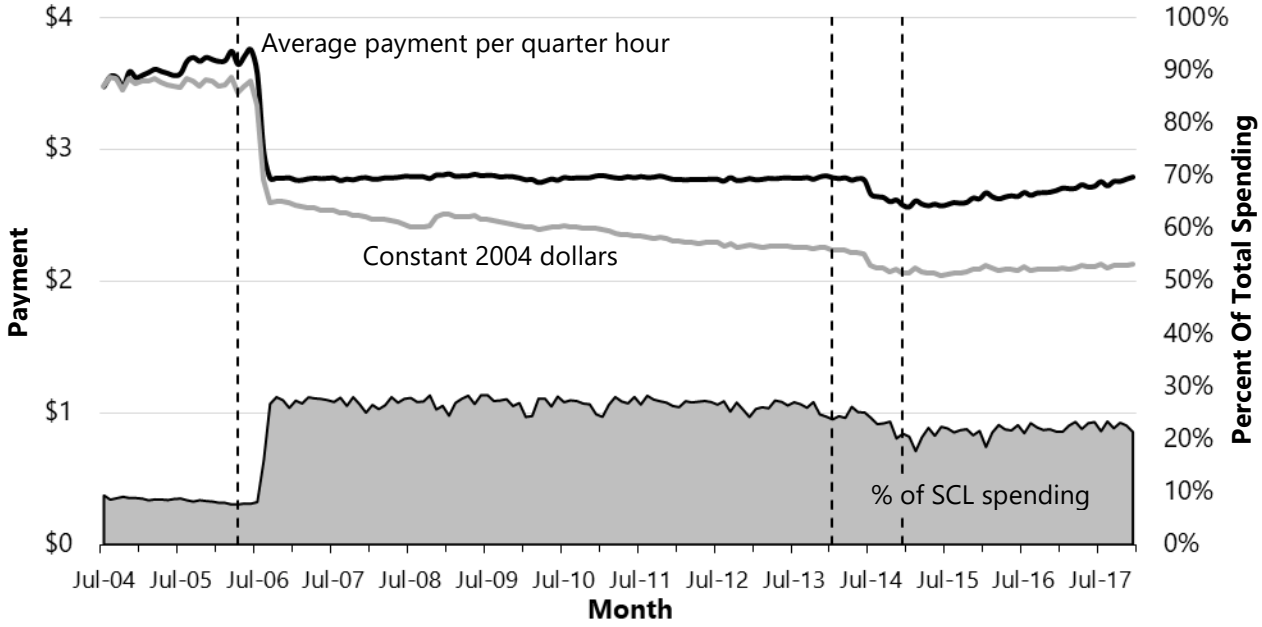
Figure G shows the average payment and percentage of spending for direct services. The fall in average reimbursement after April 2006 was due to the creation of the Adult Day Training On Site service at $2.50 per quarter hour, less than the rates for existing direct services ($2.77 and

$5.54).[f] The claims data show that the number of units billed for existing services continued at the same pace, approximately 250,000 per month, but billing for adult day services climbed to over 1 million units per month by October 2006. This change was enough to lower the average for the group from $3.74 in March 2006 to $2.78 in October. Total spending for direct services rose from approximately 8 percent of the amount spent on the SCL waiver to more than 25 percent.

In January 2014, the rate for adult day services under SCL2 fell further to $2.20 per quarter hour.[g] The overall effect was to pull down the average reimbursement for direct services. However, the use of other direct services increased, particularly community access at $8.00 per quarter hour, leading to a rebound in the average payment.

The rapid adoption of adult day services in 2006 appears to have been driven by residential providers who adopted the model of sending residents to adult day training, thereby reducing daytime staffing needs. The percentage of total spending for direct services declined with SCL2 but then rebounded as residential providers continued to use adult day services despite the lower reimbursement rate and as direct services in the community increased.

