Office of Medicaid Inspector General

Continuing Care Retirement Communities Audit Report

24-03

Office of Kansas Attorney General
Kris W. Kobach

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Letter from the Inspector General

April 1, 2024

To: Attorney General Kris W. Kobach
Kansas Department of Insurance, Vicki Schmidt, Commissioner
Kansas Department for Aging and Disability Services, Laura Howard, Secretary

Members of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight:

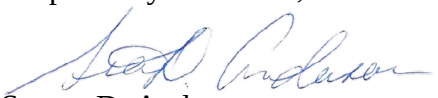
Representative Brenda Landwehr, Chair
Representative Barbara Ballard
Representative Will Carpenter
Representative Susan Concannon
Representative Emil Bergquist
Representative Susan Ruiz
Senator Beverly Gossage, Vice-Chair
Senator Michael Fagg
Senator Molly Baumgardner
Senator Pat Pettey
Senator Mark Steffen

This report contains findings and recommendations from our performance audit of the processing of Continuing Care Retirement Communities (CCRC) and Continuing Care Provider (CCP) applications. The audit includes an assessment of the eligibility for a reduced rate of the nursing facility provider tax (also known as bed tax or bed assessments) for any CCP registration certificate holder per K.S.A. 40-2231 through K.S.A 40-2238 and K.S.A. 75-7435.

This audit was completed in accordance with the Association of Inspectors General Principles and Standards for Offices of Inspector General: Quality Standards for Inspections, Evaluations, and Reviews, May 2014 Revision.

We appreciate the cooperation of the Kansas Department of Insurance (KDOI) and the Kansas Department for Aging and Disability Services (KDADS) staff throughout this audit. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Medicaid Inspector General

Executive Summary

The objectives of this audit were to determine the following:

1. **Are there currently issues within the legislative language that are allowing these facilities to falsely claim they are a part of a CCRC?** The current language and federal guideline do not provide a clear definition of CCRC.
2. **Are there currently proper procedures in place to monitor compliance within the CCRC and CCP registrations?** There are proper procedures in place; however, they were not being followed.
3. **Are there measures that can be taken to stop potential fraud, waste, and abuse of State funds and loss of potential Federal matching funds?** There are measures that can be taken, and they are addressed within this report.

The scope of our audit included all CCP registrations processed by KDOI from July 1, 2020, through August 31, 2023. K.S.A. 40-2235 requires any provider that acts as a CCP or operates a CCRC to hold a CCP certificate of registration. CCP Registration certificates are issued to providers who complete the established application process managed by KDOI.

The audit results revealed **68%** of CCP Registration certificates issued to Skilled Nursing Facilities (SNF) from July 1, 2020 through August 31, 2023, by KDOI, were not in compliance with K.S.A. 40-2231 through K.S.A. 40-2238. The primary cause for not being in compliance was the lack of an annual audit report from a certified public accountant. Due to SNFs being improperly issued CCP registrations, the State of Kansas lost Quality Care Assessment (QCA) revenue of **$87,121,090.** This resulted in additional loss of QCA Fund interest earnings revenue of an estimated **$1,376,303.20**. KDOI's failure to deny incomplete applications for CCP registrations resulted in a loss of QCA revenue totaling **$88,497,393.20**.

According to the bed tax data files provided by KDADS, **420** QCAs completed for SFY 2021-2024 were identified for SNFs claiming to be part of a CCRC, that required proof of CCP registration for the reduced QCA rate, and did not otherwise qualify for the reduced QCA rate as a small SNF or a high Medicaid volume SNF. The **420** QCAs completed for the CCRCs that required proof of CCP registration, were compared to the Adult Care Directory on the KDADS agency website. If the CCRC populated two or more facility types when researched in the directory, the CCRC was considered to have met the definition of a CCP per K.S.A. 40-2231(d). Of **420** QCAs completed for the

CCRCs that required proof of CCP registration, we identified **205** QCAs that only populated a single facility type as “Nursing Facility” when researched in the directory. This meant only SNF beds were located at the CCRC.

If we could not locate any verification that a continuum of care (either independent living or assisted living/residential healthcare in combination with the skilled nursing care) could be provided on the site/campus, we considered the CCRC to have not met the definition of a CCP per K.S.A. 40-2231(d). Our review revealed that **96, or 24%,** of the QCAs completed for CCRCs were incorrectly assessed at the reduced QCA rate. Although they were issued certificates of CCP registration by KDOI, there was no evidence that these self-attested CCRCs were providing continuing care per K.S.A. 40-2231(d).

Currently, the Kansas statutes do not further define the phrase “continuing care”, resting essentially on the federal definition. The care providers as recipients of Medicare and Medicaid subsides are familiar with these federal terms. The Kansas statutes could be amended to mimic explicitly the federal definition of "continuing care." Ultimately, the providers have to be in alignment with state and federal requirements.

Providers have ignored the definition of “continuing care” as it relates to the QCA which when combined with the lack of appropriate oversight by KDOI and KDADS, allowed SNFs to continue to be assessed at the reduced QCA rate by simply claiming CCRC status. This has resulted in an estimated **$33,374,400** loss of QCA revenue to the State for SFY 2021-2024. By following updated statutes and recommendations from OMIG, the State of Kansas will save an estimated **$12,274,090.00** each year by properly assessing 37 facilities as not being CCRCs and using the proper QCA of $4,098.00 instead of the incorrect amount of $818.00 per bed.

Our review of supporting documents and emails between KDOI staff members found numerous examples of advice from the KDOI’s General Counsel that were contrary to applicable statutes. This resulted in decisions being made by KDOI staff to issue CCP registrations to facilities that were not qualified.

Introduction

The Office of the Medicaid Inspector General (OMIG) conducted a review of CCRC and CCP regulations and statutes in the State of Kansas to determine if the program is running effectively and efficiently. The audit also included an assessment of the eligibility for a reduced rate of the nursing facility provider tax (also known as bed tax or bed assessments) for any CCP registration certificate holder per K.S.A. 40-2231 through K.S.A 40-2238 and K.S.A. 75-7435. Failure to properly follow applicable statutes and regulations for the CCP program can lead to the unnecessary spending of State General Funds (SGF) to offset the loss of Nursing Facility Quality Care Assessment (QCA) tax revenue.

The Medicaid Program

Medicaid is public health insurance funded with both federal and state dollars, designed primarily to provide health care coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The program was authorized by Title XIX of the Social Security Act, and it is administered nationally by the Centers for Medicare & Medicaid Services (CMS), a division of the United States Department for Health and Human Services. The Medicaid program is heavily regulated. KanCare is the program through which the State of Kansas administers Medicaid. It is operated and administered from offices located in Topeka, Shawnee County, Kansas, by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS). KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions.

KanCare will cover the cost of long term care in a nursing home for eligible Kansas residents who require a Skilled Nursing Facility (SNF) level of care. Nursing Home Medicaid coverage includes payment for room and board, as well as all necessary medical and non-medical goods and services. These can include skilled nursing care, physician's visits, prescription medication, medication management, mental health counseling, social activities and assistance with activities of daily living (eating, bathing, moving, dressing, toileting). Nursing Home Medicaid is an entitlement. This means that eligible Kansas residents who apply are guaranteed by law, or "entitled," to receive Nursing Home Medicaid benefits once their application has been approved.

Medicaid Financing

As mentioned above, the Medicaid program is funded by both federal and state dollars. Code of Federal Regulations (CFR), Title 42, § 400.203 defines the Federal financial participation (FFP) as the Federal Government's share of a State's expenditures under the Medicaid program and the Federal medical assistance percentage (FMAP) as the percentage used to calculate the amount of Federal share of State expenditures for services. FMAP, a calculated Medicaid matching rate, is determined by a formula that considers the average per capita income for each state in relation to the national average. The lower a state's per capita income, the higher the state's FMAP. By law, FMAPs can range from a minimum match rate of 50% to a maximum match rate of 83%.

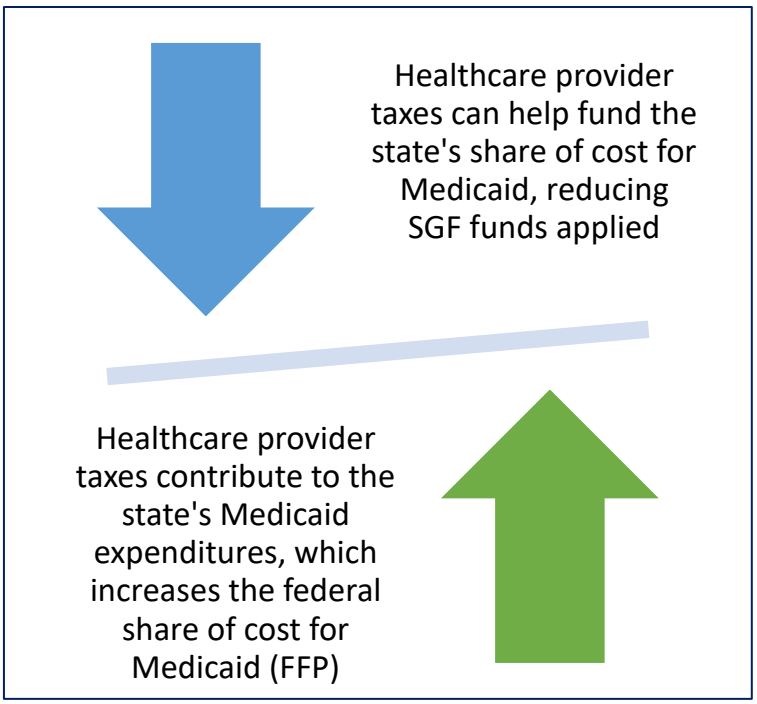
In exchange for FFP, each state must fund its share of the total Medicaid expenditures in accordance with a state plan, approved by CMS. States then establish their own Medicaid provider payment rates within federal requirements, and generally pay for services on behalf of Medicaid beneficiaries through a managed care organization (MCO) method or a fee-for-service (FFS) method.

To participate in Medicaid and receive FFP, states must meet the core federal requirements. States must provide specific required benefits such as hospital, physician, and nursing home services to the low-income population with limited resources and sometimes complicated health needs, without waiting lists or enrollment limits. Medicaid has an unusual role in state budgets as both a spending item and a source of federal revenue.

Healthcare Provider Taxes

To increase the FFP for which a state is eligible, CMS allows states to tax health care providers. The state uses the revenue it collects from these taxes to increase the rates it pays providers for qualified Medicaid services. This increases the state's total Medicaid expenditure amount to which the FMAP is applied and results in a higher amount of FFP.

States can utilize healthcare provider taxes to help fund the State share of Medicaid expenditures within specific limits and rules. Healthcare provider taxes are an essential source of Medicaid financing. All states, with the exception of Alaska, have at least one healthcare provider tax in place and many states have three or more. Although the tax is required for most providers, they subsequently benefit from increased state and federal Medicaid spending. Kansas has the two most common healthcare provider taxes in place for nursing facilities and hospitals.



Kansas Healthcare Provider Taxes for Nursing Facilities

In 2010, Kansas House Bill 2320 was enacted and the Quality Care Assessment (QCA), or nursing facility provider tax, was established. An annual tax payment of $1,950 is required on each licensed bed within skilled nursing care facilities (SNFs), which includes nursing facilities for mental health (NFMH) and hospital long-term care units (LTCU). Kansas Soldiers' Home and Kansas Veterans' Home are exempt from this assessment. Collected funds are used to finance initiatives designed to maintain or increase the quantity and quality of nursing care in licensed facilities that provide services to Medicaid beneficiaries.

If any additional funds are available, they must be used for an increase of the direct health care costs limitations and then for approved quality enhancement for skilled nursing facilities. Collected funds may also be used to pay employees who are providing direct care to a resident in a skilled nursing facility. Funds are prohibited from providing bonuses or profit-sharing for any officer, employee, or parent corporation.

In 2016, Kansas Legislature passed House Bill 2365, which raised the annual tax payment amount from $1,950 to $4,908 per licensed bed and included an expiration date of July 1, 2020. In the 2020 legislative session, Senate Bill 409 was passed, extending the expiration date for the nursing facility QCA to July 1, 2030. The extension of this

expiration date allows the QCA to continue to provide funding for increased nursing facility reimbursement rates.

