State of Kansas
Kansas Department of Health and Environment
Division of Health Care Finance
Public Notice

The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) is amending the Kansas Medicaid State Plan. The Centers for Medicare & Medicaid Services (CMS) announced that Section 1814(i)(5)(A)(i) of the Act was amended by the Consolidated Appropriations Act of 2021 (CAA) to increase the market basket reduction from 2 to 4 percentage points for any hospice provider that does not comply with the quality data submission requirements per fiscal year. The state is updating its reimbursement methodology for Hospice Care services to increase the market basket reduction from 2 to 4 percentage points.

The proposed effective date for the State Plan Amendment (SPA) is October 6, 2023.

Fee-For-Service Only	Estimated Federal Financial Participation
FFY 2024	$ 2,033
FFY 2025	$ 2,114

To request a copy of the proposed SPA, to submit a comment, or to review comments, please contact William C. Stelzner by email at william.stelzner@ks.gov , or by mail:

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The last day for public comment is November 6, 2023.

Draft copies of the proposed SPA may also be found at a Local Health Department (LHD).

Christine Osterlund
Interim Medicaid Director
Deputy Secretary of Agency Integration and Medicaid
Division of Health Care Finance
Kansas Department of Health and Environment

Hospice Services
Methods and Standards for Establishing Payment Rates

Payments for hospice services payments are effective October 1st annually and are equivalent to the annual Medicaid hospice rates published by CMS with the application of the current hospice wage index.

For each day that an individual is under the care of a hospice, the hospice is paid an amount applicable to the type and intensity of the service furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

A. Routine Home Care – The hospice is paid at one of two routine home care rates for each day the patient is under the care of the hospice and no other hospice rate is paid. This rate is paid without regard to the volume or intensity of services provided on any given day.

   1. Providers are paid at two different rates:
      a. Days 1 through 60;
      b. Days 61 and longer.

B. Continuous Home Care – The hospice is paid at the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. The hospice is paid for every hour or part of an hour that continuous care is furnished up to a maximum of 24 hours a day.

C. Inpatient Respite Care – The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Respite care is paid for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. The sixth and any subsequent days are paid at the routine home care rate.

D. General Inpatient Care – Payment is made at the general inpatient rate when general inpatient care is provided.

E. Service Intensity Add-on (SIA) – An SIA payment is paid for visits made by a social worker or a registered nurse, when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment will be equal to the continuous home care hourly rate, multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. The SIA payment will also be adjusted by the appropriate hospice wage index.

Hospice Nursing Facility Room and Board—Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income amount (amount an individual in an institution is able to contribute to cost of his/her own care) for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

Hospice providers that do not comply with hospice quality data submission will be subject to hospice payments with a 4% market basket reduction.

Physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on the lower of the actual charge or the Medicaid maximum allowable amount for the specific service.

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.