Figure G
SCL Average Payment And Percentage Of SCL Spending
Direct Personal Services Per Quarter Hour
July 2004 to December 2017



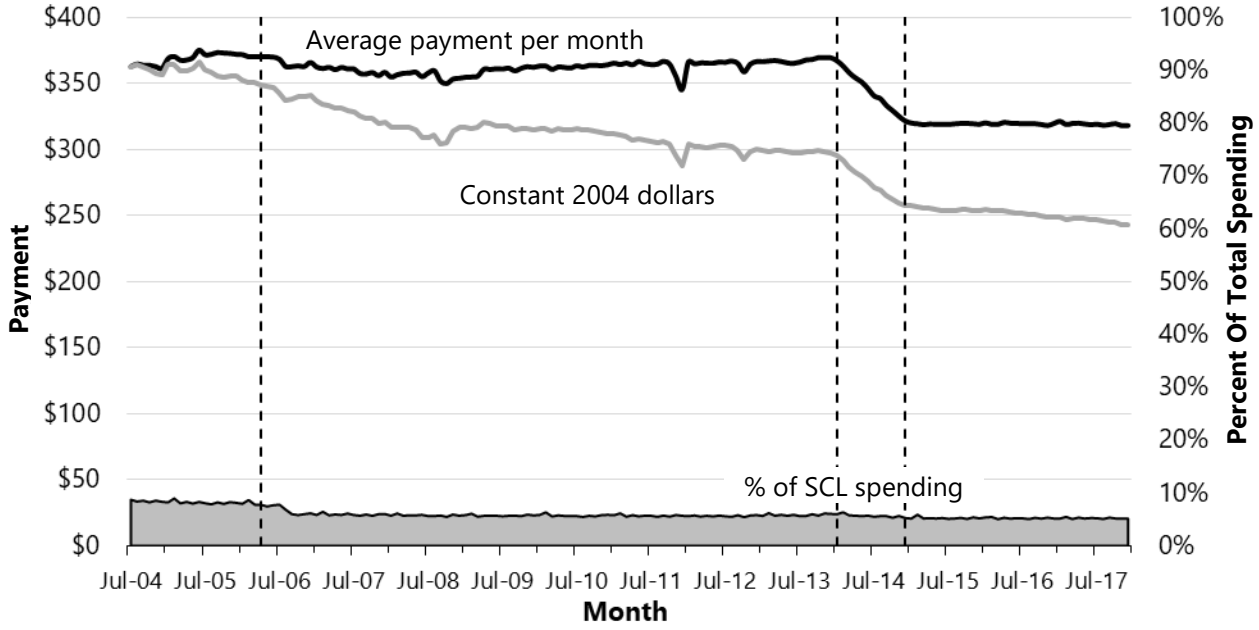
Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

[f] Adult Day Training Off Site was also introduced at $3.00 per quarter hour, but it peaked at 250,000 units in July 2009 and was not a significant contributor to the group average.
[g] A new service, Day Training (Licensed Adult Day Health Center), was reimbursed at $3.00 but was strictly limited to members needing skilled nursing care or nursing supervision.

Case Planning Reimbursement

The rates for case planning services were stable until SCL2 began in January 2014. The decline in percentage of spending shown in 2006 was due to a large overall increase in SCL spending, primarily for direct personal services. In 2014, the rate for the case management service fell from $376.06 per month to $320. Figure H shows that the decline occurred over 12 months because of the gradual transition from SCL1 to SCL2. The percentage of total spending fell from approximately 6 percent in SCL1 to an average of 5.2 percent in SCL2.

Figure H
SCL Average Payment And Percentage Of SCL Spending
Case Planning Services Per Month
July 2004 to December 2017



Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

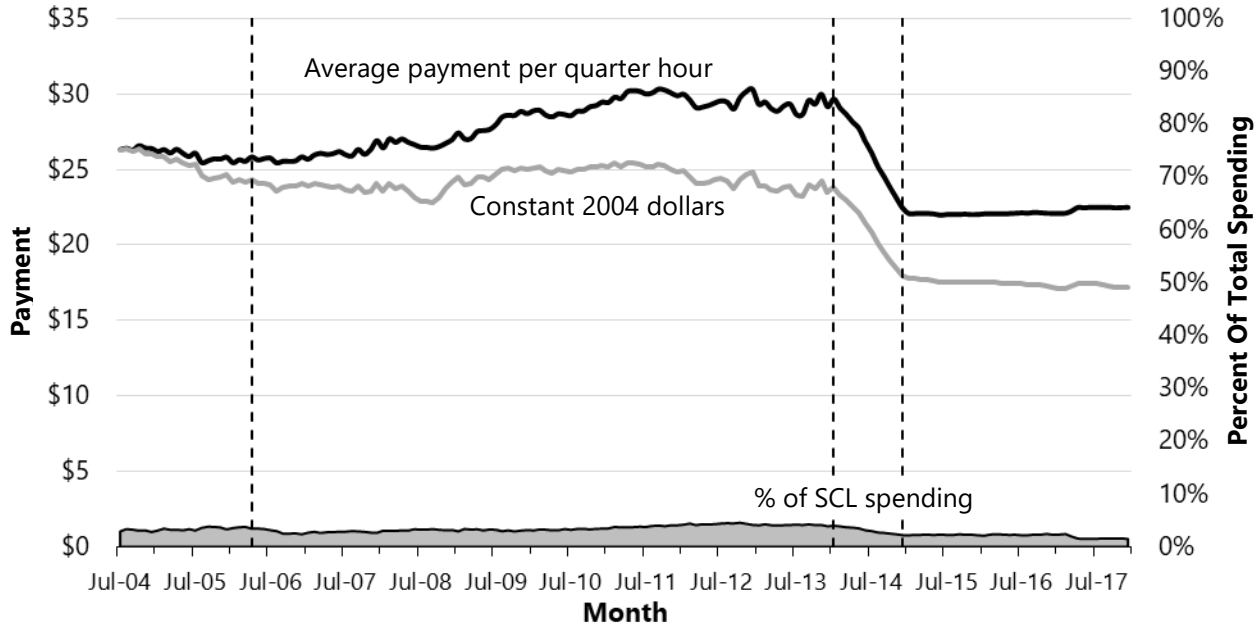
Therapy Services Reimbursement

Even though the upper rate limit for therapy services did not change from 2004 to 2013, the average payment increased during that period, as shown in Figure I. The claims data show that the number of units billed for two of the more expensive services, behavioral support and psychological services, increased relative to less expensive services. Fewer units were billed for less expensive services like speech and occupational therapy. The decline in percentage spending shown in 2006 was due to a large increase in SCL spending for direct personal services.

In January 2014, lower SCL2 rates for several therapeutic services went into effect, and new services for physical and occupational therapy by certified assistants were instituted at lower rates than those paid to therapists. The rate for psychological services also fell significantly in

SCL2. The slight increase in average payments in 2017 appears to result from the removal of speech therapy in April and of physical and occupational therapy in June. On those dates, members of all Medicaid waivers began to receive physical, speech, and occupational therapy through regular Medicaid instead of waiver programs.[h]

Figure I
SCL Average Payment And Percentage Of SCL Spending
Therapy Services Per Quarter Hour
July 2004 to December 2017



