Approved: March 30, 2010
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Jay Emler at 10:30 a.m. on March 23, 2010, in Room 548-S of the Capitol.

All members were present.

Committee staff present:
J. G. Scott, Kansas Legislative Research Department
Michael Steiner, Kansas Legislative Research Department
Dylan Dear, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Estelle Montgomery, Kansas Legislative Research Department
Jill Wolters, Office of the Revisor of Statutes
Daniel Yoza, Office of the Revisor of Statutes
Melinda Gaul, Chief of Staff
Shirley Jepson, Committee Assistant
James Fisher, Intern

Conferees appearing before the Committee:
Cindy Luxem, Kansas Health Care Association
Barbara Conant, Department on Aging

Others attending:
See attached list.

Approval of Minutes

Senator McGinn moved to approve the minutes of March 17 and March 18, as written. The motion was seconded by Senator Umbarger. Motion carried on a voice vote.

Distribution of Information

Information, as requested by the Committee, regarding the Home Telehealth Pilot project from the University of Kansas, was distributed (Attachment 1).

Proposed Amendment to the Subcommittee Report on Kansas Health Policy Authority (KHPA)

Senator McGinn presented a proposed amendment to the Subcommittee report on the Kansas Health Policy Authority (KHPA) for FY 2011 recommending that the agency revert to and reinstate its reimbursement policies, practices, and methodology for durable medical equipment, which were in effect on December 31, 2009 (Attachment 2).

Senator McGinn moved for the adoption of the Subcommittee amendment to the Kansas Health Policy Authority report for FY 2011 (per Attachment 2). The motion was seconded by Senator Schmidt. Motion carried on a voice vote.

Responding to a question from the Committee, Amy Deckard, Legislative Research Department, explained that the addition of the proposed amendment would have no fiscal impact on the State General Fund (SGF).

- The Committee requested information on how the agency intends to pay for the policy change as put forth in the Subcommittee amendment.

Discussion and Action on SB 546 - Assessments of quality assurance fee on skilled nursing care facilities to improve the quality of care.

Senator Umbarger presented an amendment to **SB 546**, limiting the assessment on all facilities to $1,325 annually per licensed bed, delete specific language from the bill and amend language addressing the members of the quality care improvement panel (Attachment 3). An explainer on the amendment was also presented

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Minutes of the Senate Ways and Means Committee at 10:30 a.m. on March 23, 2010, in Room 548-S of the Capitol.

(Attachment 4).

A revised fiscal note on **SB 546** was distributed (Attachment 5). Estelle Montgomery, Legislative Research Department, explained that the original legislation and fiscal note addressed an assessment rate of $2,550 per bed which would have generated approximately $57 million. The proposed amendment reduces the assessment rate to $1,325 per bed which would generate approximately $30 million.

Responding to questions from the Committee, Cindy Luxem, Kansas Health Care Association, stated that the assessment rate was reduced to $1,325 when the amount necessary to cover the definitive reimbursement provisions of the bill was determined. Ms. Luxem noted that the state plan must be approved by the Center for Medicare and Medicaid Services (CMS) before any action by the state can take place regarding collection of the assessment. It is anticipated that the approval from CMS could take between 6 months and 1 year.

Barbara Conant, Director of Public Affairs, Department on Aging, stated that the $1,325 was established as a "break-even" assessment rate to cover the 10 percent Medicaid cut. Ms. Conant noted the bill contains a 1 percent allowance for administrative costs. The administrative allow was reduced to .25 percent by the House in their legislation.

Jill Wolters, Revisor, explained that the legislation addresses a start date of July 1, 2010. Ms. Wolters noted that the assessment rate will be retroactive to July 1, after approval from CMS is received.

Responding to a question from the Committee regarding oversight, J.G. Scott, Legislative Research Department, explained that the program will be addressed in the annual Medicaid audit as well as the single statewide audit.

Ms. Conant presented a balloon amendment to **SB 546** as proposed by the Department on Aging (Attachment 6).

Senator Umbarger moved to amend **SB 546** by adopting the amendments as proposed in Attachment 3. The motion was seconded by Senator Taddiken. Motion carried on a voice vote.

Senator Schmidt moved to amend **SB 546** on Page 3, Line 12, after the word "collected" by inserting "pursuant to subsection (b)". The motion was seconded by Senator Kelly. Motion carried on a voice vote.

Senator Lee moved to amend **SB 546** by adding language, at the Revisor's discretion, indicating that the money received from the quality care fund can not be used for bonuses other than direct care workers or for profit sharing. The motion was seconded by Senator Teichman. Motion carried on a voice vote.

Senator Kelly moved to amend **SB 546** by adding language on Page 5, Line 16, to provide oversight by directing the quality care improvement panel to report annually to the joint committee on health policy oversight as well as the legislature. The motion was seconded by Senator Apple. Motion carried on a voice vote.

Senator Kelly moved to strike the language on Page 1, Line 19 thru 22, referring to the exemption of the Kansas soldiers' home and the Kansas veterans' home. The motion was seconded by Senator Lee. Motion carried on a voice vote.