Quality Care Assessment Rates

The QCA annual payment is based on a State fiscal year (SFY), beginning July 1st and ending June 30th. Each SNF pays the annual assessment as follows:

The QCA rate for each SNF is $4,908 per licensed bed. The rate is reduced to $818 per licensed bed if the SNF meets any of the following criteria:

- **Small SNF, any facility with fewer than 46 licensed skilled nursing beds.**

  The Survey, Certification and Credentialing (SCC) commission at KDADS conducts surveys, or inspections, of all licensed SNFs in Kansas. Part of the survey consists of verifying the resident capacity (number of licensed beds available for skilled nursing care). Survey information collected is entered into a database used by KDADS, Kansas Organization Tracking Application (KOTA). KOTA shares the resident capacity data with another KDADS database called Bed Assessment. The Bed Assessment database is programmed to calculate the QCA annual tax payment for each SNF prior to the start of each SFY. The Bed Assessment database can identify a small SNF by the count of licensed beds available for skilled nursing care recorded by the surveyors.

- **High Medicaid Volume SNF, or any facility that provided more than 25,000 days of nursing care to Medicaid recipients during the most recent calendar year cost-reporting period.**

  Form AU-3902, Monthly Census Summary, is completed by all Kansas SNF/NFMH/LTCU facilities and submitted to KDADS, in addition to the annual cost report. Instructions on KDADS' website explain:

  > A monthly summary of days for each resident will be reported. A resident day is being defined as any paid day. Resident days will include full paid days, reserve paid days and all other types of paid days. The SNF and NFMH staff are responsible for keeping documentation to support the monthly summaries reported for the residents.

The census summary form has two columns for each month. One column is for reporting Medicaid days (this is used in the Cost Report). The other column is for reporting all other resident days, hospice (including Medicaid hospice days), Medicare, private pay, Veterans Administration, etc. This documentation is used to record each SNF's Medicaid Bed Days and any SNF that reports more than 25,000 Medicaid bed days in their cost report, is considered a high Medicaid volume (HMV) SNF.

The monthly census summaries are submitted as supportive documentation for the resident days shown on the cost report forms. The period covered by the census summaries should coincide with the cost report period. Providers have the flexibility to determine the reports and documentation they maintain to support the monthly census summaries.

The Monthly Census Summary and the cost report are due to KDADS no later than the close of business on the last working day of February following the year covered by the report. Instructions for the Monthly Census Summary and the cost report are provided on KDADS' website.

- **SNF that is a part of a Continuing Care Retirement Community (CCRC).**

  Per K.S.A 75-7435(5), "Continuing care retirement facility" means a facility holding a certificate of registration issued by the commissioner of insurance pursuant to K.S.A. 40-2235, and amendments thereto.

  Per K.S.A 40-2235, No provider shall act as or hold themselves out to be a continuing care provider, as defined in this act, in this state, unless the provider shall hold a certificate of registration as a continuing care provider issued by the commissioner of insurance.

  Per K.S.A 40-2231(d), "Provider" or "continuing care provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care to residents in a home.

  Per K.A.R 129-10-31(a)(4), "Skilled nursing care facility that is part of a continuing care retirement facility" means a provider who is certified as such by

the Kansas Department of Insurance before the start of the state's fiscal year in which the assessment process is occurring.

CMS defines a CCRC as, a housing community that provides different levels of care based on what each resident needs over time. It can range from independent living in an apartment to assisted living to full-time care in a nursing home. Generally, CCRCs require a large payment before an individual moves in and charges monthly fees.

Seniors who are capable of completing daily activities like dressing and bathing can live in a single-family home, apartment, or condominium within the retirement community. Residents of this type of community can transition to an assisted living area or skilled nursing area on the same site as their health care needs change. This type of community also allows its residents to remain connected with a spouse or friends who also reside in the community, yet may have different health care needs.

When a SNF agrees to participate in the Kansas Medicaid Program, one of the CMS forms they have to complete is the Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-671, 12/02 – Appendix II). The SNF is instructed to check a box next to either "yes" or "no" in Question F27 which reads, "*Is the facility part of a continuing care retirement community (CCRC)?*" Currently, this is the only way a SNF can report that they are claiming to be a part of a CCRC to CMS. According to KDADS staff, this information was solely used for communication to CMS and was not utilized in the determination of a QCA rate.

The reduced QCA rate of $818, per K.S.A. 75-7435(5)(b)(1), cannot exceed the maximum of 1/6 of the standard QCA rate of $4,908 per licensed bed.

Continuing Care Provider Registration Process

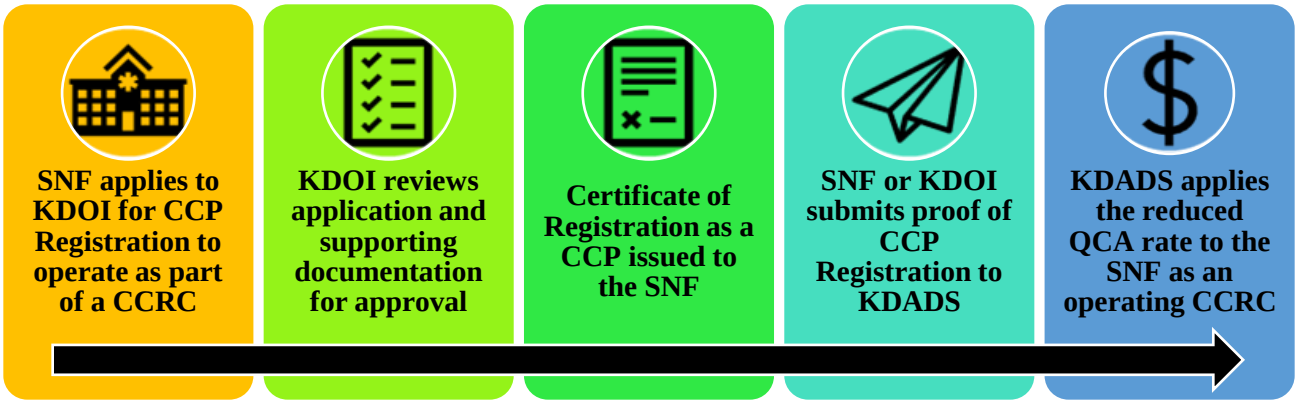
K.S.A 40-2235 requires any CCRC provider, that acts or holds themselves out to be a Continuing Care Provider (CCP), to have current certificate of registration as a CCP issued by the Kansas Department of Insurance (KDOI). According to KDOI staff, the applications are examined, along with the required supporting documentation, to

determine if K.S.A. 40-2231 through K.S.A. 40-2238 requirements have been met. The statutory requirements are outlined below:

The SNF completes the following and submits information to KDOI to apply for a CCP registration:

1. CCP Application
2. Disclosure statement along with applicable exhibits
3. Continuing care contracts which shall include:
    a. A description of all fees and/or charges required of residents, a description of all services to be provided or committed to providing in the future and a description of any services for which an extra charge is made over and above entrance fees and periodic charges that are provided for in the contract;
    b. A listing of the terms and conditions under which the agreement may be cancelled by either party to the agreement or by which any or all of the entrance fee or transfer of assets would be refunded, less the value of any services received; and
    c. A statement describing health and financial conditions required to continue as a resident, including any changes in either health or financial conditions of the resident.
4. Fee schedules
5. An annual audit certified by a certified public accountant (CPA)
6. Payment of a $50 registration or $25 registration renewal fee

The registration certificate is valid for 12 months. Prior to the end of the 12-month period, the registered CCP must submit all required documents to register to be reviewed for renewal, and pay a $25 registration renewal fee. The review process for renewals is the same as the review process for initial registrations.



Once KDOI has issued the CCP registration, the SNF may operate as a CCRC. The SNF can also submit the CCP registration to KDADS, prior to the start of the SFY, to be assessed at the reduced QCA rate for the upcoming SFY. KDADS staff communicates with both the SNFs and KDOI prior to the start of each SFY to verify CCP registration for any SNF claiming to be a part of a CCRC. Proof of CCP registration issued by KDOI is required for KDADS to apply the reduced QCA rate.

Quality Care Assessment Fund

SNFs pay their QCA annual amount in quarterly payments. These payments are deposited into a fund created by the State Treasury, the Quality Care Assessment fund. Per statute, all assessment funds collected through the QCA are used to finance initiatives designed to either maintain the quality and/or to increase the quantity of SNFs providing care to Medicaid beneficiaries in Kansas.

If a SNF fails to pay the full amount of the QCA determined July 1st of each year, when due and payable, including any extensions of time granted, a penalty will be assessed. The penalty is the lesser amount of $500 per day or 2% of the QCA amount owed for each day the assessment is delinquent. The State is authorized to establish delayed payment schedules for SNFs that are unable to meet payment deadlines because of financial difficulties as determined by the State.

No funds can be transferred to the SGF at any time or be used to replace existing funds. QCA funds cannot provide for bonuses or profit-sharing for any officer, employee, or parent corporation. However, the funds may be used to pay employees who are providing direct care to a Medicaid beneficiary in a SNF. Any moneys received by the State from the federal government as a result of FFP, in the state Medicaid program that are derived

from the QCA, shall be deposited in the QCA fund and used to finance actions to maintain or increase healthcare in SNFs.

Interest is earned based on the average daily balance of moneys in the QCA fund for the preceding month; and the net earnings rate of the pooled money investment portfolio for the preceding month. The Kansas Department of Administration's Director of Accounts and Reports is responsible for transferring the interest earnings from the SGF to the QCA fund on the 10th day of each month, per K.S.A. 75-7435(5)(d)(7).

Quality Care Improvement Panel

Per K.S.A. 75-7435(5)(k), For purposes of administering and selecting the reimbursements of moneys in the QCA fund, the Quality Care Improvement Panel (QCIP) was established. The panel is required to consist of the following members:

- Two persons appointed by LeadingAge 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 SNF 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 Kansas Department for Aging and Disability Services (KDADS) **– Nonvoting member**
- One person appointed by the governor from Kansas Department of Health and Environment (KDHE) **– Nonvoting member**
- One person appointed by the president of the senate who is affiliated with an organization representing and advocating the interests of retired persons in Kansas
- One person appointed by the speaker of the house of representatives who is a volunteer with the office of the State Long-Term Care Ombudsman

The panel is required to elect a chairperson from among the members appointed by the trade organizations stated above. The members of the QCIP serve without compensation or expense reimbursement.

The QCIP is required to report annually on or before January 10th to:

- Senate committees on Public Health and Welfare and Ways and Means
- House committees on Appropriations and Health and Human Services (HHS)
- Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

The annual QCIP report should including the following:

- 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 SNFs
- The activities of the panel during the preceding calendar year
- Any recommendations that the panel may have concerning the administration of and expenditures from the QCA fund

Quality Care Assessment Pass-Through

To compensate providers for increased expenses incurred due to the QCA payment, a daily reimbursement rate is calculated annually and paid to each Medicaid provider. The daily reimbursement rate will be added to the nursing facility Medicaid daily rate. All providers currently enrolled in the Medicaid program that also provide Medicaid nursing facility services are eligible for the daily reimbursement rate. This is referred to as the Quality Care Assessment Pass-Through in the Kansas Medicaid State Plan, Attachment 4.19 D, Part 1, Subpart U, Page 1, Methods and Standards for Establishing Payment Rates, Skilled Nursing and Intermediate Care Facility Rates (SNFs and NFMHs).

The QCA reimbursement daily rate is determined by multiplying the qualifying provider's quarterly QCA payment by four to determine an annual expense amount. The annual expense amount will be divided by the total resident days from the previous calendar year. For example, during SFY 2024 (7/1/23 through 6/30/24), the resident day total from the calendar year 2022 cost report will be used to determine the reimbursement daily rate.

Audit Objectives and Scope

Our audit objectives were to obtain sufficient evidence to answer the following questions:

1. Are there currently issues within the legislative language that are allowing these facilities to falsely claim they are a part of a CCRC?
2. Are there currently proper procedures in place to monitor compliance within the CCRC and CCP registrations and renewals?
3. Are there measures that can be taken to stop potential fraud, waste, and abuse of State funds and loss of potential Federal matching funds?

The scope of our audit included all CCP registrations processed by KDOI from July 1, 2020 through August 31, 2023. We compared the CCP registrations to the QCA rates for CCRCs by KDADS for SFY 2021-2024. CCP registrations must be valid within the SFY the QCA rate is applied. For example, a CCP registration effective May 15, 2022 through May 15, 2023 is applied to the QCA for SFY 2023 (7/1/22 – 6/30/23) because the effective dates fall within SFY 2023. A CCP registration effective July 10, 2022 through July 10, 2023 is applied to the QCA for SFY 2024 (7/1/23 – 6/30/24) because the effective dates fall within SFY 2024.

Methodology

To accomplish our objectives, we performed the following:

1. Reviewed federal and state laws, regulations, and guidance.

2. Communicated with agency officials and other staff members from KDADS, KDOI, and Myers and Stauffer to gain an understanding of the Quality Care Assessments and the CCP Registration process for CCRC operations.

