To: Representative Les Mason, Chair and Members, 2023 Special Committee on Nursing Facility Reimbursement Rate Methodology

From: Rachel Monger, President/CEO, LeadingAge Kansas

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LeadingAge Kansas is the state association for not-for-profit and faith-based aging services. We have 150 member organizations across Kansas, which include not-for-profit nursing homes, retirement communities, hospital long-term care units, assisted living, home plus, senior housing, low-income housing, home health agencies, home and community-based service programs, PACE and Meals on Wheels. Our members serve more than 25,000 older Kansans each day and employ more than 20,000 people across the state.

Nursing Facility Reimbursement Methodology Recommendations

By 2036, it is estimated the population of seniors aged 65 and older will grow by 208,000. Despite the growing demand, challenges between Medicaid cost reimbursement and the pandemic resulted in all or part of at least 47 facilities closing or reducing their offerings – limiting access to care for hundreds of Kansans. The Kansas legislature voted in the 2023 legislative session to fully fund a cost rebase and Medicaid add-on to close the gap in costs for nursing home facilities and we are grateful that the legislature acknowledged how important fully funding nursing homes is to preserving access and quality for Kansas seniors. While this appropriated funding had positive impacts, it was clear the reimbursement methodology needed to be evaluated to ensure long-term sustainability. LeadingAge Kansas offers the following recommendations to come closer to achieving that goal.

Medicaid Add-On Adjustment Based Upon Average Gap in Cost of Care

Like the appropriation made by the Legislature for State Fiscal Year 2024, an additional payment amount could be distributed to each nursing facility based upon the gap between Medicaid reimbursement under the existing formula and the average daily amount actually spent by homes in caring for residents. The $19.58 daily add-on payment has been highly successful in meeting the existing payment gap. In its Final Rate Setting Notice on June 8, 2023, KDADS estimates that the July 1 Medicaid rates covered 100% of average daily *(allowable)* costs for nursing homes and covered 94% of average direct health care costs (which includes wages spent on our direct care staff). We will not be able to analyze cost report data until later in 2024 and 2025, however anecdotally we have already heard from our providers how beneficial the rate increases have been in hiring additional caregivers and reducing the use of staffing agencies in their buildings.

Dementia Care/Behavioral Health Add-On Payment

For LeadingAge Kansas members, the biggest gap between Medicaid reimbursement and actual cost of care lies in staffing. Our providers consistently outspend the upper payments limits for direct health care because the reimbursement Medicaid gives them for direct care staffing is not enough to support quality care – especially when it comes to residents with dementia and other behavioral health diagnoses. Kansas uses the MDS assessment and RUGS-III to calculate resident acuity and the accompanying acuity adjusted payments to determine each home's reimbursement under the direct care cost center. High quality dementia care is staff and resource intensive, and much of the costs associated with it are not adequately captured under our MDS/RUGS-III payment categories. Therefore, our homes are not being paid for the care they are providing to residents with behavioral health needs. On October 1, 2024, Kansas will be switching from RUGS-III to a new Federal resident classification system called PDPM. Early indicators have shown that PDPM will not improve the issue of capturing behavioral health care costs. A Medicaid daily add-on payment to capture these costs would be extremely helpful to providers and consumers to support high quality care in our nursing homes.

Pass-Through Payments for Federal Staffing Minimums

On September 1, 2023, CMS released a proposed rule imposing mandatory staffing minimums in nursing facilities.

- Requires a Registered Nurse to be onsite 24 hours a day/7 days a week. (The current requirement is 8 hours a day/7 days a week)
- Minimum staffing hours per resident per day of .55 hours for RN and 2.45 hours for Certified Nurse Aides

We estimate that it will cost another $26 million, at least, for our providers to comply with these minimums today. However, the cost of these minimums is likely much more due to the labor premiums that accompany government mandates, the scarce availability of health care workers and increasing use of staffing agencies. CMS has proposed no new federal funding to support the staffing minimums and is encouraging states to "adequately fund" the cost of care. Without direct government funding for these government mandates, we have no hope of complying or sustaining operations.

Meaningful and Achievable Quality Incentives

Kansas currently has quality incentive add-on payments for nursing facilities. The intent of the payments is to incentivize and reward high quality care in the areas of staffing, quality measures, person centered care and Medicaid occupancy. However, only a small fraction of Medicaid funding is directed toward these incentives, they are not funded separately from cost of care reimbursement, and many providers report confusion and frustration about the path to earning them. We recommend that quality incentives be funded at a level that allows homes to pay for and achieve quality outcomes, and that the incentives be funded to supplement and bridge the cost of care gap in Medicaid daily rates. We also recommend that the measures behind the quality incentives be re-vamped to ensure transparency and relevancy to desired outcomes.

Increase the Real and Personal Property Fee

The Real and Personal Property Fee is paid in lieu of an allowable cost for mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements under the Medicaid reimbursement calculation. The current per day limit on RPPF is only $10.47. We hear from provider after provider that the $10.47 is woefully inadequate and prevents them from being able to improve their buildings or pursue any other capital projects because they will never get fully reimbursed by the Medicaid formula.

Many of our nursing homes are in buildings that were constructed in the 1960s and 1970s. They struggle to find the means to do basic maintenance and repairs, let alone the refurbishment and renovations needed to create safer, better quality, and more dignified environments for residents.