Senator Schmidt moved to adopt the balloon amendment to **SB 546** as proposed by the Department on Aging except to not strike the language on Page 1, Lines 17-18. The motion was seconded by Senator Kelly. Motion carried on a voice vote.

Senator Umbarger moved to strike the language from **HB 2320** and insert the contents of **SB 546** as amended for **Senate Substitute for HB 2320** and allow for technical adjustments as necessary. The motion was seconded by Senator Apple. Motion carried on a voice vote.

Senator Umbarger moved to recommend **Senate Substitute for HB 2320** favorable for passage. The motion

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was seconded by Senator Teichman. Motion carried on a voice vote. Senator McGinn requested to be recorded as voting "no".

Adjournment

The next meeting is scheduled for "on call of the chair".

The meeting was adjourned at 12:00 p.m.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE: __March 23, 2010___

NAME	REPRESENTING
Whitney Damron	Swisher Intl, Inc.
Danny Mays	Cigar Assn of America
Tom Palace	PMCA of KS
Jane Carter	KOSE
Levi Henry	Sandstone Group LLC
Bernie Koch	KEPC
Jen Bruning	OP Chamber
Robin Clements	DCCCA ; Youthville
Michelle Weigand	KTEC
Hattie Riegle	TFI
Steve Solomon	TFI
Dennis Phillips	KSCFF
Ed Redmon	KSCFF
TERRY FORSYTH	KNEA
Anne Marie Hughey	SKIL
Leigh Keck	Hein Law Firm
Rob Mealy	Kearney & Assoc.
April Holman	Kansas Action for Children
Dale Goter	City of Wichita
Jimi Rose	KCSL
Emily Ross	Sen. Taddiken
Hannah Edgar	Sen. Taddiken
Blaine Joonas	Sen. Taddiken

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE: __March 23, 2010___

NAME	REPRESENTING
Betty Joanou	Sen. Taddiken

KU THE UNIVERSITY OF KANSAS
Medical Center

March 19, 2010

Senator Jay Scott Emler
Chair, Ways and Means Committee
State Capitol, 545-S
300 SW 10th Avenue
Topeka, KS 66612

Dear Senator Emler:

Thank you for your letter dated March 10, 2010 inquiring about a telemedicine study being conducted at KUMC. Please find a letter from Dr. Ryan Spaulding, who is the Principal Investigator on this study, accompanying my response to you. His letter specifically outlines the answer to the question you asked regarding the completion of the study.

Thank you for your interest and please do not hesitate to contact me if you need any additional information on this or any topic relating to KUMC.

Sincerely,

Barbara Atkinson MD

Barbara Atkinson, MD
Executive Vice Chancellor
Executive Dean, School of Medicine

Encl.

Office of the Executive Vice Chancellor
Mail Stop 2015 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | (913) 588-1440 | Fax (913)

Senate Ways & Means Cmte
Date 3-23-2010
Attachment 1

Home Telehealth Pilot
Project Evaluation – Year 2

INTRODUCTION

The evaluation of Windsor Place's Home Telehealth Pilot continued through a second year beginning on June 1, 2008. The original HCBS clients from Year 1 of the pilot continued to participate in Year 2 while additional clients were added to the study. The ongoing research objective of the pilot was to assess the cost-benefit of home telehealth services across a variety of variables. Of particular interest were the more longitudinal results of Year 1 participants as they progressed through a longer period of study.

METHODS

All enrolled participants were Kansas HCBS clients, primarily from the Windsor Place service region in southeast Kansas near Coffeyville. A few clients from areas closer to Kansas City and Lawrence were selected due to the limited number of HCBS clients located near Coffeyville that fit the selection criteria.

The HCBS clients chosen for the study all had at least 1 hospitalization in the 12 months prior to their enrollment. Before receiving telehealth monitoring equipment, they provided signed Informed Consent for participating in the study and agreed to assist researchers with collecting their Centers for Medicare and Medicaid Services (CMS) claims data. These data were used to calculate the variables of interest in this study.

The research method used in the project was a within group, pre- and post-test design with data collection completed at the end of the project for both the baseline and intervention periods. The length of the baseline period was equal to the length of the intervention period for Year 2 clients. For example, if a client was on home telehealth monitoring for 223 days, the baseline period was also established as 223 days. For both Year 1 and Year 2 clients, the baseline was capped at 274 days, or approximately 9 months. This was done to standardize the baseline period for both Year 1 and Year 2 in order to complete the appropriate statistical analyses.

In addition to emergency department (E.D) and hospital utilization—and the associated costs—general client perceptions of the intervention were also gathered during the last month of Year 2. The 12 perception items assessed such issues as the patients' satisfaction with the technology, its effect on their health, safety and quality of life, and other items.

Linear regression statistical models were used to analyze the outcome data for the project. These models are robust for the uneven parameters in this study, such as the varying lengths of time in the study across participants and the unequal baseline and intervention periods. In addition, variable data were calculated as rates of utilization, such as E.D. visits per day and hospitalizations per day, in order to account for the varying periods of analysis. For the 12 perception items, means were calculated based on a scale ranging from 1 to 4, with 1 corresponding to strong disagreement and 4 corresponding to strong agreement on the items.