3. Obtained a data file from KDADS with QCAs completed during SFY 2021-2024 which included the following data elements:

    a. KDADS ID
    b. Myers Stauffer Number
    c. HP (Contractor) Medicaid Number
    d. National Provider ID (NPI)
    e. KMAP ID
    f. Facility Name
    g. DBA
    h. Facility City
    i. State ID
    j. Assessment Rate
    k. Total Beds
    l. Bed Count Change with Effective Date
    m. Medicaid Days
    n. CCRC (Y/N), Y= a current CCP Registration has been sent to KDADS
    o. Within-Stay (WS) Total Average Potentially Preventable Readmission (PPR)

4. Filtered to exclude the following data elements:

    a. SNFs assessed at $0 tax rate
        i. Kansas Soldiers Home and Kansas Veterans Home which are both excluded from the Quality Care Assessment per K.S.A. 75-7435(2) *These homes were excluded in all data sets
    b. SNFs assessed at $4,908 tax rate
    c. Small SNFs
    d. High Medicaid Volume SNFs

These data points were excluded in order to determine our universe of SNFs that were assessed at the $818 QCA rate as a CCP per KDOI/CCRC and KDADS, that did not also meet the other criteria for the reduced QCA rate, such as being a small SNF or a high Medicaid volume SNF.

5. Obtained a list of all CCP registrations completed by KDOI from July 1, 2020 through August 31, 2023, along with the application files associated to the CCP registrations completed. Application files were to include the following items:

    a. Application for either a new CCP registration or renewal for a CCP continuation.
    b. Continuing care contract which requires a present or deferred transfer of assets or an entrance fee in the amount of $5,000 or equivalent value.
    c. Disclosure statement containing the following information:
        i. The name and business address of the provider and a statement of whether the provider is an individual, partnership, corporation or any other legal entity.
        ii. The names of the individual or individuals who constitute the provider or, if the provider is a partnership, corporation or other legal entity, whether for profit or not for profit, the names of the officers, directors, trustees or managing or general partners of the provider. If the provider is a corporation, the name of any individual who owns 10% or more of the stock of such corporation shall also be disclosed.
        iii. With respect to a provider which is either not incorporated or not established and operated on a not-for-profit basis, the names and business addresses of any individual having any ownership or any beneficial interest in the provider and a description of such individual's interest in or occupation with the provider.
        iv. A statement as to whether or not the provider is, or is affiliated with, a religious, charitable or other nonprofit organization and the extent of the affiliation, if any; the extent to which any affiliate organization will be responsible for the financial and contractual obligations of the provider; the provision of the United States internal revenue code, if any, under which the provider or any of the provider's affiliates is or are exempt from the payment of federal

income taxes; and, a statement of whether the home is exempt from local property taxation.

v. A statement that the provider is required to have an annual certified audit by a certified public accountant and that a copy of such audit shall be made available upon request.

vi. If the operation of the home has not yet commenced, and with receipt of contract considerations as defined in K.S.A. 40-2231 (a) and (b), the provider shall provide a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including but not limited to:

- An estimate of such costs as financing expense, legal expense, land costs, marketing costs and other similar costs which the provider expects to incur or become obligated for prior to the commencement of operations;
- A description of any mortgage loan or any other financing intended to be used for the financing of the facility, including the anticipated terms and costs of such financing;
- An estimate of the total entrance fee to be received from or on behalf of residents at or prior to commencement of operation; and
- An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.
- A statement as to whether the manager or any official or director of the provider, has been convicted of a crime or been a party of any civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property which resulted in a judgment against such person and whether any such person has had any state or federal license or permits related to care and housing suspended or revoked.
- A statement of the years of experience of the provider and manager in the operation of homes providing continuing care.

d. An annual audit certified by a Certified Public Accountant (CPA).

e. A copy of any continuing care contract form that includes:

i. A description of all fees and or charges required of residents, a description of all services to be provided or committed to providing in the future and a description of any services for which an extra charge is made over and above entrance fees and periodic charges that are provided for in the contract;
ii. A listing of the terms and conditions under which the agreement may be cancelled by either party to the agreement or by which any or all of the entrance fee or transfer of assets would be refunded, less the value of any services received; and
iii. A statement describing health and financial conditions required to continue as a resident, including any changes in either health or financial conditions of the resident.

f. $50 filing fee for new applicants or $25 continuation fee for renewals – proof of payment on file.
g. If there is a change of ownership, or management of the provider or home, the new owners must file all required documents of this act within 90 days of change.

The application files were reviewed for completeness and timeliness outlined in K.S.A. 40-2231 through K.S.A. 40-2238.

6. Obtained a data file from KDADS for all resident capacity changes (bed count changes) for SFY 2020-2024, which included the following data elements:

a. KDADS ID
b. Myers Stauffer Number
c. HP (Contractor) Medicaid Number
d. National Provider ID (NPI)
e. KMAP ID
f. Facility name
g. DBA
h. Facility City
i. State ID
j. Old Bed Count
k. New Bed Count
l. Total Beds
m. License Effective Date
n. Bed Assessment Effective Date

The resident capacity changes were calculated by comparing the old resident capacity (bed count at the time of the resident capacity change request) to the new resident capacity (bed count as of the effective date following the resident capacity change request approval). If the new resident capacity was less than the old resident capacity, the difference was counted as a Closed SNF Bed. If the new resident capacity was more than the old resident capacity, the difference was counted as an Opened SNF Bed. The Closed SNF Beds and the Opened SNF Beds were calculated for each SFY individually and totaled for the audit period.

To determine how many SNFs had closed beds that would result in a reduced QCA rate, the Old Bed Counts column was sorted from largest to smallest. This assisted in identifying the SNFs with an old resident capacity higher than 45 beds. The New Bed Counts column was then sorted smallest to largest to identify the SNFs with a new resident capacity lower than 46 beds. These data points were sorted and analyzed to determine our universe of SNFs assessed at the $818 QCA rate as a result of a SNF resident capacity decrease from 46 beds or more down to 45 beds or less.

7. Three populations were created for analysis:

Population 1 – Incomplete CCP Registration Applications

- Identified **492** CCP registration applications approved by KDOI during the audit period. The total number of applications was calculated by combining the total number of CCP registration applications for each calendar year approved by KDOI. For example, if Facility A applied in 2021, 2022, 2023, it was counted as three.

- Of the **492** CCP registration applications identified, any applications for SNFs with less than 46 beds or SNFs that reported providing over 25,000 Medicaid bed days (MBD) during the most recent calendar year cost-reporting period were excluded. This determined our universe of **403** CCP registration applications to be reviewed. A 100% review of **403** CCP registration applications was completed to determine if KDOI approved the applications per the requirements of K.S.A. 40-2231 through K.S.A. 40-2238.

Population 2 – CCP Registrations Approved – Registered CCPs with no Evidence of Continuing Care Services

- Identified **420** QCAs completed at the $818 tax rate as a CCP per KDOI for SFY 2021-2024 with either more than 45 beds or provided less than 25,000 days of nursing facility care to Medicaid recipients during the most recent calendar year cost-reporting period.

- Compared the **420** QCAs completed to KDADS Adult Care Directory and identified **205** QCAs completed for SNFs that listed the facility type as 'Nursing Facility' only.

- The **205** QCAs completed for SNFs that listed the facility type as 'Nursing Facility' only were researched using the following information to determine if the facility provided more than one level of care:

    - Continuing Care Provider application files provided by KDOI
        - Financial statements reviewed to identify if specific level of care resident capacities were stated in Note A, for example: *The facility is made up of 54 skilled nursing beds and 23 assisted living beds.*
    - Floor plans provided by KDADS
        - Reviewed to determine if there was any identification of multiple levels of care being provided on the floor plan.
    - Current services listed on facility's website
        - Reviewed to determine if more than one level of care was in the services listed on the website.

Population 3 – Resident Capacity Changes Resulting in Reduced QCA Rate

- Identified **1,150** beds that were closed during the audit period. These beds were identified if the previous resident capacity was higher than the new resident capacity. Identified **320** beds that were opened during the audit period. These beds were identified if the previous resident capacity was lower than the new resident capacity.

- Identified **209** beds closed for the audit period that resulted in a reduced QCA rate. These beds were identified by having a previous resident capacity higher than 45 with a new resident capacity lower than 46 with an effective date on or before the start of the SFY.

8. Accessed alternative online information sources to independently perform additional analysis and confirm findings such as www.CMS.gov, www.Medicaid.gov, and www.kff.org/Medicaid.

9. Reported draft findings and recommendations to KDOI and KDADS leadership and reviewed the agency's responses.

10. Conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The evidence obtained provided a reasonable basis for the findings and conclusions based on our audit objectives.

Population 1 Audit Results – Incomplete CCP Applications Approved

According to the active CCP registrations lists for calendar years 2020-2023 provided by KDOI, a total of **492** CCP registration applications were approved. The active CCP registration lists for each year provided by KDOI were then compared to the QCA data files provided by KDADS.

A discrepancy was identified between the total SNFs that appeared on the active CCP registration lists from KDOI compared to the SNFs identified as CCRCs per KDADS. Our comparison revealed an additional **27** SNFs missing from the active CCP registration lists initially provided by KDOI.

A combined total of **519** CCP registration applications were approved by KDOI for calendar years 2020-2023. Of the **519** CCP registration applications approved, **100** applications were excluded from our review for the following reasons:

- **56** applications were for small SNFs that would have qualified for the reduced QCA rate.
- **8** applications were not assessed for QCA because they were Assisted Living facilities (ALF) and had no SNF beds to be assessed.
- **1** SNF assessed at $4,908 QCA rate due to CCP registration late submission to KDADS.
- **4** applications were for SNFs closed during the SFY and were not assessed for QCA.
- **5** applications were for SNFs that requested to cancel their CCP registration from KDOI.
- **26** applications were for high Medicaid volume SNFs that would have qualified for the reduced QCA rate.

The remaining **419** applications were for SNFs that required a CCP registration to operate as a CCRC. A 100% review of the remaining **419** applications was conducted for completeness and timeliness outlined in K.S.A. 40-2231 through K.S.A. 40-2238. Our review revealed:

- **134** applications, or **32%**, were determined **complete**
- **285** applications, or **68%**, were determined **incomplete**

New applications for CCP registration were determined incomplete if the application file was missing required documentation. Renewal applications for CCP registration were determined incomplete if the renewal file was missing required documentation or if the

required documentation was not received timely, or prior to the current CCP registration's expiration date. The table below summarizes the results from our review of CCP registration applications approved by KDOI:

Year	Reviewed	Incomplete Apps	Error Rate	Bed Count	Total Loss Amount
2020	100	65	65%	4,708	$19,255,720
2021	108	73	68%	5,542	$22,666,780
2022	113	79	70%	5,906	$24,155,540
2023	98	68	69%	5,145	$21,043,050
Total	**419**	**285**	**68%**	**21,301**	**$87,121,090**

Following our review for completeness and timeliness, the error rates and the loss amounts were calculated. Error rates were calculated by dividing the number of incomplete applications by the total number of applications reviewed. An average error rate of **68%** was determined for all CCP registration applications approved by KDOI in 2020-2023. These CCP registration applications were identified as incomplete, or not in compliance with K.S.A. 40-2231 through K.S.A. 40-2238.

Loss amounts were determined by combining the total bed counts for each SNF that an incomplete application was approved by KDOI, totaling **21,301** SNF beds**.** The **21,301** SNF beds total was then multiplied by **$4,090** (difference between the QCA rates of $4,908 and $818) totaling of **$87,121,090** in loss of QCA revenue to the State, as a result of approval of incomplete CCP registration applications.

Based on the total loss amounts per year from our review above, we estimated an additional loss to the QCA fund in interest earnings. Using the QCA General Ledger Detail and the annual QCA revenue amounts provided by KDADS, we estimated the loss by performing the following calculations:

- **Provider Assessment Loss (PAL)**, total loss amounts determined by the CCP registrations approved with incomplete applications.
- **Provider Assessment Revenue (PAR)**, QCA fund revenue amounts provided by KDADS.

- **Adjusted Provider Assessment**, the sum of the totals in the **PAL** columns to the **PAR** columns.
- **Averaged Interest Rate**, using Excel's Average formula, calculated the average of all actual interest rates listed in the QCA General Ledger Detail.
- **Potential Interest Earned,** the **Average Interest Rate** multiplied by the **Adjusted Provider Assessment**.
- **Estimated Interest Loss,** using the **Actual Interest Earned** totals from QCA General Ledger Detail, the **Actual Interest Earned** was subtracted from the **Potential Interest**.