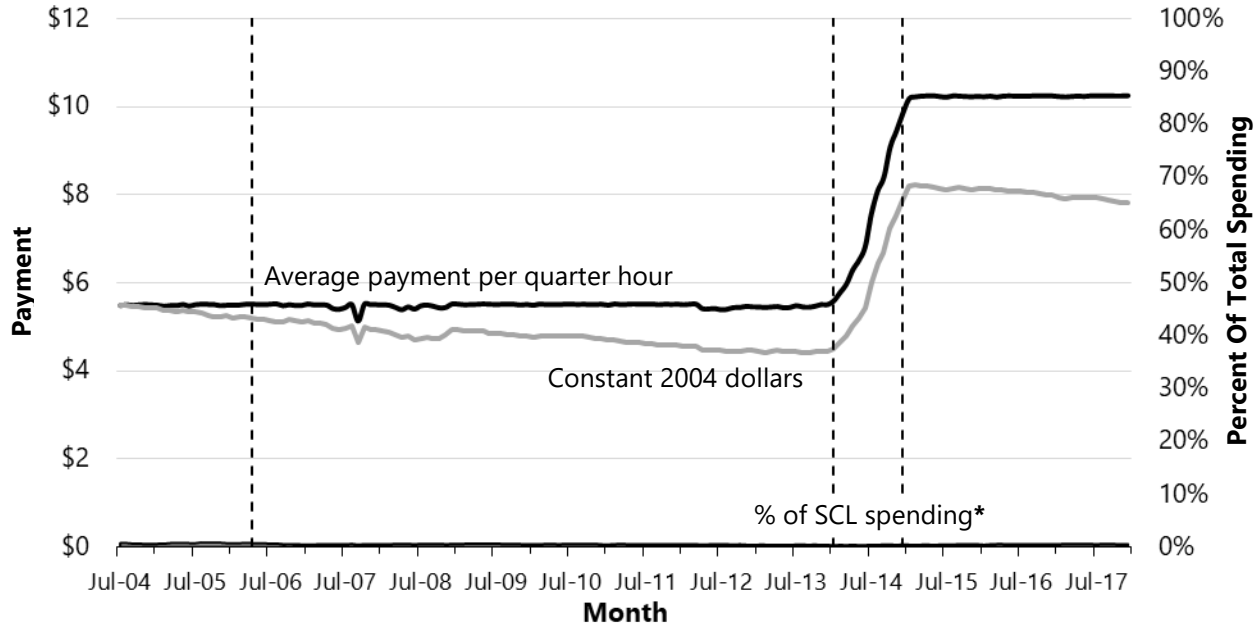
Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Supported Employment Reimbursement

The rate for services to help an SCL member obtain and keep a job remained steady throughout SCL1. In SCL2, the rate nearly doubled from $5.54 to $10.25 per quarter hour. Although the percentage of total SCL spending is too small to see in Figure J, the share of spending fell during SCL1 to a low of 0.3 percent in January 2014 but grew under SCL2 to 0.5 percent in December 2017. The number of units provided had been in decline but increased in SCL2.

[h] In 2014, Kentucky Medicaid decided to offer physical, speech, and occupational therapy to all Medicaid members through traditional Medicaid. Federal regulations prohibit a state from covering services under a waiver that are provided through traditional Medicaid. The Centers for Medicare and Medicaid Services denied Kentucky's request for an exemption from this rule, so the services were shifted from SCL to regular Medicaid in 2017.

Figure J
SCL Average Payment And Percentage Of SCL Spending
Supported Employment Services Per Quarter Hour
July 2004 to December 2017



Note: Calculations exclude consumer- and participant-directed services. Vertical lines show the service restructuring in April 2006 and the transition from SCL1 to SCL2 in 2014.
*Spending for supported employment services was less than 1 percent of SCL spending in all months.
Source: SCL claims data from Department for Medicaid Services analyzed by Program Review staff.

Rate-Setting Methodologies

Medicaid reimbursement rates are governed by this general statement in the Social Security Act: "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" (42 USC sec. 1396a(a)30(A)). The Centers for Medicare and Medicaid Services (CMS) does not dictate how states set reimbursement rates but has described several methods that states may use.[5] States are not limited to these methods. CMS does ask states to be able to explain how rates were determined.

Under a fee schedule rate methodology, every provider is paid a fixed, established rate for each type of service. A state may base its rates on provider costs, private sector prices, average use of services, or any other method. Rates do not vary by provider but may vary by geography or other factors.

Negotiated market rates involve negotiations between the state agency and each provider in order to arrive at an agreed upon market price for each type of service. Rates can vary among providers for the same services. Prior to negotiation, the state creates a permissible range of rates based on a review of prices for comparable services, staffing costs, and other factors.

A tiered rates system establishes rates for each service in a number of steps or levels (tiers). Tiers are usually based on the cost involved in serving clients with different levels of need. The provider is reimbursed at the rate tier indicated by a needs assessment of each client. [Tiers may also be established based on provider characteristics.]

