KANSAS ADVOCATES for BETTER CARE
making elder care better every day

February 24, 2020

Chairwoman McGinn and Members of the Senate Ways and Means Committee,

Kansas Advocates for Better Care appreciates the opportunity to address the committee on SB 409 and ways the bill before you can better serve older Kansans residing in nursing facilities.

Recommendation 1. Amend SB 409 to include the recommendation of the Quality Care Improvement Panel for a five year sunset of the assessment to July 1, 2025.

- Tax payers deserve accountability for use of their public dollars.
- Older Kansans deserve legislative oversight of State programs intended to assure their health and support.

Recommendation 2. Assign the 35% enriched federal Medicaid match drawn down from the Quality Care Provider Assessment to fund one or more improvement outcomes which are specific and measurable, and which provide clear benefit to older Kansans.

- Otherwise this program serves only as a handout of tax payer dollars to nursing facilities, both non-profit and for profit who are not delivering good care.
- Under the current scenario facilities receive funding regardless of the adequacy of the care elders in a given facility receives.
- Without specific measureable improvements, the program does not function as an incentive for better care of elder Kansans.

Quality care maintenance and improvement: one option

Nursing staff are the people who make the difference between someone actually coming when an elder Kansan asks for help to go the bathroom or sitting in their own urine and feces. When an older adult needs help to eat, nursing staff makes the difference between getting adequate nutrition or losing weight and failing to thrive. Nursing staff are the people who make the difference in preventing bed sores, regularly repositioning an elder who has limited mobility or the pain, infection, and suffering that comes from the wounds that will occur without it.

Nurses and Nurse Aides required to achieve minimum safe care is 4.1 hours per resident per day.

Kansas has fewer than 100 facilities which meet this safety threshold.[1] The elders in the remaining 250 nursing facilities in the state receive less care than study after study shows is needed to prevent injury, illness and death that is unnecessary and avoidable.

[1] nursinghome411.org/nursing-home-data-information/staffing/ Payroll reporting to CMS for staff whose job responsibilities are direct care of residents Q1 2019

Kansas had 53 facilities CMS rated one-star in August 2019: 36 were for profit, 8 government, 9 non-profit. [2] CMS defines one-star facilities as *much below average quality*

You have an opportunity with this bill and enriched federal funding to make a real difference in the quality of care that every older Kansan receives.

Recommendation 1.

Placement: Page 7, line 12. Remove the strike through of existing statutory language in (l) which reads: The provisions of this section shall expire on July 1, 2020.

Amendatory language: The provisions of this section shall expire on July 1, 2025.

Mitzi E. McFatrich, Executive Director - On behalf of Board of Directors and Members

KABC is a not-for-profit organization whose mission is to improve the quality of long-term care for elders in all settings – nursing and assisted facilities and in-home. KABC is not a provider of government funded services and is beholden to no commercial interests. For 45 years KABC's role has been as a resource and advocate for older adults and families and as a resource to policy makers on aging and quality care issues. KABC provides consumer education information and tracks and reports on quality care performance issues.

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[2] nursinghome411.org/other-nursing-home-information published Aug. 2019

Kansas NF VBP Incentives History and Annual Statistics

Measure and Add-on History	7/1/2008	7/1/2009	7/1/2010	7/1/2011	7/1/2012	7/1/2013	7/1/2014	7/1/2015	7/1/2016	7/1/2017	7/1/2018	7/1/2019
CMI Adjusted Staffing Ratio	2	$ 1.00	$ 1.00	$ 2.50	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 3.00	$ 3.00
Staffing Ratio Improvement		$ 0.10	$ 0.10	$ 0.25	$ 0.20	$ 0.20	$ 0.20	$ 0.20	$ 0.20	$ 0.20	$ 0.50	$ 0.50
Low Operating Expense	1											
Low Staff Turnover	2	$ 1.00	$ 1.00	$ 2.50	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 2.25		
Staff Turnover Improvement		$ 0.10	$ 0.10	$ 0.25	$ 0.20	$ 0.20	$ 0.20	$ 0.20	$ 0.20	$ 0.20		
High Staff Retention	2										$ 2.50	$ 2.50
Staff Retention Improvement											$ 0.50	$ 0.50
High Occupancy	1											
High Medicaid Utilization	1	$ 0.45	$ 0.45	$ 1.13	$ 1.13	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 0.75	$ 0.75
Combined Point Calculation	9										$ 1.25	$ 1.25
Kansas Culture Change Survey		$ 0.15	$ 0.15	$ 0.38								
PEAK Level 0										$ 0.50	$ 0.50	$ 0.50
PEAK Level 1					$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50
PEAK Level 2					$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00
PEAK Level 3					$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00
PEAK Level 4					$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 2.50	$ 2.50
PEAK Level 5					$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 3.00	$ 3.00