RESULTS

During Years 1 and 2, a total of 88 HCBS clients were enrolled in the home telehealth pilot. Fifty-nine of these remained active in the program at the end of the analysis period. The other 29 clients left the project for a variety of reasons. Thirteen passed away, 3 went to a nursing facility, 4 entered assisted

living, 8 quit and 1 moved away. Active Year 1 clients had 730 days of intervention and Year 2 clients had 313 days of intervention for inclusion. All 88 enrollees were included in the analysis as a result of using statistical methods that accounted for the varying lengths of time in the study.

The study group consisted of 73 women and 15 men. Ages ranged from 65 to 96 years, with an average age of 79. Hypertension was the single most common diagnosis with 15 clients having this condition. Eleven people had congestive heart failure (CHF), followed by diabetes (9) and chronic obstructive pulmonary disorder (COPD; 4). The remaining 49 participants had multiple comorbidities of these four illnesses.

All six variables studied in this pilot trended lower during the telehealth period as indicated by the average rates—or mean rates—listed in Table 1. One variable—E.D. visits—was statistically lower than the baseline observation. These data mean that there is likely an effect of the telehealth intervention on the study participants but that there are not enough data to detect a statistical change. More participants studied over a longer period will provide more statistical power to detect an effect. The E.D. result, though significant, was a weak association.

Variable	Baseline Mean	Intervention Mean	Significant Change?
Hospital Visits	1.7	1.6	No
Hospital Days	22.3	17.6	No
Hospital Costs	$60,253	$40,507	No
E.D. Visits	.52	.28	Yes
E.D. Costs	$3754	$1808	No
Total Costs	$94,535	$85,807	No

Table 1: Comparison of baseline and intervention mean rates of pilot variables.

Participants' perceptions of the intervention were positive. These items were scored on a scale of one to four ranging from strongly disagree to strongly agree, respectively. Two of the items were reverse coded which resulted in lower mean scores but indicated a positive response. The other ten items were all positively scored with means ranging from 2.93 to 3.35 on a four-point scale. For example, patients felt that the technology improved their health care (3.15), would help them live longer in their homes (3.36) and helped them better manage their health care (3.28). In contrast, they did not want to go to the doctor rather than use the technology (2.08) and they were not distrustful of the technology (1.96). See Table 2. It should be noted that Year 1 participants rated their perceptions higher after the second year of intervention than they rated them after the first year. This indicates that participants' perceptions became more positive over time. See Table 3 for updated perceptions of Year 1 HCBS clients.

Item	Mean (On 1-4 scale)
This health monitoring technology improves my health care.	3.15
I would rather go to my doctor than use this technology.	2.08
This technology improves my life.	3.04
I am more involved in my health care as a result of this technology.	3.19
I do not trust this technology to help me with my health.	1.96
This technology will help me live in my home longer.	3.36
Using this technology has been a positive experience for me.	3.34
This technology is easy to use.	3.26
I am confident that this technology will help me if my health starts to decline.	3.26
I feel better able to manage my health care with use of this technology than I did before.	3.28
I have gone to my doctor at least once because of what I found out with the technology.	2.94
I would like to use this technology for as long as I can.	3.33

Table 2: Mean scores of perception items on 1 (strongly disagree) to 4 (strongly agree) Likert scale for Year 1 and Year 2 participants.

Item	Mean (On 1-4 scale)
This health monitoring technology improves my health care.	3.30
I would rather go to my doctor than use this technology.	2.04
This technology improves my life.	3.09
I am more involved in my health care as a result of this technology.	3.35
I do not trust this technology to help me with my health.	2.00
This technology will help me live in my home longer.	3.52
Using this technology has been a positive experience for me.	3.48
This technology is easy to use.	3.39
I am confident that this technology will help me if my health starts to decline.	3.30
I feel better able to manage my health care with use of this technology than I did before.	3.09
I have gone to my doctor at least once because of what I found out with the technology.	3.35
I would like to use this technology for as long as I can.	3.39

Table 3: Mean scores of perception items on 1 (strongly disagree) to 4 (strongly agree) Likert scale for Year 1 participants after 2 years of telehealth.

DISCUSSION

The results of this home telehealth pilot project confirmed Year 1 results that indicated that it is technologically and logistically feasible to use home telehealth monitoring to assist HCBS clients. While the variables trended lower and were weak associations, they indicated that telehealth may have a positive effect on these outcomes. The observed indicators may become significant over time in a longer project with more participants as more data is included in the analysis. Ongoing study is recommended.

Also, a very large age range of 31 years was observed in this study. It is unlikely that telehealth monitoring affects all HCBS clients of this wide age range in the same manner. More specifically, it is possible that some clients who are benefiting from telehealth monitoring are being statistically "canceled" by other clients in the study who use many health services, particularly toward the end of life. A more focused selection of similar HCBS clients for participation in the study may be one way to control for this dynamic.

The findings also confirmed HCBS patients' satisfaction with the intervention, particularly over time. This may indicate an increasing comfort level with the technology and a sense that it has become vital to their long-term health care success. Follow-up interviews or additional survey questions may provide some explanation for the survey results.