With bundled service rates, a state creates combinations of services that are commonly provided together to meet an individual's needs. Providers receive a fixed rate for delivering the bundle of services for a period of time.

Under cost reconciliation rate setting, providers are reimbursed at a predetermined interim rate and later file cost reports to determine the true costs of services. If the costs were greater than the interim payments, the provider receives the difference; if lower, the provider must repay the difference.

Kentucky's Rate-Setting Methodology

The Department for Medicaid Service sets SCL rates for most services using a fee schedule method with a fixed upper payment limit. Services also have a limit on the number of billable units in a time period. Regulation includes a tiered component permitting a higher rate of reimbursement or more units—but not both—when a client has unusually high needs. These needs are met through existing services using additional staff or additional units and are called "exceptional supports." Providers may request additional units and exceptional reimbursement rates from the Department for Behavioral Health, Developmental and Intellectual Disabilities based on the provider's cost but not to exceed twice the fixed upper limit for the service.

The HCBS waiver application requires states to describe how payment rates are established and how the public provides input into the process.[6] Kentucky's SCL revision application from 2015 stated that

> Provider rates are established utilizing a fee-for-service system. Paid claim data was reviewed for waiver participants for [dates] of service, fiscal years 2011-2014, which included total units paid per service, total unduplicated users, total cost, average units of service and average cost. Data was trended forward, using historical information, factoring in rate of growth.[7]

A revised application from 2017 had a similar description and also stated, "There is not a cost of living increase. The state continuously evaluates rates to determine that adequate access to and statewide coverage of services is available."[8]

Although the rates are published in the Kentucky Administrative Regulations, the rate methodology used to set them has not been published for any fiscal year since 2001. The Department for Medicaid Services was unable to provide the methodology and calculations used to set the rates for 2004 and later. The SCL applications suggest that the department sets rates based on its projected budget and availability of services rather than on provider costs or market prices. As long as SCL providers make adequate services available statewide at these rates, the state has fulfilled the requirements of the Social Security Act, and the department has no obligation to adjust reimbursement rates.

[1] United States. Dept. of Justice. Civil Rights Division. "Statement of the Department of Justice on Enforcement of the Integrations Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*" n.d.
[2] Earl Gresham. Email to Van Knowles. June 8, 2018.
[3] United States. Bureau of Labor Statistics. Consumer Price Index All Urban Consumers Seasonally Adjusted All Items. Series ID CUSR0000SA0. Accessed April 4, 2018.
[4] Sarah Puttoff. Email to Deborah Bailey. Oct. 12, 2017.
[5] Ralph F. Lollar. United States. Center for Medicaid and CHIP Services. "Rate Methodology in a FFS HCBS Structure." PowerPoint presentation. Feb. 2016.
[6] United States. Centers for Medicare and Medicaid Services. *Application for a §1915(c) Home and Community-Based Waiver Instructions Technical Guide and Review Criteria*. Jan. 2015. P. 252.
[7] Kentucky. "Application for a §1915(c) Home and Community-Based Services Waiver." Sep. 1, 2015. App. I, sec. I-2-a. n.pag.
[8] Kentucky. "Application for a §1915(c) Home and Community-Based Services Waiver." Mar. 1, 2017. App. I, sec. I-2-a. n.pag.