Incentive Participation History	7/1/2008	7/1/2009	7/1/2010	7/1/2011	7/1/2012	7/1/2013	7/1/2014	7/1/2015	7/1/2016	7/1/2017	7/1/2018	7/1/2019
CMI Adjusted Staffing Ratio						60	59	62	56	58	58	51
Staffing Ratio Improvement						76	22	14	23	23	27	33
Low Operating Expense												
Low Staff Turnover						72	62	69	61	50		
Staff Turnover Improvement						48	43	39	29	29		
High Staff Retention											55	58
Staff Retention Improvement											26	33
High Occupancy												
High Medicaid Utilization						104	106	113	93	87	69	87
Combined Point Calculation												
Quality Measures											61	72
Total Incentive Qualifiers						226	196	211	187	132	193	212
Kansas Culture Change Survey												
PEAK Level 0 or Level 1						120	145	155	90	46	58	65
PEAK Level 2						4	3	1	1	0	1	0
PEAK Level 2 and Level 1						0	5	59	56	68	55	58
PEAK Level 3						0	2	2	5	3	4	5
PEAK Level 4						2	1	1	2	5	7	5
PEAK Level 5						6	6	6	7	4	5	5
Total PEAK						132	162	224	161	126	130	138

Kansas NF VBP Incentives History and Annual Statistics

Fiscal Impact History	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**7/1/2012**	**7/1/2013**	**7/1/2014**	**7/1/2015**	**7/1/2016**	**7/1/2017**	**7/1/2018**	**7/1/2019**
Total Est. Fiscal Impact	$ 2,877,076	$ 2,457,296	$ 2,571,640	$ 6,441,892	$ 6,120,909	$ 6,443,798	$ 6,682,332	$ 7,074,664	$ 7,302,112	$ 7,350,303	$ 7,864,948	$ 8,088,279
Impact with Reductions	NA	NA	NA	NA	NA	$ 5,085,916	$ 4,560,783	$ 5,902,631	$ 5,476,143	$ 4,675,794	$ 5,843,946	$ 6,677,978
Medicaid Days	$ 3,879,048	$ 3,502,328	$ 3,449,585	$ 3,594,037	$ 3,346,309	$ 3,610,224	$ 3,562,189	$ 3,504,635	$ 3,452,197	$ 3,385,222	$ 3,353,595	$ 3,336,897
Average Medicaid Rate	$ 136.26	$ 135.21	$ 145.44	$ 149.10	$ 150.47	$ 153.55	$ 158.31	$ 158.33	$ 167.51	$ 177.59	$ 190.24	$ 192.00
Average Incentive Per Diem	$ 0.74	$ 0.70	$ 0.75	$ 1.79	$ 1.83	$ 1.41	$ 1.28	$ 1.68	$ 1.59	$ 1.38	$ 1.74	$ 2.00
Incentive Reimbursement %	0.54%	0.52%	0.51%	1.20%	1.22%	0.92%	0.81%	1.06%	0.95%	0.78%	0.92%	1.04%

Statewide Measures History	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**7/1/2012**	**7/1/2013**	**7/1/2014**	**7/1/2015**	**7/1/2016**	**7/1/2017**	**7/1/2018**	**7/1/2019**
Average Case Mix Index						1.0175	1.0130	1.0145	1.0231	1.0225	1.0302	1.0416
Avg CMI Adjusted Staffing Ratio						4.20	4.28	4.26	4.33	4.37	4.42	4.35
Average Staff Turnover Rate						59.70%	62.57%	65.33%	69.69%	73.42%		
Average Staff Retention Rate											62.09%	61.72%

Direct Health Care Cost Coverage	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**7/1/2012**	**7/1/2013**	**7/1/2014**	**7/1/2015**	**7/1/2016**	**7/1/2017**	**7/1/2018**	**7/1/2019**
Average DHC Cost Coverage	96.84%	97.08%	95.54%	96.63%	94.93%	90.75%	91.11%	89.43%	91.56%	92.27%	96.79%	95.96%

Per Diem Add-on 0-3 Points	$ -
Per Diem Add-on 4 Points	$ 1.00
Per Diem Add-on 5 Points	$ 2.00
Per Diem Add-on 6-9 Points	$ 3.00

Report of the Quality Care Improvement Panel

To

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services

and KanCare Oversight

January 10, 2020

The Kansas Legislature created the Quality Care Improvement Panel in 2010 with the enactment of K.S.A. 75-7435. The Quality Care Improvement Panel reports annually to the Senate Committees on Public Health and Welfare and Ways and Means, the House Committees on Appropriations and Health and Human Services and the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