The calculations are summarized in the table below:

Year	Provider Assessment Loss	Provider Assessment Revenue	Adjusted Provider Assessment	Averaged Interest Rate	Potential Interest Earned	Actual Interest Earned	Estimated Interest Loss
2020	$19,255,720.00	$41,316,763.90	$60,572,483.90	1.243%	$ 752,865.50	$ 338,023.59	$ 414,841.91
2021	$22,666,780.00	$33,985,627.92	$56,652,407.92	0.095%	$ 53,576.99	$ 33,385.87	$ 20,191.12
2022	$24,155,540.00	$29,161,657.03	$53,317,197.03	0.120%	$ 63,891.77	$ 20,957.30	$ 42,934.47
2023	$21,043,050.00	$28,421,009.08	$49,464,059.08	2.721%	$1,346,081.93	$ 447,746.23	$ 898,335.70
TOTAL							**$1,376,303.20**

Based on these calculations, the loss of interest earnings to the QCA fund totaled an estimated **$1,376,303.20** for the audit period. The total loss, **$87,121,090**, was added to the loss of interest earnings, **$1,376,303.20**, for a comprehensive loss amount of **$88,497,393.20**.

Population 2 Audit Results – Registered CCPs with no Evidence of Continuing Care Services

Any SNF that claims to be part of a CCRC, must be a registered CCP. The CCP, as defined in K.S.A. 40-2231(d): "Provider" or "continuing care provider" means the person, corporation, partnership, association or other legal entity which agrees to **provide continuing care** to residents in a home.

The CCP registration application process requires a description of the services provided, as detailed in K.S.A. 40-2234(a): A description of all fees and or charges required of residents, **a description of all services to be provided or committed to providing in the future** and a description of any services for which an extra charge is made over and above entrance fees and periodic charges that are provided for in the contract.
A review of KDOI's CCP registration procedure was conducted. The procedure provided by KDOI is as follows:

Continuing Care Provider Registration Procedure

Pursuant to the provisions of the Kansas Insurance Code, specifically K.S.A. 40-2231, et seq., a continuing care provider cannot lawfully transact business in the state of Kansas without first obtaining a Certificate of Registration from the Kansas Department of Insurance. The Rate and Form Compliance Division is involved in the registration process as well as oversight of the continuing care providers.

When a continuing care provider desires to register in the state of Kansas, the appropriate application materials are available on the department's website. The applicant shall submit the application, the disclosure statement and accompanying exhibits, an audited financial report certified by a CPA, the application fee, and any additional information as requested by the department.

The disclosure statement, pursuant to K.S.A. 40-2232, must also be made available to residents and prospective residents of the provider.

Once the review process has been completed, a determination is made as to whether a certificate should be issued to the provider in question. If the entity is deemed in compliance with all aspects of the application requirements, a Certificate of Registration shall be submitted for the Commissioner's signature. After the Certificate of Registration is signed by the Commissioner, the continuing care provider is authorized to transact business in this state.

A continuing care provider must seek renewal of the certificate annually by following the same procedure as stated for the initial application process.

We were unable to identify within the procedure provided by KDOI, that the description of services detailed in K.S.A. 40-2234(a) were being confirmed, nor were we able to identify that any verification took place to ensure that the applicant met the definition detailed in K.S.A. 40-2231(d): "Provider" or "continuing care provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care.

An analysis of the bed tax data files provided by KDADS was conducted to determine our universe of CCRCs that required a CCP registration issued by KDOI for a reduced QCA rate. The categories for the analysis are as follows:

- **SNF QCAs Completed** – QCAs completed for SNFs.
- **SNF QCAs Completed, CCRC Indicator** – QCAs completed for SNFs identified as CCRCs in bed tax data files provided by KDADS.
- **SNF QCAs Completed – Universe** – QCAs completed for SNFs identified as CCRCs in bed tax data files provided by KDADS that required proof of CCP registration for the reduced QCA rate. These CCRCs did not otherwise qualify for the reduced QCA rate as a small SNF or a high Medicaid volume SNF.

The table below summarizes our results:

SFY	SNF QCAs Completed	SNF QCAs Completed, CCRC Indicator	SNF QCAs Completed - Universe
2021	329	116	96
2022	327	129	110
2023	319	125	107
2024	306	132	107
Total	**1,281**	**502**	**420**

According to the bed tax data files provided by KDADS, **420** QCAs completed for SFY 2021-2024 were identified for SNFs claiming to be part of a CCRC, that required proof of CCP registration for the reduced QCA rate, and did not otherwise qualify for the reduced QCA rate as a small SNF or a high Medicaid volume SNF.

The **420** QCAs identified were reviewed to determine if the CCRC that required proof of CCP registration met the definition of a CCP per K.S.A. 40-2231(d): "Provider" or "continuing care provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care.

The **420** QCAs completed for the CCRCs that required proof of CCP registration, were compared to the Adult Care Directory on the KDADS agency website. If the CCRC populated two or more facility types when researched in the directory, the CCRC was considered to have met the definition of a CCP per K.S.A. 40-2231(d). Of **420** QCAs completed for the CCRCs that required proof of CCP registration, we identified **205** QCAs that only populated a single facility type as “Nursing Facility” when researched in the directory. This meant only SNF beds were located at the CCRC.

Of those **205** QCAs identified, a 100% review was performed using the following information to determine if there was evidence that the CCRC provided any additional level of care beds or offered independent living housing on a single contiguous campus:

1. Financial statements from the CCP registration application file were reviewed if provided. In Note A of the financials, a description of the bed types could be located, such as: *The facility is made up of 54 skilled nursing beds and 23 assisted living beds.*

2. Nursing facility floor plans, provided by KDADS, were reviewed to determine if there was any indication for the provision of multiple levels of care.

3. Facility websites were reviewed to determine if more than one level of care was listed in the service information.

If we could not locate any verification that a continuum of care (either independent living or assisted living/residential healthcare in combination with the skilled nursing care) could be provided on the site/campus, we considered the CCRC to have not met the definition of a CCP per K.S.A. 40-2231(d). Our review revealed that **99 or 24%** of the CCRCs were incorrectly assessed at the reduced QCA rate. Although they were issued certificates of CCP registration by KDOI, there was no evidence that these self-attested CCRCs were providing continuing care per K.S.A. 40-2231(d).

Currently, the Kansas statutes do not define the phrase “continuing care", resting essentially on the federal definition. The care providers as recipients of Medicare and

Medicaid subsides are familiar with these federal terms. The Kansas statutes could be amended to mimic explicitly the federal definition of "continuing care." Ultimately, the providers have to be in alignment with state and federal requirements.

Providers have ignored the definition of “continuing care” as it relates to the QCA which when combined with the lack of appropriate oversight by KDOI and KDADS, allows SNFs to continue to be assessed at the reduced QCA rate by simply claiming CCRC status. This has resulted in an estimated **$33,374,400** loss of QCA revenue to the State for SFY 2021-2024. Estimated loss amounts are summarized in the table below:

SFY	Universe CCRC QCAs	Single LOC NF facility type	Multiple LOC	Single LOC	Single LOC Bed Count	Estimated QCA Loss
2021	96	35	83	13	1,081	$4,421,290
2022	110	54	87	23	1,842	$7,533,780
2023	107	58	76	31	2,502	$10,233,180
2024	107	58	75	32	2,735	$11,186,150
Total	**420**	**205**	**321**	**99**	**8,160**	**$33,374,400**

Our table headers are defined as:

- **Universe CCRC QCAs – QCAs** completed for SNFs identified as CCRCs, in bed tax data files provided by KDADS, that required proof of CCP registration for the reduced QCA rate. These CCRCs did not otherwise qualify for the reduced QCA rate as a small SNF or a high Medicaid volume SNF.
- **Single Level of Care (LOC) Nursing Facility (NF) facility type –** KDADS Adult Care Directory identified the SNF as only having SNF beds and no other LOC beds.
- **Multiple LOC –** Our review identified additional LOC offered, beyond the skilled nursing.
- **Single LOC –** Our review identified no additional LOC offered, beyond the skilled nursing.
- **Single LOC Bed Count –** the bed counts of the SNFs identified in the Single LOC when the QCA was completed.

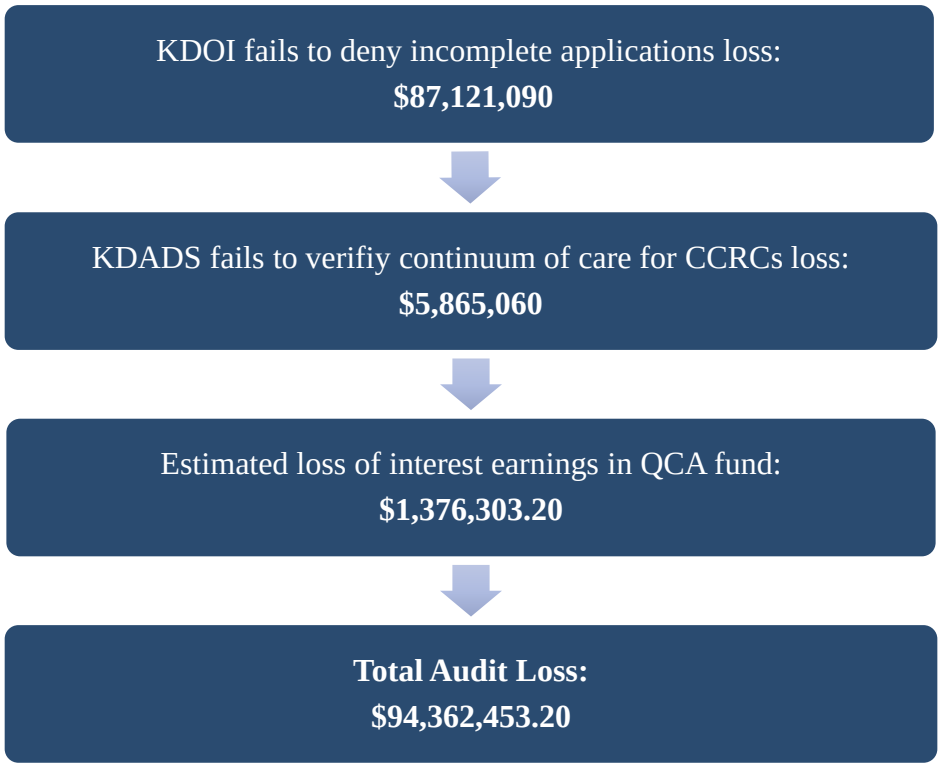
- **Estimated QCA Loss –** Estimated loss amounts were determined by adding the total bed count for each CCRC identified as not meeting the definition of a CCP per K.S.A. 40-2231(d).

The total bed count of these CCRCs identified for the audit period was **8,160.** This total bed count was then multiplied by **$4,090** (the difference between $4,908 and $818) for an estimated **$33,374,400** loss of QCA revenue to the State for SFY 2021-2024.

Of the estimated **$33,374,400** in loss due to the unclear definition of a CCRC, **$27,509,340** of that loss was already accounted for in the **$87,121,090** identified from incomplete applications approved by KDOI. The applications associated to the QCAs were not only incomplete, they also did not provide evidence of any level of care/housing beyond the skilled nursing care.

The remaining **5,865,060** is an additional loss. The SNF did not provide evidence of any level of care/housing beyond the skilled nursing care, however, their CCP registration application was complete and was approved by KDOI.

Total Loss Summary



Population 3 Audit Results – Reducing SNF Beds to Reduce QCA Rate

Analysis of the QCA rate data files provided by KDADS revealed that each year numerous SNFs reduced the number of certified beds. An obvious benefit to the SNF is that this lowers their QCA rate from $4,908 to $818 per licensed bed in the upcoming SFY.

A report of resident capacity changes for SFY 2021-2024 was requested for review. The review of this data identified a total of **1,150** SNF beds closed compared to **320** SNF beds opened during SFY 2021-2024. Of the **1,150** SNF beds closed, **209** resulted in a reduced QCA rate. The SNF resident capacity changes and the loss to QCA revenue are summarized in the table below:

SFY	Closed Beds	Opened Beds	Closed SNF Beds Resulted in Reduced QCA	QCA Loss Amount
2021	172	100	10	$ 40,900
2022	402	25	55	$ 224,950
2023	311	117	74	$ 302,660
2024	265	78	70	$ 286,300
Total	**1,150**	**320**	**209**	**$ 854,810**

QCA loss amounts were calculated by the **209** closed beds during SFY 2021-2024 that resulted in a reduced QCA rate, multiplied by **$4,090** (difference between $4,908 and $818) totaling **$854,810** in decreased QCA revenue to the State.

Unintended Consequences, Bed Closures for a Reduced QCA Rate

Our review of the Resident Capacity changes that occurred during the audit period revealed a total of **209** SNF beds that were closed and resulted in a reduced QCA rate. The **209** SNF beds identified, assessed at the reduced rate, resulted in **$854,810** in loss of QCA revenue.