One question that could arise from this type of monitoring project is the presence of the Hawthorne effect in determining the outcomes of the study. The Hawthorne effect refers to a change in behavior of the study subjects as a result of being observed rather than the intervention itself. While this is normally an undesirable dynamic, in the case of home telehealth monitoring—by definition—observation is actually a component of the intervention. It is likely that future home telehealth projects will always have a monitoring aspect. Thus, the Hawthorne effect does not apply to this study or to home monitoring projects as a confounding variable.

As noted in the Year 1 report, it would be useful to monitor nursing home admissions and deferrals. These data will be most important for assessing the effect of home telehealth on state Medicaid expenditures. This variable is planned for Year 3 of the project.

In summary, the home telehealth pilot continues to be successful from a number of perspectives. While more evaluation is needed, these data indicated a positive trend toward reduced health care costs and resource utilization as a result of home telehealth monitoring.

The University of Kansas Medical Center

Center for TeleMedicine & TeleHealth

March 16, 2010

Senator Jay Scott Emler
State Senator, 35th District
State Capitol 545-S
Topeka, KS 66612

Dear Senator Emler,

I am writing in response to your letter to Dr. Barbara Atkinson dated 3/10/10. As the Principal Investigator on the telehealth pilot study referenced in your correspondence, I am pleased to update you on the study progress.

Earlier this year I provided a report to the Kansas Department on Aging outlining the results of Years 1 and 2 of the pilot study. The results were encouraging but not conclusive. I have enclosed a copy of that report for your review.

We are currently in Year 3 of the pilot study. Participants for Year 3 were enrolled in the project as late as February 2010. As a result, their participation in the project and their data are incomplete, making any analysis of the data impractical at this time. We will have more complete data later this summer and will complete our analysis in the fall. At that time, we will submit a final project report to KDOA for review and completion of the pilot study. We will be pleased to send you a copy as well.

I hope this information is helpful. Please let me know if you have any further questions.

Sincerely,

Ryan Spaulding, PhD
Director

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3901 Rainbow Blvd. Kansas City, KS 66160-7171 913-588-2226 Fax: 913-588-2227

Proposed Addition to the Kansas Health Policy Authority FY 2011 Subcommittee Report

The Senate Committee recommends that agency reverts to and reinstates its reimbursement polices, practices, and methodology for durable medical equipment, which were in effect on December 31, 2009, and the the agency meet with all interested parties with the intention of establishing provider reimbursements sufficient to enlist enough qualified providers so that health care products and services will be available to recipients, at least to the extent that the products are available to the general public, with such reimbursements to be implemented not before August 31, 2010.

The Senate Committee notes that this recommendation is in response to information which indicated the Durable Medical Equipment providers are currently refusing services to Medicaid recipients in response to the 10.0 percent provider reimbursement reduction and payment reforms implemented by the agency, including requiring durable medical equipment supplies provide the actual costs of products to ensure reimbursement no greater than 135 percent of costs, review potential overpayments, and the intent of the agency to pursue manufacturer rebate programs.

Senate Ways & Means Cmte
Date 3-23-2010
Attachment 2

Proposed amei
March 22, 201(

Senate Ways & Means Cmte
Date 3-26-2010
Attachment 3

Session of 2010

SENATE BILL No. 546

By Committee on Ways and Means

2-15

AN ACT providing for assessments on certain nursing facilities; prescribing powers, duties and functions for the Kansas health policy authority; creating the quality care assessment fund; providing for implementation and administration.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) As used in this section, and amendments thereto, unless the context requires otherwise:

(1) Words and phrases have the meanings respectively ascribed thereto by K.S.A. 39-923 and amendments thereto.

(2) "Skilled nursing care facility" means a licensed nursing facility providing skilled nursing care but shall not include the following: Skilled nursing care facilities which are waived from paying the assessment, the Kansas soldiers' home and the Kansas veterans' home.

(3) "Licensed bed" means those beds within a skilled nursing care facility which the facility is licensed to operate.

(4) "Authority" means the Kansas health policy authority.

(b) (1) Except as otherwise provided in this section and in subsection (f), there is hereby imposed and the authority shall assess an annual, uniform assessment per licensed bed, hereinafter called a quality care assessment, on each skilled nursing care facility. The assessment on all facilities in the aggregate shall be an amount fixed by rules and regulations of the authority, shall not exceed ~~the maximum percentage of nursing facility inpatient revenues allowed under federal law~~ and shall be imposed as an amount per licensed bed. No rules and regulations of the authority shall grant any exception to or exemption from the quality care assessment. The assessment shall be paid quarterly, with one fourth of the annual amount due by the 30th day after the end of the month of each calendar quarter. The assessment made for years subsequent to the third year from the date the provisions of this section are implemented shall not exceed 60% of the first assessment made under this section.

$1,325 annually per licensed bed

(2) Beds licensed after July 1 each year shall pay a prorated amount of the applicable annual assessment so that the assessment applies only for the days such new beds are licensed. The proration shall be calculated by multiplying the applicable assessment by the percentage of days the

Office of Revisor of Statutes
JWolters 3/22

beds are licensed during the year. Any change which reduces the number of licensed beds in a facility shall not result in a refund being issued to the skilled nursing facility.