Appendix

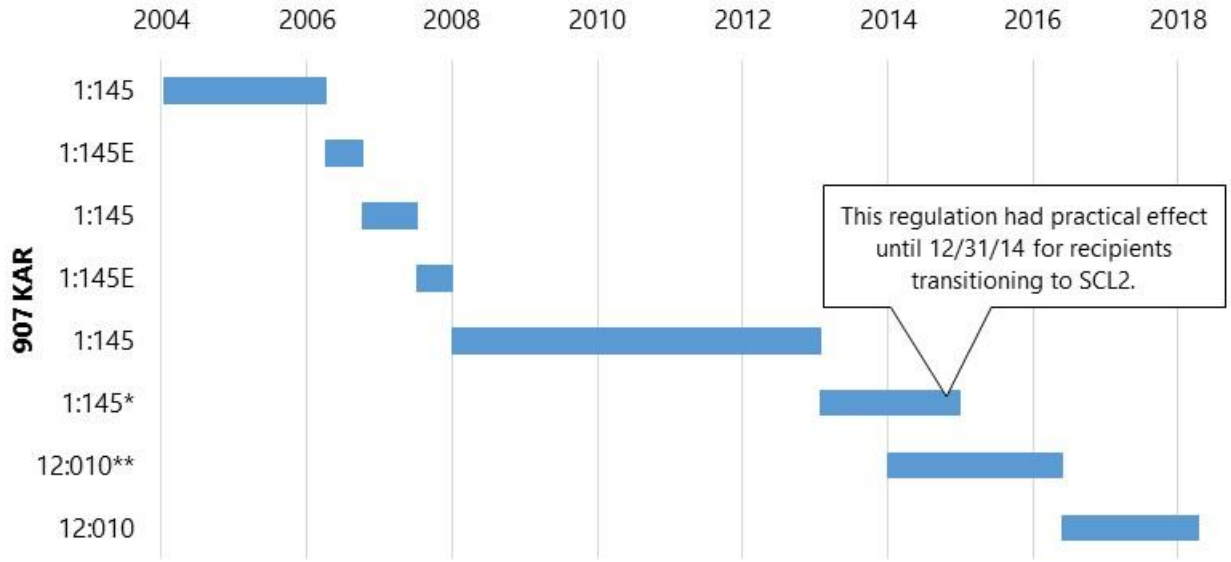
Supports For Community Living Services And Rates

Regulatory History

The regulations governing Supports for Community Living (SCL) were 907 KAR 1:145 and 1:155 for the period 2004 to 2014. This period was referred to as SCL1. An amended waiver, referred to as SCL2, went into effect in 2014 and was governed by 907 KAR 12:010 and 12:020.

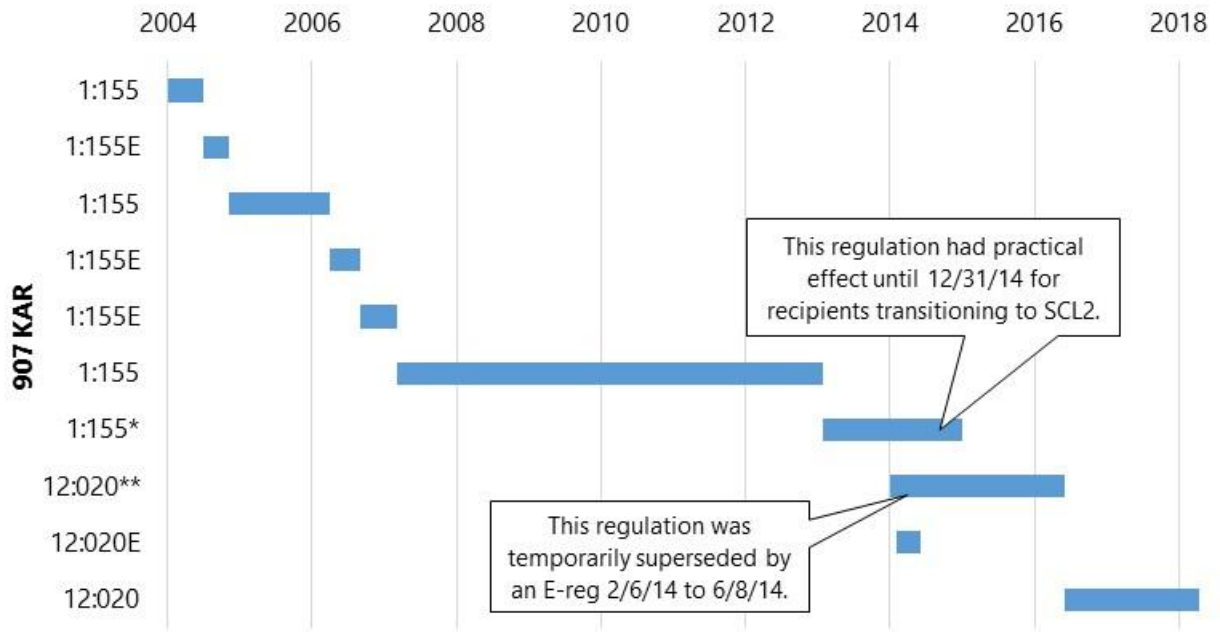
From 2004 to 2018, Program Review staff reviewed several revisions to determine the changes in covered services and rates. Figure A shows the history of regulations concerning covered services. Figure B shows the history of regulations concerning reimbursement rates.

