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MEMORANDUM

TO: Senator Danny Carroll, Co-Chair
Representative Jason Nemes, Co-Chair
Representative Lynn Bechler, Vice Chair

FROM: Gerald W. Hoppmann, Committee Staff Administrator
Van Knowles, Analyst
Legislative Oversight and Investigations Committee

RE: Final Update and Closure on the Supports for Community Living Study

DATE: April 14, 2021

Study Request And Closure

In March 2017, the Legislative Oversight and Investigations Committee authorized a study of the reimbursements for private providers as addressed in 2017 RS HCR 100 for the Supports for Community Living (SCL) program. Providers had asserted that the reimbursement for services was too low to support their continued operation.

In November 2018, Legislative Oversight staff presented an analysis of rates and spending trends based on SCL claims data but later learned that some claims were missing. Staff also noted that the Department for Medicaid Services (DMS) had engaged a consulting firm, Navigant, to review and make recommendations to its internal procedures dealing with home and community-based services (HCBS), including SCL. After several delays, DMS decided to postpone any changes until 2022.

Meanwhile, effective July 1, 2018, the General Assembly appropriated additional funds and directed the SCL program to increase all SCL provider reimbursement rates by 10 percent (2018 RS HB 200). The increase remains in effect.

As a result of legislative action to increase SCL rates and delays in the waiver redesign, Legislative Oversight staff proposes to close out this study without a formal report. This memo summarizes staff's findings to this point, based in part on updated claims data. A new detailed claims analysis is available on request.

Background

Medicaid offers states the option of developing 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 such as nursing homes. Unlike regular Medicaid, which must accept everyone who is eligible, a state is permitted to limit the number of members in an HCBS waiver program.

Kentucky has HCBS waivers for the elderly and others with disabilities who need nursing-level care, for individuals with acquired brain injury, and for individuals dependent on a ventilator. Supports for Community Living is Kentucky's HCBS waiver program for individuals with an intellectual or developmental disability (IDD). SCL reduces the use of intermediate care facilities (ICF) for individuals with IDD.[1] It helps the state to comply with the Americans with Disabilities Act and the related *Olmstead* decision of the US Supreme Court by enabling individuals with IDD to receive services in the least restrictive environment that is economically feasible.

The Department for Community Based Services determines eligibility for the Medicaid program. DMS funds SCL, sets rates for waivers, and participates in SCL enrollment for eligible Medicaid members and providers. The Department for Behavioral Health, Developmental and Intellectual Disabilities also participates in enrollment of members and providers and administers SCL services.

Rates And Spending On SCL Services, 2004 To 2017

DMS provided SCL claims data for each month from July 2004 through December 2017. This section and the next describe the main findings from staff's analysis of corrected claims data.

From 2004 until 2018, there had been no across-the-board rate increase. Rates for various services had gone up, remained the same, or gone down. The services themselves changed from time to time. Legislative Oversight staff examined the service changes described in DMS regulations and in policy documents from the Department for Behavioral Health, Developmental and Intellectual Disabilities in order to place similar services into groups. This made it possible to track reimbursement for each group of services over time.

In April 2006, 6 days after finalizing a settlement in *Michelle P. v. Birdwhistell*, the Cabinet for Health and Family Services submitted emergency amendments to 907 KAR 1:145 and 1:155.

[1] 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.

The filing stated that the cabinet expected an increase in the number of individuals with IDD receiving services in the community.[2] The amendments restructured services and included significant rate increases for group homes and residential family care, bringing them closer to the rate for staffed residences.[3] At the same time, the rates for direct personal services were reduced. Other rates remained nearly the same. The stated purpose in Kentucky regulations was "to accommodate individuals who may be displaced from an intermediate care facility" and to align reimbursement more closely with provider costs (907 KAR 1:155).

