KANSAS
DEPARTMENT ON AGING

Mark Parkinson, Governor
Martin Kennedy, Secretary
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Senate Ways & Means
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SB 546/Provider Assessment

Bill McDaniel, Commissioner
KDOA Program and Policy

Chairman Emler and members of the committee, thank you for the opportunity to appear today in support of SB 546. I am Bill McDaniel, Commissioner of Program and Policy at the Kansas Department on Aging (KDOA).

A provider assessment for Kansas nursing homes is not a new idea. It has been proposed several times as a means of financing increases in nursing facility rates and quality improvement initiatives. While recognizing the value of such programs adopted in other states, KDOA remained neutral with regard to adopting such an assessment in Kansas. The neutral position was based on the fact that the provider community has been split on the issue

KDOA has shifted its position to support of the provider assessment because of the current fiscal crisis which has limited the State's ability to fund Medicaid services, including nursing facility rates. The provider assessment is a legitimate method of leveraging additional federal funds for the nursing home program and is approved by the Centers for Medicare and Medicaid Services (CMS). Currently, 36 states and the District of Columbia utilize a nursing home provider assessment.

The Department on Aging administers long term care services under KSA 75-5945 and would administer the assessment as described in SB 546. KDOA has tracked this issue closely, maintained on-going discussions with the nursing home provider associations and considered the experience of our consultants in evaluating provider assessment proposals.

KDOA staff members participated in the Kansas Health Policy Authority (KHPA) Nursing Facility Provider Assessment Advisory Committee meetings and were actively involved in the related technical workgroup meetings, which occurred periodically in 2008 and 2009. The technical workgroup prepared a report, "Nursing Facility Provider Assessment Parameters and Impact Analysis," which was presented and accepted by the KHPA board in January. Many of the parameters and mechanisms recommended in the report are included in SB 546.

It should be noted that SB 546 does not use the nursing home provider assessment to leverage federal funds for the Home and Community-Based Services (HCBS) Frail Elderly and Physically Disabled waivers. The HCBS advocates were members of the advisory committee and such provisions have been part of provider assessment bills put forth in recent years. Their inclusion offers an opportunity to support community-based services that have also been affected by recent budget constraints.

I have included with my testimony a copy of the KHPA report and the related Provider Assessment Summary/Model. The modeling demonstrated the ability to meet the federal requirements for a permissible health care related assessment. We will perform similar modeling for the parameters in SB 546 to help ensure a Medicaid State Plan will be approved by the federal Centers for Medicare and Medicaid Services.

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Nursing Facility Provider Assessment Parameters and Impact Analysis
To the KHPA Board: January 26, 2010

General Parameters

- Assess all Licensed Beds except for nursing facilities for mental health and the state operated Soldiers Home and Veterans Home
- Generate $15.97 million using a uniform rate of approximately $725
- A fund should be established to hold the assessment revenues, and the funds should only be used for the Medicaid NF and other Medicaid (HCBS) programs
- Split revenue 85/15 between NF program and other programs
- An advisory board would provide recommendations to the Secretary of Aging on how the funds should be used
- Add $33.38 million NF reimbursement system with adjustments for
    - Removing the 85% occupancy rule
    - Passing through the Medicaid share of the assessment
    - Applying additional inflation to all costs
    - Increasing incentive payments 250%
    - Spending up to $1,000,000 on a satisfaction survey program

Impact Analysis

- Fiscal Impact to Nursing Facilities
    - 314 homes (91%) gain and average of $57,408
    - 28 homes (8%) lose and average of $22,669
    - 2 homes (1%) neutral
- Provides $5.98 million for other programs such as HCBS
- Private pay impact
    - 36 new nursing homes would be subject to a private pay limit unless they raised their private pay rates (the average increase would be $4.56)
    - If any provider were to pass the assessment directly through to private pay residents, the expense would amount to about $2.30 per resident day

Pros and Cons

Pros	Cons
$40 M ($24 M net) Medicaid increase	Potential private pay increases
Reward quality performance	Some providers have net loss
Encourage Medicaid participation	Not all funding tied to quality
Encourage bed closure or recycling	

Cash Flow Analysis

- If enhancements were effective July 1st and assessment was collected quarterly by the end of the first month of each quarter, the nursing homes would have a net loss (of $1.2 M) for the first month but would be ahead from the second month on
- If enhancements were effective July 1st and assessment was collected quarterly due by the end of the quarter, the state would have a net loss (of $2.2 M total) for the first two months, but would be ahead from the third month on