The membership of the Quality Care Improvement Panel consists of the following: two persons appointed by Leading Age Kansas; two persons appointed by the Kansas Health Care Association; one person appointed by Kansas Advocates for Better Care; one person appointed by the Kansas Hospital Association; one person appointed by the Governor who is a member of the Kansas Adult Care Executives Association; one person appointed by the Governor who is a skilled nursing care facility resident or the family member of such a resident; one person appointed by the Kansas Foundation for Medical Care; one person appointed by the Governor from the Kansas Department for Aging and Disability Services; one person appointed by the Governor from the Kansas Department for Health and Environment; one person appointed by the President of the Senate who is an Advocate and one person appointed by the Speaker of the House who is a Long-Term Care Ombudsman. A Long-Term Care Ombudsman has not been appointed, so currently there are 12 voting members.

The Current members are: Rhonda Parks, Chairperson; Debra Zehr, Scott Hines, Mike Tryon, Mitzi McFatrich, Andy Sutter, Sara Sourk, Janet Schalansky, Sara Irsik-Good, Melissa Warfield, Adam Proffitt, and Kathy Wade.

The Quality Care Improvement Panel is charged by the Legislature to report annually to the above mentioned legislative committees on the progress to reduce the incidence of antipsychotic drug use in elders with dementia, participation in the nursing facility quality and efficiency outcome incentive factor, participation in the culture change and person-centered care incentive program, annual resident satisfaction ratings for Kansas skilled nursing care facilities and 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.

The Quality Care Improvement Panel had not met and or made any recommendations since February, 2016.

Background

Like many other industries, the nursing home industry continues to see an era of change. These changes are largely driven by two factors: 1) money, primarily due to Medicaid reform, and 2) competition. Nursing home residents and family members must be assured of more control over their lives, including such things as choosing the time they get up and what and when they want to eat.

Many of the changes are intended to benefit residents and their families. Programs such as those funded in part by the quality care incentive initiative are intended to make it easier for families to judge the quality of Kansas nursing home care. Those programs are intended to promote excellence in health care coverage and encourage nursing homes to move from an institutional model of care to make person-centered care as the standard for Kansas nursing home residents.

The current Medicaid model allots reimbursement to nursing homes based on their costs for nursing and direct care workers, medical equipment and supplies, indirect care costs such as dining workers and food, real property costs and limited operational costs. To ensure efficiency, costs are capped for each cost center. Additionally, Kansas provides an incentive program for facilities to be reimbursed for performance on specific quality indicators and overall operational efficiency.

Myers and Stauffer, who are recognized as a leader in providing solutions to state government agencies in design, implementation, operation and evaluation of government-sponsored health care programs, presented information to the Panel on the quality and efficiency outcome incentive factors, the measurements for the participation in culture change and person-centered care incentive program and the annual resident satisfaction ratings. Myers and Stauffer are the current rate setting vendor for Kansas Department for Aging and Disability Services (KDADS).

The Panel also reviewed data from Myers and Stauffer regarding the Average Case Mix History and the Direct Health Care Cost. In 2018 and 2019, the average direct health care cost coverage was 97% and 96% respectfully.

The Provider Assessment Model was presented to the Panel by Myers and Stauffer. The average assessment rate is an annual per bed amount resulting from a weighted average calculation for homes at the base rate of $4,908 per bed, and homes that qualify for the lower rate of $818 per bed. The current average assessment rate is $1,844. There are 20,727 licensed beds for an estimated assessment revenue of $38,214,506.

The Quality Care Improvement Panel reviewed the Incidence of Antipsychotic Drug Use in Nursing Homes and in 2011, Kansas ranked 51st in the nation in the use of anti-psychotic drugs in nursing homes. Kansas ranked 42nd in 2018 and Kansas now ranks 38th in the nation. In Fourth Quarter of 2018, 17% of long-stay residents in Kansas were receiving an anti-psychotic medication. The national quarterly prevalence is 14.6%.

Recommendations of the Quality Care Improvement Panel

Recommendation 1: The Quality Care Improvement Panel recommends that the quality incentive program be continued for five years, thereby changing the sunset day to July 1, 2025.

Recommendation 2: The Quality Care Improvement Panel recommends that the Kansas Legislature provide full rebasing using the last three years average specifically, 2017-2019 and use inflation to the midpoint of the rate period.
There was a dissenting recommendation: Review and Revise Quality Improvement Incentives paid to qualifying facilities.

The Quality Care Improvement Panel will continue to meet annually.