Figure A
SCL Covered Services Regulatory History
2004 To 2018



*This regulation technically is still in effect but had practical effect only until Dec. 2014 for recipients transitioning to SCL2.
**Although this regulation technically went into effect in Feb. 2013, the service provisions were not implemented until Jan. 2014.
Source: Program Review staff examination of regulatory history from Administrative Regulation Review Subcommittee

Figure B
SCL Reimbursement Rates Regulatory History
2004 To 2018



*This regulation technically is still in effect, but it had practical effect only until Dec. 2014 for recipients transitioning to SCL2.
**Although this regulation technically went into effect in Feb. 2013, the rate provisions were not implemented until Jan. 2014.
Source: Program Review staff examination of regulatory history from Administrative Regulation Review Subcommittee

Reimbursement Rate Comparison

Program Review staff combined SCL services into groups for comparison. Grouping was based on whether the purposes, billing units, and rates of the services were comparable. The table shows the services for each group in chronological order.

Table
SCL Services Grouped For Analysis

Group	Service	Earliest	Latest
Case Planning	Support Coordinator	July 2004	Dec. 2013
	Behavioral Support Plan	Aug. 2004	Dec. 2013
	Behavioral Support Plan – Traditional	Jan. 2014	Dec. 2014
	Support Coordinator - Traditional	Jan. 2014	Apr. 2015
	Case Management - Traditional	Jan. 2014	Dec. 2017
	Positive Behavior Support Plan - Traditional	Jan. 2014	Dec. 2017
Direct Personal	Community Living Support	July 2004	Dec. 2013
	Respite	July 2004	Dec. 2013

Group	Service	Earliest	Latest
Direct Personal	Adult Day Training Off Site	Apr. 2006	Dec. 2013
	Adult Day Training On Site	Apr. 2006	Dec. 2013
	Adult Day Training On Site - HA- Traditional*	Jan. 2014	June 2014
	Community Living Support- Traditional	Jan. 2014	Dec. 2014
	Adult Day Training Off Site- Traditional	Jan. 2014	Mar. 2015
	Respite- Traditional	Jan. 2014	Mar. 2015
	Adult Day Training On Site - HB- Traditional*	Jan. 2014	Apr. 2015
	Community Access - Individual - Traditional	Jan. 2014	Dec. 2017
	Day Training - Traditional	Jan. 2014	Dec. 2017
	Day Training (Licensed Adult Day Health Center) - Traditional	Jan. 2014	Dec. 2017
	Personal Assistance - Traditional	Jan. 2014	Dec. 2017
	Respite - Traditional	Jan. 2014	Dec. 2017
	Person centered coach - Traditional	Mar. 2014	Dec. 2017
	Community Access - Group - Traditional	Apr. 2014	Dec. 2017
	Community Guide - Traditional	May 2015	Dec. 2017
Employment	Support Employment	July 2004	Dec. 2013
	Supported Employment- Traditional	Jan. 2014	Dec. 2014
	Supported Employment (JOB ACQUISITION WITH SUPPORT) - Traditional	Jan. 2014	Dec. 2017
	Supported Employment (LONG TERM SUPPORT AND FOLLOW-UP) - Traditional	Jan. 2014	Dec. 2017
	Supported Employment (PCJS DISCOVERY)- Traditional	Jan. 2014	Dec. 2017
	Supported Employment (JOB DEVELOPMENT AND ANALYSIS) - Traditional	Feb. 2014	Dec. 2017
Group Home	Group Home	July 2004	Dec. 2013
	Group Home- Traditional	Jan. 2014	Dec. 2014
	Residential Level I ? (4 to 8 residents) – Traditional	Jan. 2014	Dec. 2017
Staffed Residence	Staffed Residence	July 2004	Dec. 2013
	Staffed Residence- Traditional	Jan. 2014	Apr. 2015
	Residential Level I - (3 or fewer residents) - Traditional	Jan. 2014	Dec. 2017
Therapy	Psychological	July 2004	Dec. 2012
	Behavioral Supports	July 2004	Dec. 2013
	Occupational Therapy	July 2004	Dec. 2013
	Physical Therapy	July 2004	Dec. 2013
	Speech Therapy	July 2004	Dec. 2013
	Functional Analysis	Aug. 2004	Dec. 2013
	Functional Analysis - Traditional	Jan. 2014	Dec. 2014
	Occupational Therapy - Traditional	Jan. 2014	Dec. 2014
	Physical Therapy - Traditional	Jan. 2014	Dec. 2014
	Behavioral Supports - Traditional	Jan. 2014	Mar. 2015
	Speech Therapy - Traditional	Jan. 2014	Mar. 2017