Time Line

- CMS Regional staff have stated that the expectation would be to review both the assessment proposal and any related state plan amendment concurrently
    - The assessment proposal would be reviewed at the CMS central office
    - The state plan amendment would be reviewed at the regional office
- At least four months should be allowed to gain CMS approvals
    - For a July 1, 2010 effective date both the assessment proposal and related state plan amendment should be submitted no later than March 1, 2010, unless it would be implemented retroactively

Provider Assessment Summary

Assessment Input Parameters

Assessable Provider Options		# of Homes Excluded	
Include	State Operated Providers	0	
Include	Hospital Based LTCU	0	Total (Unduplicated) # of Homes Excluded
Include	NF-MH	0	0
Include	Government Owned Facilities	0	
Include	Continuing Care Ret. Comm. (CMS defined)	0	

Assessment Basis Options				Assessment Basis	Licensed Beds
Beds		Assessment Rates		Revenue Test	1.50%
		$725.00	< 500		
		$725.00	500 < Mdcd Days < 30000		
		$600.00	> 30000		
		$0.00	State Operated		
		$0.00	NF-MH		
23,093	Total Assessable Beds	$691.69	Average Assessment Rate	15,973,175	Revenue Generated

Statistical Tests

P1/P2	
P1	0.54
P2	0.53
P1/P2	1.011888

B1/B2	
B1	0.0000001659
B2	0.0000001536
B1/B2	1.079582

Provider Assessment Summary

Assessment Revenue Use

Assessment Revenue Distribution Options

		Assessment Contribution	FMAP Rate	Total New Program Funds	Net New Funds
0%	Non-Medicaid Programs	0	N/A	0	0
0%	Non-LTC Medicaid Programs	0	40.08%	0	0
15%	Medicaid Home and Community Based Services	2,395,976	40.08%	5,977,985	3,582,008
40%	Medicaid Nursing Facility Program Base Maintenance	6,389,270	40.08%	15,941,292	9,552,022
45%	Medicaid Nursing Facility Program - Quality Enhancements	7,187,929	40.08%	17,933,954	10,746,025
	Totals	15,973,175		39,853,231	23,880,056

NF Program Use and Impact

NF Reimbursement Program Adjustments

			Total Benefit	Homes Impacted	Subject to PPL
Remove 85% Occupancy Rule	for homes with < 200 beds	Yes	2,448,479	61	Yes
Cost Center Limit Adjustments					
	Operating Cost Center Limit Increase	0.00%	0	0	Yes
	IDHC Cost Center Limit Increase	0.00%	0	0	Yes
	DHC Cost Center Limit Increase	0.00%	0	0	Yes
Inflate the Real and Personal Property Fee					
	Additional Inflation		-	0	Yes
	New Limit	8.62			
Pass-Through Medicaid Share of Assessment		Yes	8,454,383	316	No
Apply Inflationary Increase					
	Inflation Factor	3.16%	16,273,206	324	Yes
Increased Funding for Current Incentive or Other Outcomes-Based Measure					
	Increase to Current Incentive	250.00%	5,207,138	255	No
Funding for Statewide Satisfaction Survey Program					
	PPD/RFP Limit	0.26	1,000,000	324	No

Provider Assessment Summary

NF Program/Provider Fiscal Impact Analysis

Total Increase to NF Program Expenditures	33,383,205.42				
Net Increase to NF Program Expenditures	17,410,030.42				
Number of Providers with Net Gain	314	Avg Gain	57,408	Max Gain	279,291
Number of Providers with Net Loss	28	Avg Loss	-22,669	Max Loss	-76,850
Number of Providers with 0 Impact	2				

The Losers

#	Loss		Avg % Medicaid	Avg # of Beds
28	-$22,669	(avg)	13%	52
4	over $40k		0%	82
9	$20-$40k		10%	66
15	under $20k		19%	36

The Winners

#	Gain		Avg % Medicaid	Avg # of Beds
314	$57,408	(avg)	57%	68
186	up to $50k		51%	56
78	$50-$100k		62%	76
50	over $100k		70%	103

The Average

#	Avg Gain		Avg % Medicaid	Avg # of Beds
344	$50,556	(avg)	53%	67