(3) If an entity conducts, operates or maintains more than one licensed skilled nursing care facility, the entity shall pay the nursing facility assessment for each facility separately. No skilled nursing care facility shall create a separate line-item charge for the purpose of passing through the quality care assessment to residents. No skilled nursing care facility shall be guaranteed, expressly or otherwise, that any additional moneys paid to the facility under this section will equal or exceed the amount of its quality care assessment.

(4) The payment of the quality care assessment to the authority shall be an allowable cost for medicaid reimbursement purposes. A rate adjustment pursuant to paragraph (5) of subsection (d) shall be made effective on the date of imposition of the assessment, to reimburse the portion of this cost imposed on medicaid days.

(c) Each skilled nursing care facility shall prepare and submit to the authority any additional information required and requested by the authority to implement or administer the provisions of this section.

(d) (1) There is hereby created in the state treasury the quality care fund, which shall be administered by the authority. All moneys received for the assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the quality care fund. All expenditures from the quality care fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the authority or the authority's designee.

(2) All moneys in the quality care fund shall be used to finance initiatives to maintain or improve the quantity and quality of skilled nursing care in skilled nursing care facilities in Kansas. No moneys credited to the quality care fund shall be transferred to or otherwise revert to the state general fund at any time. Notwithstanding the provisions of any other law to the contrary, if any moneys credited to the quality care fund are transferred or otherwise revert to the state general fund, 30 days following the transfer or reversion the quality care assessment shall terminate and the authority shall discontinue the imposition, assessment and collection of the assessment. Upon termination of the assessment, all collected assessment revenues, including the moneys inappropriately transferred or reverting to the state general fund, less any amounts expended by the authority, shall be returned on a pro rata basis to skilled nursing

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3-3

care facilities that paid the assessment.

(3) Any moneys received by the state of Kansas from the federal government as a result of federal financial participation in the state medicaid program that are derived from the quality care assessment shall be used to finance actions to maintain or increase healthcare in skilled nursing care facilities.

(4) Moneys in the fund shall be used exclusively for the following purposes:

(A) To pay administrative expenses incurred by the authority or its agent in performing the activities authorized by this section, except that such expenses shall not exceed a total of 1% of the aggregate assessment funds collected for the prior fiscal year;

(B) to increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as may be negotiated;

(C) to reimburse the medicaid share of the quality care assessment as a pass-through medicaid allowable cost;

(D) to restore the medicaid rate reductions implemented January 1, 2010;

(E) to restore funding for fiscal year 2010, including re- basing and inflation;

(F) The remaining amount, if any, shall be expended for quality enhancement of skilled nursing care facilities but shall not be used directly or indirectly to replace existing state expenditures for payments to skilled nursing care facilities for providing services pursuant to the state medicaid program.

(5) ~~Of the amount allocated pursuant to this subsection to increase or supplement the rates paid to skilled nursing care facilities for providing services pursuant to the state medicaid program, a rate adjustment shall first be made to reimburse the portion of the assessment imposed.~~

~~(6)~~ Adjustment payments shall be paid on a quarterly basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit. (6)

~~(7)~~ On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the quality care fund interest earnings based on:

(A) The average daily balance of moneys in the quality care fund for the preceding month; and

(B) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) If a skilled nursing care facility fails to pay the full amount of the quality care assessment imposed pursuant to subsection (b), when due and payable, including any extensions of time granted under that subsec-

tion, the authority shall assess a penalty in the amount of the lesser of $500 per day or 2% of the quality care assessment owed for each day the assessment is delinquent.

(f) (1) The authority shall assess and collect quality care assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), from skilled nursing care facilities on and after July 1, 2010, except that no assessments or penalties shall be assessed under subsections (a) through (f) until:

(A) An amendment to the state plan for medicaid, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (f) is approved by the federal government; and

(B) the skilled nursing care facilities have been compensated retroactively at the increased rate for services provided pursuant to the federal medicaid program for the period commencing on and after July 1, 2010.

(2) The authority shall implement and administer the provisions of subsections (a) through (f)in a manner consistent with applicable federal medicaid laws and regulations. The authority shall seek any necessary approvals by the federal government that are required for the implementation of subsections (a) through (f).

(3) The provisions of subsections (a) through (f) shall be null and void and shall have no force and effect if either of the following occur:

(A) The medicaid plan amendment, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (f)is not approved by the federal centers for medicare and medicaid services; or

(B) the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program are reduced below the rates calculated on June 30, 2010, increased by revenues in the quality care fund and matched by federal financial participation and rebasing as provided for in K.S.A. 2009 Supp. 75-5958, and amendments thereto.

(g) If the provisions of subsections (a) through (f) are repealed, expire or become null and void and have no further force and effect, all moneys in the quality care fund which were paid under the provisions of subsections (a) through (f) shall be returned to the skilled nursing care facilities which paid such moneys on the basis on which such payments were assessed and paid pursuant to subsections (a) through (f).

(h) The authority may adopt rules and regulations necessary to implement the provisions of this section.