Group	Service	Earliest	Latest
Therapy	Occupational therapy by occupational therapist - Traditional	Jan. 2014	May 2017
	Physical therapy by physical therapist - Traditional	Jan. 2014	May 2017
	Consultative clinical and therapeutic (Functional Analysis) - Traditional	Jan. 2014	Dec. 2017
	Consultative clinical and therapeutic (Positive Behavior Supports) - Traditional	Jan. 2014	Dec. 2017
	Consultative clinical and therapeutic (Psychological Services) - Traditional	Jan. 2014	Dec. 2017
	Occupational therapy by certified occupational therapy assistant - Traditional	Feb. 2014	Mar. 2017
	Consultative clinical and therapeutic (Diet/Nutrition) - Traditional	Feb. 2014	Dec. 2017
	Physical therapy by physical therapy assistant - Traditional	Mar. 2014	Mar. 2017

Note: Service codes are shown as they appeared in the claims data. "Traditional" was a term used in the claims system from Jan. 2014 onward to identify claims that were submitted by traditional SCL provider agencies.
*These codes appeared briefly in claims data and received approximately the same reimbursement rate.
Source: Medicaid claims data from the Department for Medicaid Services analyzed by Program Review staff.

Because Behavior Support Plan was billed in quarter-hour increments in SCL1 but its successor, Positive Behavior Support Plan, was billed per plan in SCL2, staff estimated the SCL1 per-plan payment by assuming that there should have been one plan for each member submitting a claim for this service in a given month. It is possible that the actual reimbursement was higher than the estimate because the claims for one or more of those members might have been denied, making the number of plans reimbursed smaller than the number of members submitting claims.

Functional Analysis could be considered a case planning service, but Program Review staff classified it instead as a therapy service. It was billed in quarter-hour units in both versions of the waiver and became a consultative and therapeutic service in SCL2. In contrast, case planning services were billed by the month or by the plan.

At the time of this writing, available information suggested that most adult foster care and family home providers operated under contract with SCL provider agencies rather than directly as SCL providers. It was not known how much of the reimbursement was retained by the provider agencies and how much was passed on to the families. These services were excluded from the table because the amount of provider revenue was not known. This memorandum discusses them briefly because they represent a large and growing portion of SCL spending.

Under SCL1, additional intensity (exceptional) payments were not distinguished from other payments, so it was impossible to determine their amount. Under SCL2, exceptional payments were reported separately, but Program Review staff added them back into the basic service so the SCL1 and SCL2 rates would be comparable. These additional payments sometimes caused the average reimbursement rate for a service to exceed the upper limit listed in regulation.

Exclusions From Rate Comparison

Certain services paid through the Consumer Directed Option and Participant Directed Services were excluded because they were not provided by SCL provider agencies. Services using negotiated and one-time rates were also excluded because there was no fixed rate for them.