In 2014, DMS again restructured SCL services. The previous period is known as SCL1, and the following period is known as SCL2. Rates for most types of services were reduced, but rates for supported employment and residential family care increased significantly. Exceptional payments, which are the additional amount paid on behalf of some members whose needs exceed the usual requirements of a given service, seemed to offset some of the reductions, especially for direct personal services and staffed residences.

SCL Spending Trends

Health insurers often manage their expenses by calculating the amount spent per member per month. Looking at SCL as a whole, spending per member was increasing rapidly from 2004 until the restructuring in April 2006—on average, $22.60 per member per month. Afterward, monthly spending per member increased more slowly—on average, $4.39—until the transition from SCL1 to SCL2 in 2014. After an initial drop in spending, the amount per member per month began to go up at a somewhat faster rate—on average, $6.59—but still far less than in the 2004-2006 period.

Adjusted for inflation using constant 2004 dollars, monthly spending per member declined over the period, remaining nearly flat since 2014. Without information about provider costs, it is impossible to tell from the spending data alone whether there was an increase or decrease in net provider earnings.

The mix of spending on different types of SCL services has been nearly stable since 2004. The most significant changes occurred after the transition to SCL2, when more members chose to use participant-directed services and the spending on therapy services declined. The percentage spent on group homes also rose, and the total spent on residential care increased. The spending on therapy services went down because speech therapy, occupational therapy, and physical therapy were dropped from SCL and provided instead through the regular Medicaid program.

Sometimes providers appeared to change the mix of services they provided in response to reimbursement rates. For example, according to providers, an increase in the rate for residential family care in SCL2 led to increased use of that service in preference to staffed residences.

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[2] The *Michelle P.* lawsuit alleged that the state's use of ICFs violated the Americans with Disabilities Act and the US Supreme Court's *Olmstead* decision because supportive services could be provided in the community. In 2004, the US Department of Justice had separately found that Kentucky's ICFs housed individuals who could have lived in the community; the two parties signed a memorandum in 2004 and settled remaining issues in August 2006.
[3] In residential family care, such as adult foster care, a family agrees to include from one to three SCL members in their home (907 KAR 12:010 under Residential Level II).

SCL Rates Since Fiscal Year 2019

Of the providers who answered Legislative Oversight staff's questions about the increase, more than 71 percent had either mixed or negative responses. More than half thought the increase was insufficient, and some expressed concern that future increases would be needed to cover changes in the cost of living.

Guidelines And Requirements For Waiver Rates

Federal cost neutrality rules require the average total cost to Medicaid for HCBS waiver members to be no more than the total estimated average cost that Medicaid would pay if the members were in an institution. Federal rules do not address the number of waiver members.

As of June 2018, DMS estimated that the average total cost to serve an ICF resident would be $343,109 per year and that the average total cost to provide services to an SCL member was $75,673 per year.[4] The per-member cost of SCL, then, was less than one-fourth of the cost per ICF resident. In this case, federal cost neutrality rules permit the state to increase expenditures on SCL members by more than four times and permit the state to increase the number of eligible members served.

State budget constraints, however, limit the number of waiver members and reimbursement rates. Staying within the existing state budget while adjusting these numbers is called budget neutrality. Rate adjustments between 2004 and 2018 were approximately budget neutral for the state, and the legislatively mandated increase in 2018 included an additional appropriation.

Medicaid reimbursement rates must meet the requirement of the Social Security Act that

> payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area (42 USC sec. 1396a(a)30(A)).

In addition, they must comply with federal regulations stating that a state's plan "must describe the policy and the methods used in setting payment rates for each type of service" (42 CFR sec. 447.201(b)).

Although federal courts have barred direct legal challenges to a state's Medicaid reimbursement rates, they have also reinforced the responsibility of the Centers for Medicare and Medicaid Services for ensuring that rates are sufficient and consistent with approved rate methodologies. Affected individuals and providers may sue that agency for enforcement, and the agency may withhold federal funds if a state fails to meet legal requirements or to implement the rate methodology in its own waiver application.