- **209** beds assessed at $4,908 = $1,025,772
- **209** beds assessed at $818 = $170,962
    - Difference in assessments = **$854,810**

Audit Findings

On March 1, 2024, a draft report of our preliminary findings, recommendations, and observations was forwarded to KDOI and KDADS. The response from KDADS was received on March 15, 2024, and they did not agree with some of our findings and recommendations. The response from KDOI was received on March 18, 2024, and they did not agree with our findings or recommendations. We acknowledge their responses and stand behind our report. The responses letters from KDOI and KDADS are attached to the end of this report.

Finding #1: Kansas Department of Insurance, Non-Compliance with State Statutes

K.S.A. 40-2235, requires any provider that acts as a CCP or operates a CCRC to hold a CCP certificate of registration. CCP Registration certificates are issued to providers who complete the established application process managed by KDOI.

The audit results revealed **68%** of CCP Registration certificates issued to SNFs from July 1, 2020 through August 31, 2023, by KDOI, were not in compliance with K.S.A. 40-2231 through K.S.A. 40-2238. The following items of non-compliance were identified:

- Applications were approved, but were missing the required annual audits by a CPA.
- Certificates were backdated with effective dates inserted as prior to July 1st in order to benefit the SNF for reduced QCA rates, although statutorily required documenation was received after established deadlines – sometimes several months after due date provided. Per K.S.A. 40-2233, *A provider shall file with the commissioner within four months of completion of such provider's fiscal year the annual disclosure statement referred to.*
- SNFs with changes of ownership or management were issued new CCP registrations, although they did not meet the statutorily required filing date within the first 90 days of change of ownership or management.

A **68%** error rate of CCP registrations issued that did not follow requirements in K.S.A. 40-2231 through K.S.A. 40-2238 resulted in a loss to the State's QCA revenue of **$87,121,090.** This resulted in a loss of QCA Fund interest earnings revenue of an estimated **$1,376,303.20**. KDOI's failure to deny incomplete applications for CCP registrations resulted in a total loss to the State's QCA revenue of **$88,497,393.20**.

Recommendations:

1. Reassign responsibility for management and oversight of CCP registration applications from KDOI to KDADS Survey Certification & Credentialing (SCC) commission. Update statutes K.S.A. 75-7435 and K.S.A. 40-2231 through K.S.A. 40-2238 accordingly. The processing and collection of QCA payments should remain within the Long-Term Services & Supports (LTSS) commission at KDADS. These two commissions already share the same databases for surveys, cost reports, and QCAs via the Kansas Organization Tracking Application (KOTA) and the web application, Bed Assessment.

2. The staff responsible for processing the CCP registration applications should include at least one CPA or equivalent accounting background. This role would be responsible for making determinations for any red flags identified in the required financial documentation.

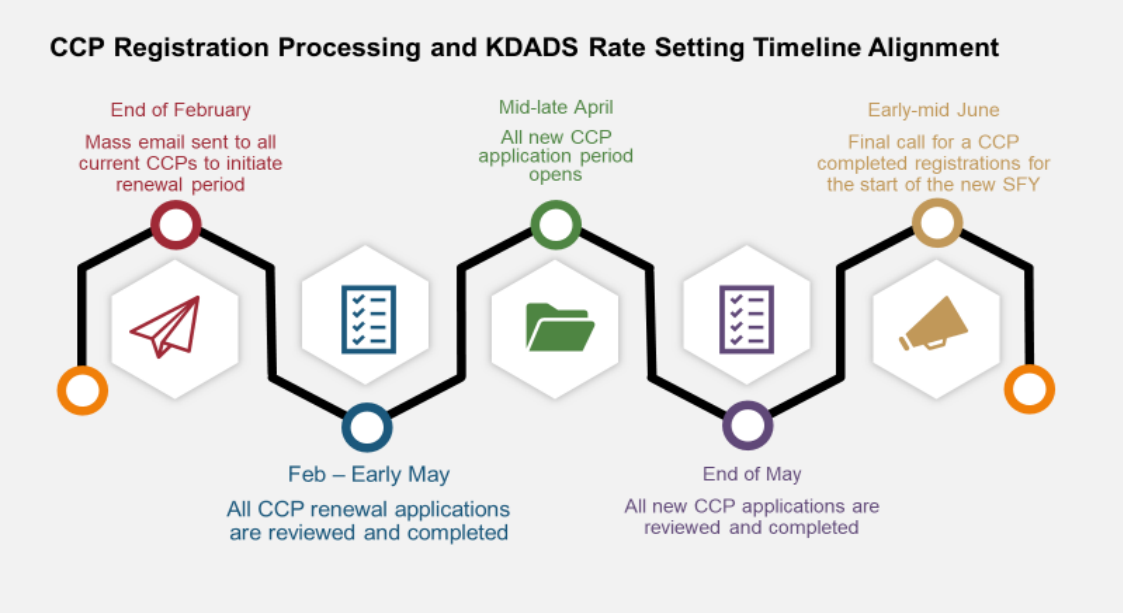
3. Update KDADS' SNF change of ownership procedures to include identifying a SNF that operates as part of a CCRC. If this type of SNF is identified when processing a change of ownership, the SNF should be directed to the CCP registration process and informed that K.S.A 40-2237 requires that new owners must file all required documents of this act within 90 days of change. This information should also be communicated in the applicable databases/web applications used by KDADS, as mentioned above.

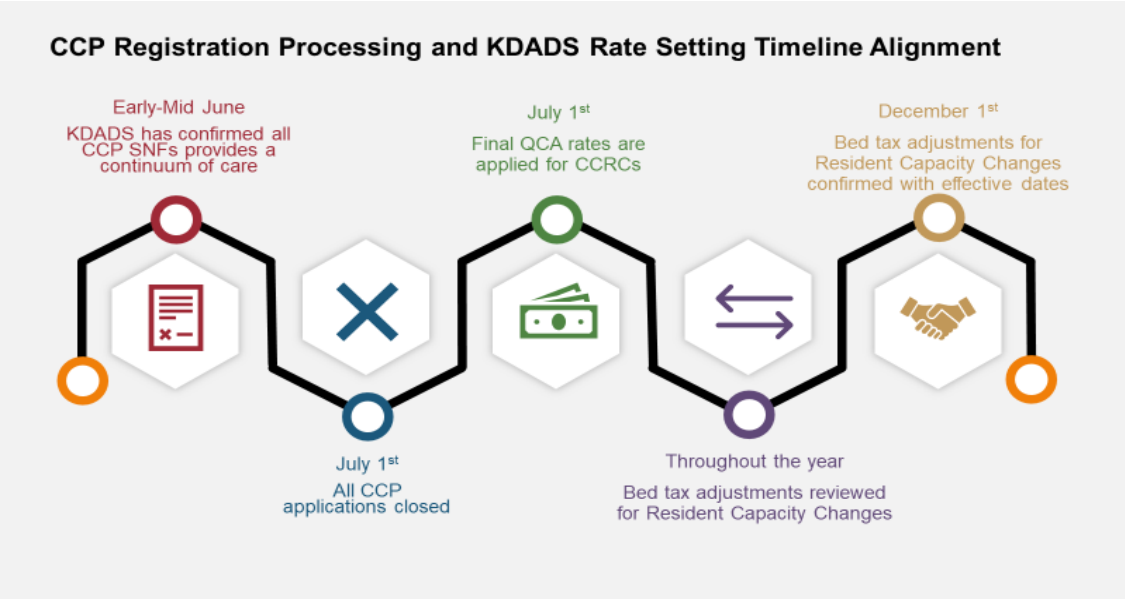
4. Allocate sufficient staff needed for administrative duties to allow CCP registration applications to be processed appropriately per K.S.A. 40-2231 through K.S.A. 40-2238, verifying the CCRCs have continuum of care through survey data or through access to information regarding the Independent Living communities in the State. All necessary staff members involved with QCAs should have access to the databases KOTA, Bed Assessment, and CASPER to properly manage the data that determines a QCA rate for a SNF.

5. Quality control steps should be initiated to review the 285 incomplete applications. Thereafter, quality controls should be in place to ensure each SNF receives an accurate QCA annually and all SNFs are following K.S.A. 75-7435 and K.S.A. 40-2231 through K.S.A. 40-2238.

6. Currently, CCP registration effective dates span throughout SFY, which creates year-round maintenance of renewal applications, communication, and processing. If the CCP application timelines were aligned with the cost reporting timelines for rate setting, already established by KDADS, it would eliminate continuous maintenance throughout the SFY. This would also ensure all documentation (cost reports, Medicaid bed days reporting, and CCP registration applications) is provided in the same quarter and to one agency.

Timeline Recommendation:





Finding #2: Missed Opportunity by KDADS to verify SNFs that were claiming to be a CCRC, but did not offer a continuum of care.

When KDADS completed the QCA rate determinations for the new SFY, any SNF that provided a CCP registration from KDOI to KDADS was assessed as a CCRC. There was no verification of continuing care provided as described in the following statutes:

> K.S.A 40-2231(d): "Provider" or "Continuing Care Provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care to residents in a home.
>
> K.S.A. 75-7435(5): "Continuing care retirement facility" means a facility holding a certificate of registration issued by the commissioner of insurance pursuant to K.S.A. 40-2235, and amendments thereto.
>
> K.S.A. 40-2235: No provider shall act as or hold themselves out to be a continuing care provider, as defined in this act, in this state, unless the provider shall hold a certificate of registration as a continuing care provider issued by the commissioner of insurance.

The team that utilizes the databases for the QCAs has access to the type of beds that are surveyed and documented. If a SNF assessed for the QCA only had SNF beds listed in KOTA, there was no additional research completed to ensure a continuum of care was being provided. As a result, SNFs were allowed to claim to be a part of a CCRC, even when the only level of care described in the QCA was skilled nursing care.

Recommendations:

1. Update the statutory definition of a CCRC to:

   "Continuing Care Retirement Community" means a range of housing and services designed to meet changing health needs without the need for the resident to relocate to another location. A community where a continuum of aging care need – from Independent Living, Assisted Living/Residential Healthcare, and Skilled Nursing Care – can be met on a single contiguous campus. Providing "continuing care" would refer to the multiple levels of care provided within this type of community.

This update to the definition in the statutes would require verification of continuum of care services for all CCP registration applicants. KDADS would need to be named as the responsible agent for this verification.

2. Independent living verification should be accessible information to the team verifying the SNF claiming to be a part of the CCRC. The team should confirm the continuum of care is possible prior to reducing the QCA rate for any facility.

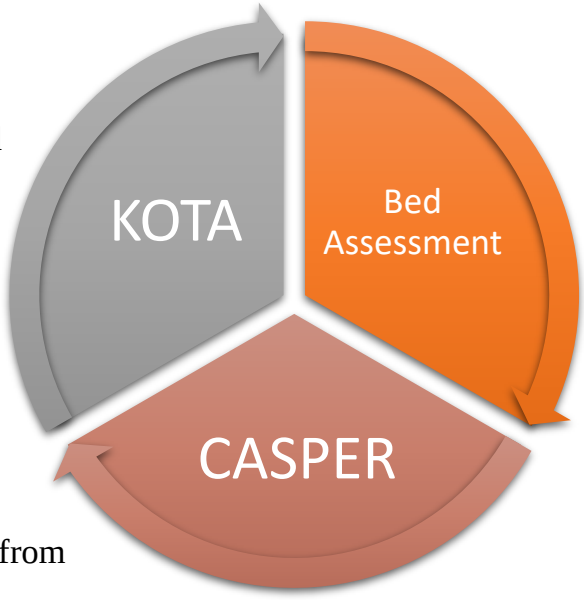
Finding #3: SNFs reporting to KDADS as a CCRC, yet not reporting to CMS as a CCRC.

Data extracted from the Nursing Home Provider Info report from CMS, on 9/1/2023, identified **100** SNFs in Kansas that claimed to be a part of a CCRC. When the 2023 CMS report was compared to the SFY 2024 bed tax data file from KDADS (QCA rates effective 7/1/2023), **129** SNFs claimed to be a part of a CCRC.

Our review identified a discrepancy of **29 or 22%** of SNFs claiming to be a part of a CCRC to KDADS did not claim to be a part of a CCRC on the Long-Term Care Facility Application for Medicare and Medicaid, Form CMS-671. KDADS did not utilize the CMS site data to identify these discrepancies.

Recommendation:

1. Incorporate shared data between KOTA and Bed Assessment and CASPER (Certification and Survey Provider Enhanced Reports, a database for communication between KDADS and CMS) to best manage changes within SNFs that would impact the QCA rates within a fiscal year, such as: changes in resident capacity (bed count) for SNF beds and changes in Medicaid bed days reported from year to year.



This would also automatically update CMS when a SNF was identified as a CCRC by KDADS, eliminating the opportunity for the SNF to not report operating as a CCRC to CMS.