(i) For purposes of administering and selecting the reimbursements

3-4

of moneys in the quality care assessment fund, the quality care improvement panel is hereby established. The panel shall consist of the following members: Two persons appointed by Kansas homes and services for the aging; two persons appointed by the Kansas health care association; one person appointed by Kansas advocates for better care; one person appointed by the governor who is an executive of a Kansas adult care home not affiliated with any of the trade organizations specified in this subsection; one person appointed by the Kansas foundation for medical care; one person appointed by the governor from the department on aging; and one person appointed by the governor from the Kansas health policy authority. The panel shall meet as soon as possible subsequent to the effective date of this act and shall elect a chairperson from among the members appointed by the trade organizations specified in this subsection. The members of the quality care improvement panel shall serve without compensation or expenses. The quality care improvement panel shall report annually on or before January 10 to the legislature concerning the activities of the panel during the preceding calendar year and any recommendations which the panel may have concerning the administration of and expenditures from the quality care assessment fund.

(j) The authority shall certify to the director of the budget of the department of administration the date upon which the provisions of this section are implemented. The provisions of this section shall expire four years subsequent to the implementation of this section.

Sec. 2. This act shall take effect and be in force from and after its publication in the Kansas register.

one person appointed by the Kansas hospital association;

a member of the Kansas adult care executives association,

and whose employing home is

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Proposed amendment to SB 546
March 23, 2010

1. The amendment limits the assessment to $1,325 annually, per bed. In the bill, the assessment would not exceed "the maximum percentage of nursing facility inpatient revenues allowed under federal law." At the time the bill was introduced, the amount was unknown. The $1325 was what Dept. on Aging determined the assessment needed to be to generate the SGF necessary to cover the definitive reimbursement provisions of the bill. Those definitive reimbursement provisions included restoring the 10% cut for Jan-Jun requiring about $6.8 million SGF, rebasing and inflating NF rates requiring approximately $17.8 million, and passing through the Medicaid share of the assessment requiring around $5.7 million. The total required SGF then is approximately $30.3 million. With 22,978 licensed beds an assessment of $1325 would generate about $30.45 million and provide enough SGF to cover the definitive reimbursement provisions and still provide funds for the administration of the assessment.

2. Page 3, striking lines 27-30. States are not allowed, pursuant to federal guidelines, to attempt to hold harmless facilities. There were some concerns that the stricken language would be viewed as a hold harmless by CMS. The language could be interpreted as a way to shelter some providers from the assessment. If this provision was deemed to be a hold harmless, CMS would disallow the assessment.

3. Adds one member to the quality care improvement panel, appointed by the Kansas hospital association, and clarifies that the member appointed by the Governor who is an executive of an adult care home not affiliated with a trade organization otherwise represented on the panel will be a member of the Kansas adult care executives association.

Senate Ways & Means Cmte
Date 3-23-2010
Attachment 4

KANSAS
DEPARTMENT ON AGING

Mark Parkinson, Governor
Martin Kennedy, Secretary
www.agingkansas.org

REVISED 3/23/10

March 23, 2010

Duane Goossen, Director
Division of the Budget
900 SW Jackson, Rm. 504
Topeka, KS 66612-1575

RE: SB 546

Dear Mr. Goossen,

The following information is in response to a March 23, 2010 request regarding SB 546.

Analysis: SB 546 concerns the establishment of a new quarterly assessment on licensed nursing facility beds excluding the Veterans Home at Winfield and the Soldiers Home at Fort Dodge. The assessment amount is not specified, but the assessment revenue generated would be used to establish the quality care fund. The quality care fund would be eligible for federal matching funds. The quality care fund must be spent as follows:

Up to 1% - "To pay administrative expenses incurred by the authority or its agents..."

The balance would be used to increase nursing facility payments: "to reimburse the Medicaid share of the quality care assessment"; "to restore Medicaid rate reductions implemented January 1, 2010"; "to restore funding for fiscal year 2010, including re-basing and inflation"; and "for quality enhancement of skilled nursing facilities."

Affect on Agency Responsibility: SB 546 delegates responsibility for the implementation and administration of this bill to the Kansas Health Policy Authority or its agent. Since the Department on Aging licenses nursing facilities and manages the Medicaid nursing facility program, KDOA will act as agent for KHPA and manage the quality care assessment. The bill allows for administration costs to be paid out of the generated assessment funds. The agency requests funding for two FTEs to implement and administer the program(s) created by this bill, and to track required payments back to the facilities. The agency also requests a consulting allowance to acquire expert analysis and guidance to insure compliance with federal regulations.

Fiscal Impact: To effectively implement and administer this new program, the agency will need to hire one Program Consultant II and one Senior Administrative Specialist, and also obtain consultant services for a total cost of $124,774 ($59,519 SGF). This includes one-time costs to set-up work space, and all on-going cost including professional fees for rate setting.

The following agency estimates are based on the Governor's recommended nursing facility budget of $373.7 million ($133,149,324 SGF) in fiscal year 2011 which restored the Medicaid

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rate reductions implemented on January 1, 2010. The agency estimates that it would require an additional $50.8 million ($17,766,027 SGF) to re-base to the three most recent cost report years (2007-2009) and apply inflation to the midpoint of FY 2011. The agency estimates that it will require $19.4 million ($6,806,907 SGF) to restore the Medicaid cuts imposed between January 1, 2010 and June 30, 2010. The agency also estimates that it will take $16.2 million ($5,676,143 SGF) to pass-through the Medicaid share of the quality care assessment.