Critical Access Nursing Home Model

Overall, nearly 85,000 Kansans live in areas with only one nursing and residential care provider within a 30-minute drive. If the local provider closes, they'll join the 23,000 Kansans already living in a senior care desert. Much like rural hospitals, many of whom are designated as "critical access hospitals", rural nursing homes provide desperately needed access to care for rural Kansans and play a large economic role in their communities. Rural nursing homes also face similar workforce and financial challenges as critical access hospitals, putting them at near constant risk of closure. To preserve these services for rural communities, we strongly encourage Kansas to explore a "critical access" model for senior care.

Additional Areas for Consideration

Move to Annual Cost Rebasing

Under KSA 75-5958 the State of Kansas is required to adjust the rates of nursing facilities every year based upon the average of that provider's last three years of reimbursable costs. We refer to it as "cost rebasing" or just "rebasing." As we have pushed harder since the pandemic to better capture actual costs of care in our reimbursement methodology, many providers have suggested that Kansas shorten rebasing from three years down to one year. The state of Kansas often suggests that averaging together three years of cost reports helps providers by smoothing out reimbursement rate changes for homes that experience cost of care fluctuations. However, an increasing number of our providers have criticized the three-year rebasing because it leads to significant rate inadequacy due to providers being paid for the costs of years past and the inflation factors being used for later years not keeping up with the actual cost inflations providers experienced.

Other states with similar Medicaid reimbursement systems to Kansas successfully rebase at one year cost report intervals. We would ask that more research and modeling be performed by KDADS on the 3 years vs. 1 year cost report rebasing to determine whether the improved reimbursement accuracy outweighs the concerns about rate volatility for providers.

Provider Tax Increase Concerns

Since the enactment of the nursing home provider tax in 2010, Kansas has periodically chosen to raise the bed tax assessment rate to draw down additional federal funds through Medicaid. While this may seem like an obvious, and simple, method to increase available Medicaid dollars for long term care, it comes at a heavy cost for some providers and even some consumers. As a condition of allowing provider tax schemes, the federal government requires that any provider tax have "winners" (providers who receive more in leveraged provider tax payments than they paid in) and "losers" (providers who receive less dollars back than they paid in). For a variety of reasons, most of the overall "losers" in the provider tax game are nonprofit nursing homes, small nursing homes, nursing homes that are not part of large corporate systems, and continuing care retirement communities.

Any increase in provider tax rates or decrease in availability of the 1/6th rate tiers will have an enormous impact on the operations of nursing homes across the state, and we ask that any such discussions be weighed carefully, and the needs of all provider circumstances be considered.

We thank the Chairman and committee members for their time and dedication to this critical issue.

Summary of Recommendations

LeadingAge Kansas believes the following recommendations will help bring nursing facilities closer to achieving full cost reimbursement, thereby increasing access and quality of care to residents and their families.

1. **Medicaid Add-On Adjustment Based Upon Average Gap in Cost of Care.** Like the State Fiscal Year 2024 appropriation, an additional payment amount could be distributed to each nursing facility based upon the gap between Medicaid reimbursement under the existing formula and the average daily amount actually spent by homes in caring for residents.
2. **Dementia Care/Behavioral Health Add-On Payment.** Our providers consistently outspend the upper payments limits for direct health care because the reimbursement Medicaid gives them for direct care staffing is not enough to support quality care – especially when it comes to residents with dementia and other behavioral health diagnoses. A Medicaid daily add-on payment to capture these costs would be extremely helpful to providers and consumers to support high quality care in our nursing homes.
3. **Pass-Through Payments for Federal Staffing Minimums.** On September 1, 2023, CMS released a proposed rule imposing mandatory staffing minimums in nursing facilities. We estimate that it will cost another $26 million, at least, for our providers to comply with these minimums today. CMS has proposed no new federal funding to support the staffing minimums and is encouraging states to "adequately fund" the cost of care. Without direct government funding for these government mandates, we have no hope of complying or sustaining operations.
4. **Meaningful and Achievable Quality Incentives.** We recommend that quality incentives be funded at a level that allows homes to pay for and achieve quality outcomes, and that the incentives be funded to supplement and bridge the cost of care gap in Medicaid daily rates. We also recommend that the measures behind the quality incentives be re-vamped to ensure transparency and relevancy to desired outcomes.
5. **Increase the Real and Personal Property Fee.** The Real and Personal Property Fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements under the Medicaid reimbursement calculation. We hear from provider after provider that the $10.47 is woefully inadequate and prevents them from being able to improve their buildings or pursue any other capital projects because they will never get fully reimbursed by the Medicaid formula.
6. **Critical Access Nursing Home Model.** Much like rural hospitals, many of whom are designated as "critical access hospitals", rural nursing homes provide desperately needed access to care for rural Kansans and play a large economic role in their communities. To preserve these services for rural communities, we strongly encourage Kansas to investigate a "critical access" model for senior care.
7. **Move to Annual Cost Rebasing.** Other states with similar Medicaid reimbursement systems to Kansas successfully rebase at one year cost report intervals. We would ask that more research and modeling be performed by KDADS on the 3 years vs. 1 year cost report rebasing to determine whether the improved reimbursement accuracy outweighs the concerns about rate volatility for providers.