Finding #4: A SNF assessed for QCA at $4,908 per bed pays an average of $296,752.65 more annually than a SNF assessed for QCA at $818 per bed.

A Quality Care Assessment Pass-Through, or bed tax per diem, table was created to compare the two QCA rates ($818 or $4,908) with generalized occupancy rates. A generic facility was created named, “Facility X", which represents a SNF in Kansas with an average bed count of 75 beds. The average bed count was determined using the 2023 Registered CCP list received from KDOI. The average number of beds registered in 2023 was 75, which was used for all examples below. The generalized occupancy rates in the totals of 75%, 50%, and 25% were used to represent a high, medium, and low occupancy for “Facility X."

There are six examples in total, three at the reduced rate of $818 and three at the standard rate of $4,908. For each of the six examples, the following calculations were performed:

- **Total Bed Days Available**, the number of beds (75) multiplied by the number of days in the year (365), totaling 27,375 bed days available. This total represents the number of days a patient could occupy a bed in the facility.

- **Inpatient Bed Days**, the total bed days (27,375) multiplied by the **Occupancy Rate** (.75, .50, or .25). This total represents the number of days patients were occupying a bed in the facility.

- **Annual QCA**, the number of beds (75) multiplied by the assessment rate ($818 or $4,908). This total represents the annualized assessment expense. **Bed Tax per Diem**, dividing the **Annual QCA** amount by the **Inpatient Bed Days** (e.g. 61,350/20,531 = 2.99).

- **Annual Reimbursement per Assessment Rate**, the **Bed Tax per Diem** is multiplied by the number of days in the year (365). This total represents the annual reimbursement amount “Facility X" could receive. This is a comparison of the total annual reimbursement amount that could be received, per assessment rate ($818 or $4,908).

- **Annual QCA, After Reimbursement**, the **Annual Reimbursement per Assessment Rate** was subtracted from the **Annual QCA**. This total represents the final cost to the SNF for the annualized assessment expense. This is a comparison

of the final cost to the SNF for the annualized assessment expense, per assessment rate ($818 or $4,908).

- **Difference**, the **Annual QCA, After Reimbursement** for the $4,908 assessment rate is subtracted from the **Annual QCA, After Reimbursement** for the $818 assessment rate.

For a SNF with 75 beds, our analysis identified substantial annual savings to the SNF when assessed at the reduced QCA rate of $818 per bed. When applying the annual reimbursement amount based on occupancy rate, the savings to the annual final QCA amount ranged from **$290,390.70** to **$301,296.90**, summarized in the table below:

FACILITY X					
Occupancy & Assessment Rate	**Bed Count**	**Bed Tax Per Diem**	**Annual QCA**	**Annual Reimbursement**	**Annual QCA after Reimbursement**
75% @ $ 818	75	2.99	$ 61,350	$ 1,091.35	$ 60,258.65
75% @ $4,908	75	17.93	$ 368,100	$ 6,544.45	$ 361,555.55
Difference					**$ 301,296.90**
50% @ $ 818	75	4.48	$ 61,350	$ 1,635.20	$ 59,714.80
50% @ $4,908	75	26.89	$ 368,100	$ 9,814.85	$ 358,285.15
Difference					**$ 298,570.35**
25% @ $ 818	75	8.96	$ 61,350	$ 3,270.40	$ 58,079.60
25% @ $4,908	75	53.78	$ 368,100	$ 19,629.70	$ 348,470.30
Difference					**$ 290,390.70**

Recommendations:

1. Close the one-sixth gap between the standard QCA rate of $4,908 and the reduced QCA rate of $818. A rate study should be completed to determine rates that follow all statutes, regulations, and any applicable waivers that encourage SNFs to keep beds open and for the bed taxes to be affordable for those beds to stay open. Lowering the standard QCA rate and increasing the reduced QCA rate would allow more SNF beds to be available to meet the demands of increasing skilled nursing care needed without such a burdensome tax assessment associated with higher resident capacity, a lower Medicaid volume, or CCRC status.

2. The definition of a small SNF should be reviewed concerning the number of beds that is used as the cut-off. Changing the cut-off number from 45 to 55 would allow facilities that are only SNFs to benefit from the reduced QCA rate and remain profitable, while encouraging them to reopen beds.

Finding #5: One KDADS Staff Member Responsible for All Bed Counts for the State.

During an interview with KDADS staff, it was reported that a single surveyor reports, records, and verifies all bed counts for all Kansas Nursing Homes. This is not always done in person, as the surveyor used floorplans, pictures, and the surveyor's ability to recall the SNF floorplan from memory to "verify" bed counts. These certified bed counts are entered into the Kansas Organization Tracking Application (KOTA) used by KDADS. Bed Assessment, an automatic bed assessment rate calculator, pulls in this bed count data from KOTA to determine if the facility qualifies for the reduced bed tax rate of $818 based on having less than 46 beds.

Recommendation:

1. Any time there is a request to change bed counts (increase or decrease), an onsite inspection should be completed by KDADS within 30 days of the requested change. This onsite inspection must be documented in KOTA. This information must also be communicated to CMS.

Finding #6: Unnecessary processing of CCP applications due to current language in state statutes K.S.A. 40-2231 and K.S.A. 40-2235.

Currently, per K.S.A. 40-2231 and K.S.A. 40-2235: Any provider who acts as or holds themselves out to be a CCP can voluntarily apply for a certificate. A review of the CCP registration applications, processed for the audit period, identified a total of **97** applications for facilities that for various reasons do not require CCP registration to reduce the QCA rate:

- **8** applications were for Assisted Living Facilities (ALF), QCAs do not apply to ALF beds
- **25** applications were for high Medicaid volume SNFs, automatically eligible for reduced QCA rate
- **64** applications were for small SNFs, automatically eligible for reduced QCA rate

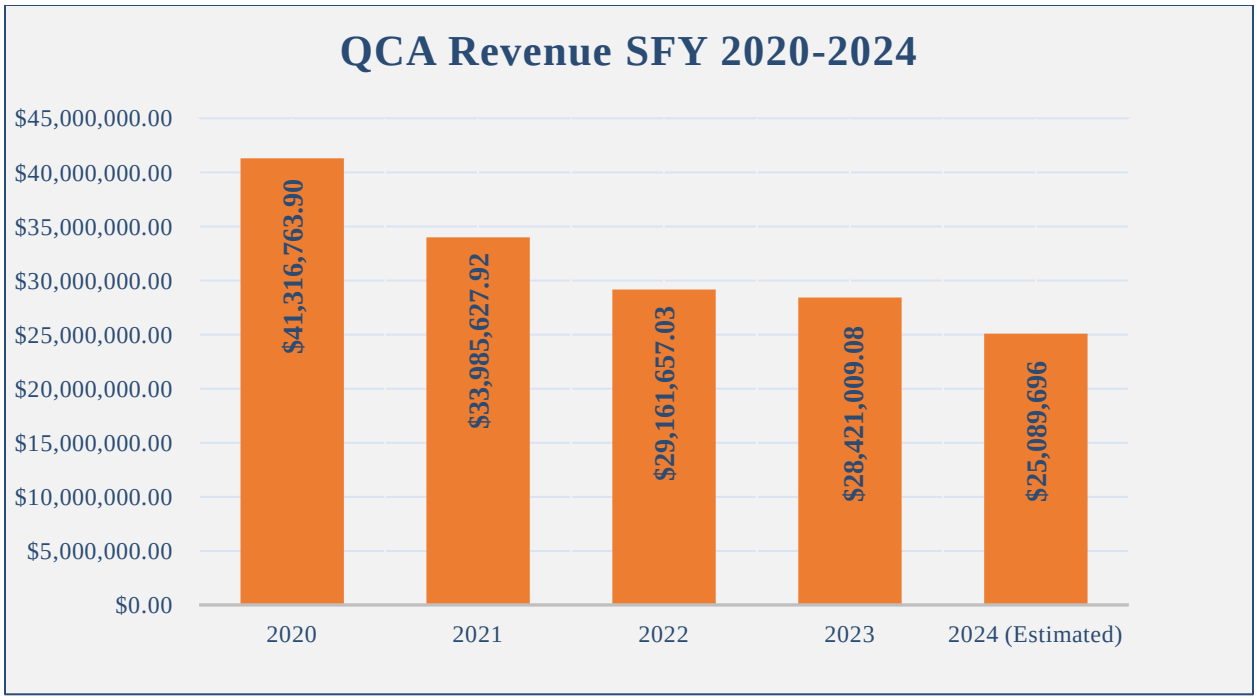
State resources were wasted on processing these unnecessary applications. The facilities also wasted their time and money filing the CCP registration applications that were not required.

Recommendation:

1. Update statute to only allow/require CCP Registrations for SNFs that are not defined as a small SNF or a high Medicaid volume SNF per K.A.R. 129-10-31, and require that the SNF is a part of a CCRC that can provide a continuum of care. If the SNF does not meet that criteria, they do not need to register as a CCP.

Finding #7– Use of SGF Increases as QCA Declines

Our audit results demonstrated as QCA revenue decreased each year, the usage of State General Funds (SGF) increased each year.

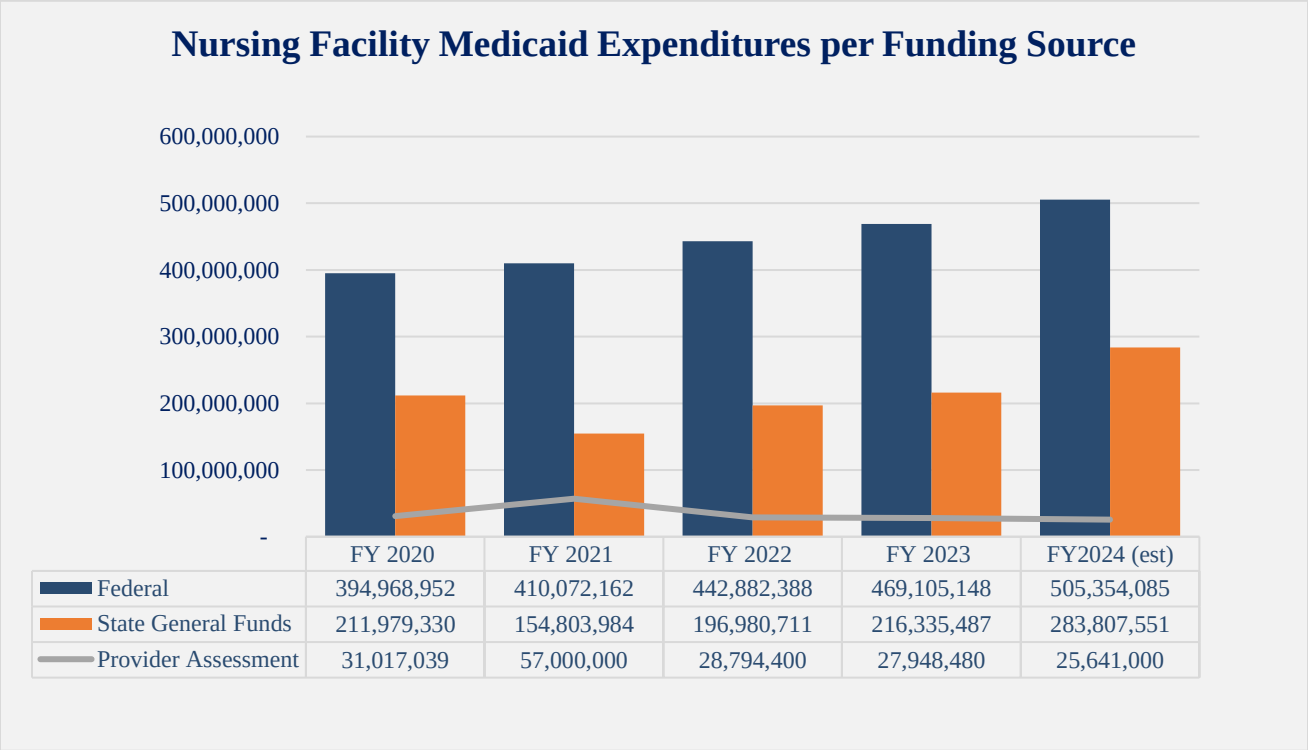


The state's share of the Nursing Facility Medicaid expenditures are partially funded by the QCA revenues. The decrease of the QCA revenue from SFY 2020 through SFY 2024 directly caused an increased need for the SGF to supplement the State's share.

The chart below illustrates the relation of the Provider Assessment expenditures and SGF. In SFY 2020, the State's share of the Nursing Facility Medicaid expenditures was **$242,996,369.** The Provider Assessment contributed **$31,017,039**, leaving **$211,979,330** to be paid by the SGF.