To fulfill the prescribed funding obligations, the agency estimates the assessment would need to generate approximately $30.4 million and result in an annual assessment of approximately $1,325 per bed.

The agency estimates that federal regulations would allow for an assessment that would generate approximately $57.3 million. This would require an annual assessment of approximately $2,550 per bed. It would produce a balance of $26.9 million in additional revenue that when matched with federal Medicaid dollars would result in $75.6 million available for other quality enhancements.

Assumptions Used: The agency estimates that expenditures for FY 10 would have been approximately $370.0 million without the Medicaid cut implemented January 1, 2010. The agency also estimates that expenditures would have increased about 1% to $373.3 million from FY 2010 to FY 2011. The agency estimates that rebasing to the three most current cost reports and inflating to the midpoint of FY 2011 would increase expenditures another 13.05%. The agency estimates that there are approximately 22,978 licensed nursing facility beds that would be subject to the assessment.

Staffing Impact: KDOA will hire 2 FTEs - one Program Consultant II and one Senior Administrative Specialist.

Long-Range Fiscal Effect: The ongoing costs to administration associated with this bill include wages, benefits, rent, utilities, communication, professional fees for rate setting, and general supplies for SFY 2010. Future years may increase by any approved pay plan or any changes in the ongoing costs. Nursing facility program expenditures will increase approximately $86.6 million ($30.3 SGF) or about 23.2% beyond the recommended budget. These expenditures will increase the base Medicaid budget in future years.

Sincerely,

Barbara A. Conant
Director of Public Affairs

DH/HEB

c: Julie Thomas, DOB
Martin Kennedy, KDOA Secretary
Alice Knatt, KDOA Commissioner
Bill McDaniel, KDOA Commissioner
Greg Reser, KDOA Commissioner
Heidi Burris, KDOA Budget Director

Session of 2010

SENATE BILL No. 546

By Committee on Ways and Means

2-15

AN ACT providing for assessments on certain nursing facilities; prescribing powers, duties and functions for the Kansas health policy authority; creating the quality care assessment fund; providing for implementation and administration.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) As used in this section, and amendments thereto, unless the context requires otherwise:

~~(1) Words and phrases have the meanings respectively ascribed thereto by K.S.A. 39-923 and amendments thereto.~~

(1)~~(2)~~ "Skilled nursing care facility" means a licensed nursing facility providing skilled nursing care but shall not include the following: Skilled nursing care facilities which are waived from paying the assessment~~,~~ the Kansas soldiers' home and the Kansas veterans' home.

(2)~~(3)~~ "Licensed bed" means those beds within a skilled nursing care facility which the facility is licensed to operate.

(3)~~(4)~~ "Authority" means the Kansas health policy authority.

(b) (1) Except as otherwise provided in this section and in subsection (f), there is hereby imposed and the authority shall assess an annual, uniform assessment per licensed bed, hereinafter called a quality care assessment, on each skilled nursing care facility. The assessment on all facilities in the aggregate shall be an amount fixed by rules and regulations of the authority, shall not exceed the maximum percentage of nursing facility inpatient revenues allowed under federal law and shall be imposed as an amount per licensed bed. No rules and regulations of the authority shall grant any exception to or exemption from the quality care assessment. The assessment shall be paid quarterly, with one fourth of the annual amount due by the 30th day after the end of the month of each calendar quarter. The assessment made for years subsequent to the third year from the date the provisions of this section are implemented shall not exceed 60% of the first assessment made under this section.

(2) Beds licensed after July 1 each year shall pay a prorated amount of the applicable annual assessment so that the assessment applies only for the days such new beds are licensed. The proration shall be calculated by multiplying the applicable assessment by the percentage of days the

Senate Committee on Ways & Means

Balloon amendment for SB 546

3/23/10 Doug Taylor

, nursing facility for mental health as defined in K.S.A. 39-923, and amendments thereto, or a hospital long term care unit licensed by the Kansas department of health and environment.

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(4) "Agent" means the Kansas department on aging.

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beds are licensed during the year. Any change which reduces the number of licensed beds in a facility shall not result in a refund being issued to the skilled nursing facility.

(3) If an entity conducts, operates or maintains more than one licensed skilled nursing care facility, the entity shall pay the nursing facility assessment for each facility separately. No skilled nursing care facility shall create a separate line-item charge for the purpose of passing through the quality care assessment to residents. No skilled nursing care facility shall be guaranteed, expressly or otherwise, that any additional moneys paid to the facility under this section will equal or exceed the amount of its quality care assessment.

(4) The payment of the quality care assessment to the authority shall be an allowable cost for medicaid reimbursement purposes. A rate adjustment pursuant to paragraph (5) of subsection (d) shall be made effective on the date of imposition of the assessment, to reimburse the portion of this cost imposed on medicaid days.

(c) Each skilled nursing care facility shall prepare and submit to the authority any additional information required and requested by the authority to implement or administer the provisions of this section.

(d) (1) There is hereby created in the state treasury the quality care fund, which shall be administered by the authority. All moneys received for the assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the quality care fund. All expenditures from the quality care fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the authority or the authority's ~~designee~~ agent.