Since 2003, Kentucky has had no codified methodology for setting or reviewing waiver rates. DMS noted that Kentucky's waiver applications, including explanations of rates, have all been approved so far; however, that does not preclude a legal challenge to the approval itself, and stricter review could occur with future applications. Kentucky can help avoid challenges to rates

[4] This is the most recent estimate available from DMS.

by using rate methodologies that consider actual provider costs and allowing for provider input and appeals where necessary.

Waiver Rate Study

In 2017, DMS contracted with the private consulting group Navigant to recommend a plan for HCBS waiver redesign and a rate study. The Navigant rate study surveyed providers about their costs as a starting point for developing new rates. Basing rates on current costs can be misleading because cost and wage data tend to reflect existing reimbursement rates, so if current rates are too low, then costs might be artificially depressed. Providers also asserted that the survey did not accurately capture their costs.

A large portion of provider cost is wages. Navigant considered current reported costs, wage data from the Bureau of Labor Statistics, and comparable information from other states. However, Navigant was unable to fully apply this information because DMS also required the results to be budget neutral across all of Kentucky's HCBS waivers: If some rates increased, others had to decrease so that there would be no change in the total waiver budget. This is another artificial constraint that fails to account for realistic actual costs of providing services.

Navigant found that rates across waivers for similar services were unequal. DMS indicated that a budget increase of up to $43 million would be required to bring rates for all HCBS waiver services up to the highest rate currently being paid for that service. If a rate study were conducted that considered the realistic costs of providing services of sufficient quality, not limited to the existing budget, it would probably require an even greater increase.

Direct Care Workforce

A significant factor in providing SCL services is the availability of direct care workers. Even though market wages for similar jobs are similar to those paid by SCL providers, these jobs experience high turnover, making it difficult to retain enough workers who have the needed training and experience. Some other jobs with lower levels of stress also offer higher pay, further reducing the workforce. One provider said, "We simply cannot compete at all with even the gas station down the street."

A focus group of caregivers for adults with autism reported that they were able to hire reliable and diligent direct care workers by paying them significantly more than the market wage via participant-directed services. Information from DMS showed that participant-directed employees received significantly higher wages than employees of SCL providers.

Of providers who answered Legislative Oversight staff's questions about the 2018 rate increase, more than half said they had passed some or all of the increase to direct care workers' wages. Some of them reported a significant improvement in workforce stability as a result.

Several reports have recommended increasing wages for direct care workers in order to retain a stable, high-quality workforce. Some states have considered or enacted a requirement that HCBS waiver rate increases be passed through entirely to direct care workers' wages.

Agency Responses

Legislative Oversight staff sent DMS a summary of findings. The agency agreed with the findings with a few exceptions. Legislative Oversight staff incorporated the agency's suggested edits into the present memo, along with the following comments.

- DMS stated that the 10 percent rate increase remains in effect, but that the agency cannot determine the net value of reimbursement to providers. Staff removed the term *net value* from the memo and clarified that there was a decline in inflation-adjusted spending.
- DMS noted that the Navigant contract began earlier than the date indicated. Staff edited the memo to show the correct date.
- DMS noted that federal authorities had approved Kentucky's rates. Staff respond that prior federal approval may be challenged and that stricter review might be applied in the future.
- DMS clarified the reasons for having provided different figures for potential budget increases. Staff edited the memo to state that "up to $43 million" would be needed.
- DMS supplied additional context for Navigant's proposed direct-care service rates. Staff respond that even though Navigant found that direct-care workers' wages were similar to those paid in similar settings, the literature states consistently that such wages are too low to ensure a stable, high-quality workforce in any direct-care setting.
- DMS stated that waiver waiting lists must be considered when raising rates or adjusting program cost. Staff respond that the need for such consideration supports the finding that the state's budget, not federal law, determines how many members will be served and what reimbursement rates will be.