An increase in Provider Assessment expenditures for SFY 2021 was due to outstanding funds held over from SFY 2019 and SFY 2020. The funds were applied to the QCA fund under the direction of the Division of Budget. The outstanding funds were used to subsidize the State's share of the Nursing Facility Medicaid expenditures. In SFY 2022, the Provider Assessment amount decreased from both the SFY 2021 and from SFY 2020.

In SFY 2023, the SGF utilized increased by **$19,354,776** when compared to SFY 2022**.** Additionally, in SFY 2024 the SGF utilized increased by **$67,647,064** when compared to SFY 2023.



	FY 2020	FY 2021	FY 2022	FY 2023	FY2024 (est)
Federal	394,968,952	410,072,162	442,882,388	469,105,148	505,354,085
State General Funds	211,979,330	154,803,984	196,980,711	216,335,487	283,807,551
Provider Assessment	31,017,039	57,000,000	28,794,400	27,948,480	25,641,000

Recommendations:

1. Conduct yearly analysis of QCA revenue and expenditures to identify trends that should be addressed by the Quality Care Improvement Panel and included in the annual QCIP reports.

Finding #8: Quality Care Improvement Panel (QCIP) annual reports have not been provided to the committees named in K.S.A. 75-7435(5)(k) since 2020.

Per K.S.A. 75-7435(5)(k), the QCIP is required to report annually to Senate committees on Public Health and Welfare and Ways and Means, House committees on Appropriations and Health and Human Services (HHS), and the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

The annual QCIP report should include 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 SNFs, the activities of the QCIP during the preceding calendar year, and any recommendations that the panel may have concerning the administration of and expenditures from the QCA fund.

Research of the reports provided to the committees named in K.S.A. 75-7435(5)(k) from 2020 to 2023 was conducted. A Senior Research Analyst from Kansas Legislative Research Department confirmed that only one testimony could be located that contained a report from the QCIP in 2020. Reports for years 2021, 2022, or 2023 could not be located.

KDADS staff did provide some draft reports updating how many Medicaid SNFs had a QCA at the $4,908 rate and how many had a QCA rate of $818. For the Medicaid SNFs with a QCA rate of $818, they provided the reason for the reduced rate along with how many Medicaid SNFs were associated to each reason. The reasons provided were CCRC, small SNF, and high Medicaid volume SNF. The draft reports also included a separate table for the Non-Medicaid SNFs, including all of the same information as the Medicaid SNFs. However, none of the drafts were submitted to the required committees.

Recommendations:

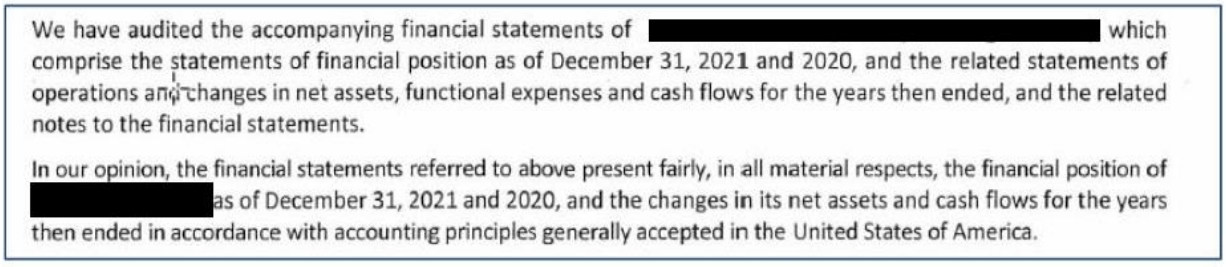
1. Report to the required committees annually. Reports should contain the requirements in the K.S.A. 75-7435(5)(k).
2. The QCIP should meet quarterly to discuss areas of concerns within the QCAs, the QCA fund, or any other nursing facility issues related to K.S.A. 75-7435.
3. A representative from the Office of Inspector General should be added to the QCIP.

Finding #9: Legal advice from KDOI's General Counsel led to non-compliance with K.S.A. 40-2233.

Our review of supporting documents and emails between KDOI staff members found numerous examples of advice from the KDOI's General Counsel that were contrary to applicable statutes. This resulted in decisions being made by KDOI staff to issue CCP registrations to facilities that were not qualified.

A certified audit, review, compilation report and engagement letter are four important but separate services, provided by an auditing firm or CPA, to furnish insight on the financial statements of a company.

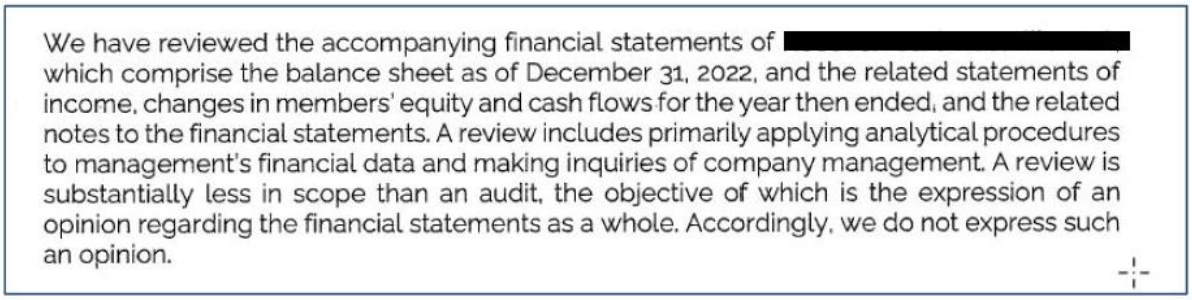
A certified audit is the most comprehensive service and provides a defined account of the auditor's responsibilities, their opinion, and the financial standing of the company undergoing the audit. In addition to the financial statements, the auditor evaluates the company's internal accounting systems. An example of a certified audit is below:



We have audited the accompanying financial statements of [redacted] which comprise the statements of financial position as of December 31, 2021 and 2020, and the related statements of operations and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

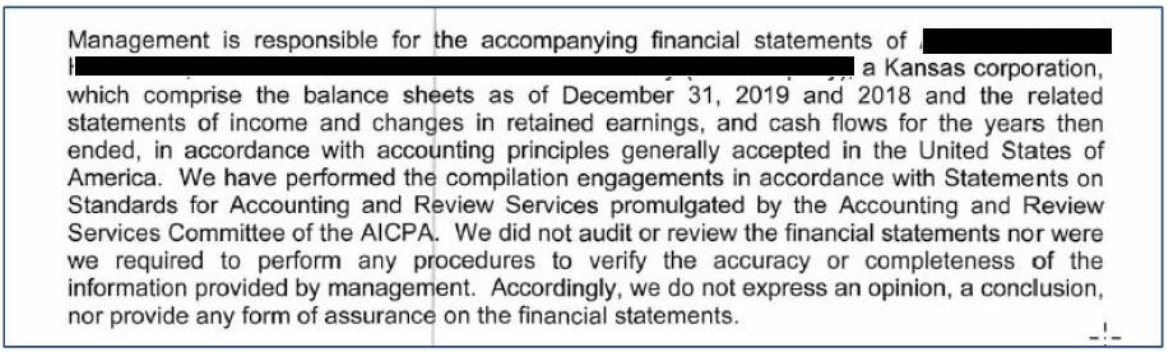
In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of [redacted] as of December 31, 2021 and 2020, and the changes in its net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

A review is more limited in scope compared to a certified audit. The auditor performs analytical review of the financial statements to get a general understanding of the company's finances. The most important difference between an audit and a review is that the audit provides a reasonable assurance of the financial state of the company. Also, a review does not include an auditor's opinion. An example of a review is below:



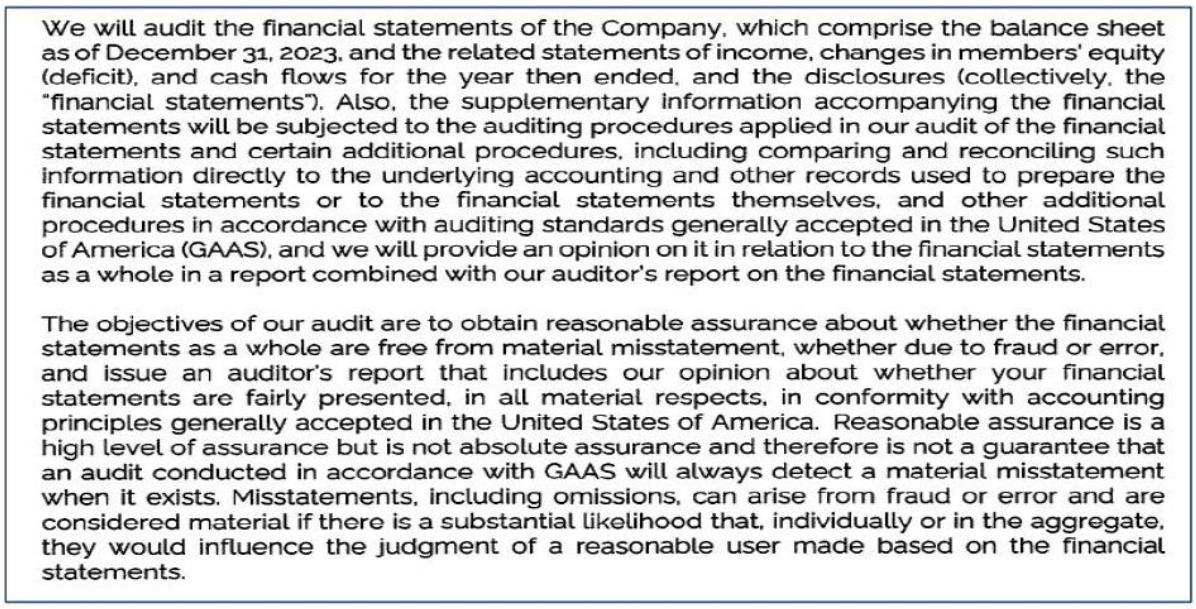
We have reviewed the accompanying financial statements of [redacted] which comprise the balance sheet as of December 31, 2022, and the related statements of income, changes in members' equity and cash flows for the year then ended, and the related notes to the financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

A compilation involves compiling the financial information of a company into their general financial statements. This type of service aids the company in planning their budgets or preparing other documents for reporting. A compilation provides no assurance on the financial state of the company. An example of a compilation is below:



Management is responsible for the accompanying financial statements of [redacted] a Kansas corporation, which comprise the balance sheets as of December 31, 2019 and 2018 and the related statements of income and changes in retained earnings, and cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America. We have performed the compilation engagements in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the financial statements.

An engagement letter is a formal, written agreement that outlines the scope of the requested audit, what the company is responsible for providing, an estimated timeframe, and other various expectations. Engagement letters are generally a binding contractual agreement between the auditor and the company. This option provides a promise that an audit will take place, but no audit, review or compilation has taken place. An example of an engagement letter is below:



We will audit the financial statements of the Company, which comprise the balance sheet as of December 31, 2023, and the related statements of income, changes in members' equity (deficit), and cash flows for the year then ended, and the disclosures (collectively, the "financial statements"). Also, the supplementary information accompanying the financial statements will be subjected to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America (GAAS), and we will provide an opinion on it in relation to the financial statements as a whole in a report combined with our auditor's report on the financial statements.

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and issue an auditor's report that includes our opinion about whether your financial statements are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. Misstatements, including omissions, can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment of a reasonable user made based on the financial statements.

Recommendations:

1. The KDOI Commissioner should ensure all KDOI staff members are following applicable federal and state statutes.
2. Conduct a review of other decisions made by the General Counsel to ensure other statutes have not been ignored.

Observations

1. **During the audit, KDADS made improvements to the current procedures for CCP registration verification, communication with KDOI, and overall QCA rates involving CCRCs.**

   KDADS staff provided updated Work Instructions for Obtaining the CCP Provider list from KDOI. These updates were completed 1/25/2024 and shared with our office.

   KDADS previously was able to run a Registered CCP report on KDOI's website. As of 6/12/2023, this report was no longer available. The report is now only available via the National Association of Insurance Commissioner's State-Based Services website.

   KDOI will provide the KDADS CCRC inbox (KDADS.CCRC@ks.gov) with an up-to-date list of CCRC facilities in the State of Kansas by May 15th and November 15th of each year, as well as sending periodic emails throughout the year as initial approvals, renewals, contingencies, denials etc. for individual facilities are processed.

2. **Non-Medicaid Facilities Pay QCA Tax and Receive No Reimbursement**

   Non-Medicaid facilities pay the QCA tax, but do not get any reimbursement for these taxes as a non-Medicaid provider. The table below shows the financial burden to each non-Medicaid facility with $0 reimbursement for taxes paid.