(2) All moneys in the quality care fund shall be used to finance initiatives to maintain or improve the quantity and quality of skilled nursing care in skilled nursing care facilities in Kansas. No moneys credited to the quality care fund shall be transferred to or otherwise revert to the state general fund at any time. Notwithstanding the provisions of any other law to the contrary, if any moneys credited to the quality care fund are transferred or otherwise revert to the state general fund, 30 days following the transfer or reversion the quality care assessment shall terminate and the authority shall discontinue the imposition, assessment and collection of the assessment. Upon termination of the assessment, all collected assessment revenues, including the moneys inappropriately transferred or reverting to the state general fund, less any amounts expended by the authority, shall be returned on a pro rata basis to skilled nursing

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care facilities that paid the assessment.

(3) Any moneys received by the state of Kansas from the federal government as a result of federal financial participation in the state medicaid program that are derived from the quality care assessment shall be used to finance actions to maintain or increase healthcare in skilled nursing care facilities.

(4) Moneys in the fund shall be used exclusively for the following purposes:

(A) To pay administrative expenses incurred by the authority or ~~its~~ the agent in performing the activities authorized by this section, except that such expenses shall not exceed a total of 1% of the aggregate assessment funds collected for the prior fiscal year;

(B) to increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as may be negotiated;

(C) to reimburse the medicaid share of the quality care assessment as a pass-through medicaid allowable cost;

(D) to restore the medicaid rate reductions implemented January 1, 2010;

(E) to restore funding for fiscal year 2010, including re- basing and inflation;

(F) The remaining amount, if any, shall be expended for quality enhancement of skilled nursing care facilities but shall not be used directly or indirectly to replace existing state expenditures for payments to skilled nursing care facilities for providing services pursuant to the state medicaid program.

(5) Of the amount allocated pursuant to this subsection to increase or supplement the rates paid to skilled nursing care facilities for providing services pursuant to the state medicaid program, a rate adjustment shall first be made to reimburse the portion of the assessment imposed.

(6) Adjustment payments shall be paid on a quarterly basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit.

(7) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the quality care fund interest earnings based on:

(A) The average daily balance of moneys in the quality care fund for the preceding month; and

(B) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) If a skilled nursing care facility fails to pay the full amount of the quality care assessment imposed pursuant to subsection (b), when due and payable, including any extensions of time granted under that subsec-

tion, the authority shall assess a penalty in the amount of the lesser of $500 per day or 2% of the quality care assessment owed for each day the assessment is delinquent.

(f) (1) The authority shall assess and collect quality care assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), from skilled nursing care facilities on and after July 1, 2010, except that no assessments or penalties shall be assessed under subsections (a) through (f) until:

(A) An amendment to the state plan for medicaid, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (f) is approved by the federal government; and

(B) the skilled nursing care facilities have been compensated retroactively at the increased rate for services provided pursuant to the federal medicaid program for the period commencing on and after July 1, 2010.

(2) The authority shall implement and administer the provisions of subsections (a) through (f)in a manner consistent with applicable federal medicaid laws and regulations. The authority shall seek any necessary approvals by the federal government that are required for the implementation of subsections (a) through (f).

(3) The provisions of subsections (a) through (f) shall be null and void and shall have no force and effect if either of the following occur:

(A) The medicaid plan amendment, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (f)is not approved by the federal centers for medicare and medicaid services; or

(B) the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program are reduced below the rates calculated on June 30, 2010, increased by revenues in the quality care fund and matched by federal financial participation and rebasing as provided for in K.S.A. 2009 Supp. 75-5958, and amendments thereto.

(g) If the provisions of subsections (a) through (f) are repealed, expire or become null and void and have no further force and effect, all moneys in the quality care fund which were paid under the provisions of subsections (a) through (f) shall be returned to the skilled nursing care facilities which paid such moneys on the basis on which such payments were assessed and paid pursuant to subsections (a) through (f).

(h) The authority may adopt rules and regulations necessary to implement the provisions of this section.

(i) For purposes of administering and selecting the reimbursements

of moneys in the quality care assessment fund, the quality care improvement panel is hereby established. The panel shall consist of the following members: Two persons appointed by Kansas homes and services for the aging; two persons appointed by the Kansas health care association; one person appointed by Kansas advocates for better care; one person appointed by the governor who is an executive of a Kansas adult care home not affiliated with any of the trade organizations specified in this subsection; one person appointed by the Kansas foundation for medical care; one person appointed by the governor from the department on aging; and one person appointed by the governor from the Kansas health policy authority. The panel shall meet as soon as possible subsequent to the effective date of this act and shall elect a chairperson from among the members appointed by the trade organizations specified in this subsection. The members of the quality care improvement panel shall serve without compensation or expenses. The quality care improvement panel shall report annually on or before January 10 to the legislature concerning the activities of the panel during the preceding calendar year and any recommendations which the panel may have concerning the administration of and expenditures from the quality care assessment fund.

(j) The authority shall certify to the director of the budget of the department of administration the date upon which the provisions of this section are implemented. The provisions of this section shall expire four years subsequent to the implementation of this section.

Sec. 2. This act shall take effect and be in force from and after its publication in the Kansas register.

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