Facility #	SFY 2023 QCA Rate	SNF Beds	Annual Assessment	Reimbursement
1	818	80	$65,440	$0
2	818	45	$36,810	$0
3	818	50	$40,900	$0
4	818	38	$31,084	$0
5	818	34	$27,812	$0
6	818	17	$13,906	$0
7	818	40	$32,720	$0
8	818	45	$36,810	$0
9	818	18	$14,724	$0

3. **Discrepancy of Statute and Regulation for Small SNFs**

A discrepancy was identified in definitions of a "small skilled nursing care facility" between the Kansas Administrative Regulations, § 129-10-31(5) and the Kansas Statutes Annotated, 75-7435(5)(b)(1). The regulation defines the small SNF as fewer than 46 beds, while the statute allows the secretary of health and environment to define the threshold, as long as it's not fewer than 40 beds. Kan. Admin. Regs. § 129-10-31(5) defines a "small skilled nursing care facility" as any facility with fewer than 46 licensed nursing facility beds.

K.S.A. 75-7435(5)(b)(1): As used in this paragraph, the terms "small skilled nursing care facilities" and "high Medicaid volume skilled nursing care facilities" shall be defined by the secretary of health and environment by rules and regulations, except that the definition of "small skilled nursing care facility" shall not be fewer than 40 beds.

4. **A group of four registered CCPs under one umbrella company had their CCP registrations cancelled for not providing their annual certified audit by a CPA.**

A group of four registered CCPs, under one umbrella company, was questioned by KDOI about their provided financials during a renewal period. The company was asked to provide their annual audit certified by a CPA, per K.S.A. 40-2233. When the company's vice president responded to the request, he stated the company does not conduct annual audits for the facilities. When KDOI explained that the certified audit was required per statute, the vice president argued that this has never been required by KDOI in the 20+ years he has worked with CCRCs. This led to KDOI referring the issue to their legal department.

Legal advised per K.S.A. 40-2235, KDOI can deny a renewal registration that is not in compliance with the CCP registration statutes, but only after notice and hearing. A notice of non-renewal was sent to the facility's administrator and vice president. The notice stated the group of CCPs was not in compliance with the requirements for the registration and the registration would not be renewed. The notice included rights to a hearing for an appeal, if requested in writing within 15 days of the nonrenewal of registration. If an appeal was not requested within the 15 days, the registration would become effective as a final agency action to not renew following the expiration of the 15-day period.

While the communication between KDOI and the vice president of the group of CCPs continued, the vice president reached out to KDADS explaining the renewal of CCP registration was in question and a final decision to the renewal was currently pending. KDADS provided an extension for the deadline of the registration renewal due to the pending status of the renewal. KDOI also provided an extension to the deadline for the certified audit and stated they could accept evidence that the facilities have contracted with an auditor, to meet the bed tax deadline for KDADS, and the registration renewal would be contingent upon the submission of the audited financial statements for all four entities.

The CCP registrations were cancelled as of 08/05/2021, following the expiration of the 15-day period, for non-compliance for not providing their annual audit certified by a CPA per K.S.A. 40-2233 and were not awarded the reduced QCA rate for SFY 2022.

For SFY 2022, out of a total of **108** CCP applications/renewals for registration, **73 or 68%** of the applications were approved without their annual audit certified by a CPA, as required in K.S.A. 40-2233. As a result of these applications being approved without the certified audit by a CPA, these SNFs were awarded the reduced QCA rate for **5,542** SNF beds resulting in a loss to the State QCA revenue of **$22,666,780**. Yet a group of four registered CCPs under one umbrella company had their CCP registrations cancelled for not providing their annual certified audit by a CPA.

Appendix

Appendix I - Applicable Laws and Regulations
Appendix II - CMS-671 Long Term Care Facility Application
Appendix III - Acronyms
Appendix IV - Response letter from KDADS dated March 15, 2024.
Appendix V – Response letter from KDOI date March 18, 2024.

Appendix I – Applicable Laws and Regulations

Quality Care Assessment

K.A.R 129-10-31(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be $818 annually per licensed bed for the following:

> (A) Each skilled nursing care facility that is part of a continuing care retirement facility, per **K.A.R 129-10-31(a)(4)** "Skilled nursing care facility that is part of a continuing care retirement facility" means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.
>
> (B) each small skilled nursing care facility, per **K.A.R 129-10-31(a)(5)** Small skilled nursing care facility" means any facility with fewer than 46 licensed nursing facility beds.
>
> (C) each high Medicaid volume skilled nursing care facility, per K.A.R **129-10-31(a)(1**) High Medicaid volume skilled nursing care facility" means any facility that provided more than 25,000 days of nursing facility care to Medicaid recipients during the most recent calendar year cost-reporting period.

(2) The assessment amount for each skilled nursing care facility other than those identified in paragraphs (c)(1)(A) through (C) shall be $4,908 annually per licensed bed.

Determination of bed assessment rates (bed tax amount)

KSA 75-7435(5)(b)(1) The assessment on all facilities in the aggregate shall be an amount fixed by rules and regulations of the secretary of health and environment, shall not exceed $4,908 annually per licensed bed, shall be imposed as an amount per licensed bed and shall be imposed uniformly on all skilled nursing care facilities except that the assessment rate for skilled nursing care facilities that are part of a continuing care retirement facility, small skilled nursing care facilities and high Medicaid volume skilled nursing care facilities shall not exceed 1/6 ($818) of the actual amount assessed all other skilled nursing care facilities.

Adult Care Home Definitions

KSA 75-7435 (2) "Skilled nursing care facility" means a licensed nursing facility, 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 department of health and environment, providing skilled nursing care, but shall not include the Kansas soldiers' home or the Kansas veterans' home.

K.S.A. 39-923 (2) "Nursing facility" means any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations.

K.S.A. 39-923 (3) "Nursing facility for mental health" means any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care and special mental health services to compensate for activities of daily living limitations.

K.S.A. 39-923 (11) "Skilled nursing care" means services performed by or under the immediate supervision of a registered professional nurse and additional licensed nursing personnel. Skilled nursing includes administration of medications and treatments as prescribed by a licensed physician or dentist; and other nursing functions that require substantial nursing judgment and skill based on the knowledge and application of scientific principles.

Quality Care Fund

K.S.A 75-7435(d) (1) There is hereby created in the state treasury the quality care fund to be administered by the secretary of health and environment. 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 secretary of health and environment or the secretary's 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 secretary of health and environment 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 secretary of health and environment, shall be returned on a pro rata basis to skilled nursing 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 deposited in the quality care fund and 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 secretary of health and environment or 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 pursuant to subsection (b) 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 rebasing and inflation to be applied to rates in fiscal year 2011; and

(F) the remaining amount, if any, shall be expended first to increase the direct health care costs center limitation up to 150% of the case mix adjusted median, and then, if there are remaining amounts, for other quality care enhancement of skilled nursing care facilities as approved by the quality care improvement panel 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) Any moneys received by a skilled nursing care facility from the quality care fund shall not be expended by any skilled nursing care facility to provide for bonuses or profit-sharing for any officer, employee or parent corporation but may be used to pay to employees who are providing direct care to a resident of such facility.

(6) Adjustment payments may be paid quarterly or within the daily Medicaid rate to reimburse covered Medicaid expenditures in the aggregate within the upper payment limits.

(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.

(5)(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 subsection, the secretary of health and environment 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. The secretary of health and environment is authorized to establish delayed payment schedules for skilled nursing care facilities that are unable to make installment payments when due under this section because of financial difficulties, as determined by the secretary of health and environment.

(5) (f) (1) The secretary of health and environment 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 (h) until:

(A) An amendment to the state plan for Medicaid that increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal Medicaid program and that is proposed for approval for purposes of subsections (a) through (h) is approved by the federal government, in which case the initial assessment is due not earlier than 60 days after state plan approval; and

(B) the skilled nursing care facilities have been compensated retroactively within 60 days after state plan approval 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 secretary of health and environment shall implement and administer the provisions of subsections (a) through (h) in a manner consistent with applicable federal Medicaid laws and regulations. The secretary of health and environment shall seek any necessary approvals by the federal government that are required for the implementation of subsections (a) through (h).

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

(A) The Medicaid plan amendment that increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal Medicaid program and that is proposed for approval for purposes of subsections

(a) through (h) is not approved by the United States centers for Medicare and Medicaid services;

(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 December 31, 2009, increased by revenues in the quality care fund and matched by federal financial participation and rebasing as provided for in K.S.A. 75-5958, and amendments thereto;

(C) any funds are utilized to supplant funding for skilled nursing care facilities as required by subsection (g);

(D) any funds are diverted from those purposes set forth in subsection (d)(4); or

(E) upon the governor signing, or allowing to become law without signature, legislation that, by proviso or otherwise, directs any funds from those purposes set forth in subsection (d)(4) or that would propose to suspend the operation of this section.

(5) (g) On and after July 1, 2010, reimbursement rates for skilled nursing care facilities shall be restored to those in effect during December 2009. No funds generated by the assessments or federal funds generated therefrom shall be utilized for such restoration, but such funds may be used to restore the rate reduction in effect from January 1, 2010, to June 30, 2010.

(5) (h) Rates of reimbursement shall not be limited by private pay charges.

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

(5) (j) The department of health and environment may adopt rules and regulations necessary to implement the provisions of this section.

Quality Care Improvement Panel (QCIP)

75-7435(5) (k) 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 LeadingAge 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 executive's 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 department for aging and disability services;
- One person appointed by the governor from the department of health and environment; one person appointed by the president of the senate who is affiliated with an organization representing and advocating the interests of retired persons in Kansas; and
- One person appointed by the speaker of the house of representatives who is a volunteer with the office of the state long-term care ombudsman established by the long-term care ombudsman act.

The person appointed by the governor from the department for aging and disability services and the person appointed by the governor from the department of health and environment shall be nonvoting members of the panel.

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 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

concerning 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 that the panel may have concerning the administration of and expenditures from the quality care assessment fund.

(5) (l) The provisions of this section shall **expire on July 1, 2030**.

History: L. 2010, ch. 159, § 1; L. 2012, ch. 102, § 53; L. 2013, ch. 55, § 1; L. 2016, ch. 107, § 2; L. 2020, ch. 7, § 3; April 9.

Continuing Care Provider Registration Requirements

K.S.A. 40-2231. Continuing care contracts; definitions. As used in this act:

(a) "Continuing care contract" means an agreement pursuant to which a provider undertakes to furnish to a person, not related by consanguinity or affinity to the provider, shelter and medical or nursing services or other health-related benefits which require a present or deferred transfer of assets or an entrance fee in the amount of $5,000 or equivalent value or such greater amount as set by the commissioner in rules and regulations in addition to or in lieu of periodic charges. Continuing care contract shall also mean an agreement of any other provider who voluntarily applies for a certificate pursuant to K.S.A. 40-2235.

(b) "Entrance fee" means the total of any initial or deferred transfer to, or for the benefit of, a provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance of a person as a resident pursuant to a continuing care contract.

(c) "Home" means the facility or facilities occupied, or planned to be occupied, by five or more residents where the provider undertakes pursuant to the continuing care contract to provide continuing care to such residents.

(d) "Provider" or "continuing care provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care to residents in a home.

(e) "Resident" means an individual or individuals who have entered into an agreement with a provider for continuing care in a home.

(f) "Commissioner" means commissioner of insurance of the state of Kansas.

History: L. 1989, ch. 73, § 1; July 1. Source or prior law: 16-1101.

K.S.A. 40-2232. Same; provider's annual disclosure statement; contents; requirement to furnish. A provider shall be required to complete an annual disclosure statement prescribed by the commissioner and shall be required to deliver the disclosure statement to individuals who are prospective residents, or current residents who request such disclosure statement. The text of the disclosure statement shall contain the following information:

(a) The name and business address of the provider and a statement of whether the provider is an individual, partnership, corporation or any other legal entity.

(b) The names of the individual or individuals who constitute the provider or, if the provider is a partnership, corporation or other legal entity, whether for profit or not for profit, the names of the officers, directors, trustees or managing or general partners of the provider. If the provider is a corporation, the name of any individual who owns 10% or more of the stock of such corporation shall also be disclosed.

(c) With respect to a provider which is either not incorporated or not established and operated on a not-for-profit basis, the names and business addresses of any individual having any ownership or any beneficial interest in the provider and a description of such individual's interest in or occupation with the provider.

(d) A statement as to whether or not the provider is, or is affiliated with, a religious, charitable or other nonprofit organization and the extent of the affiliation, if any; the extent to which any affiliate organization will be responsible for the financial and contractual obligations of the provider; the provision of the United States internal revenue code, if any, under which the provider or any of the provider's affiliates is or are exempt from the payment of federal income taxes; and, a statement of whether the home is exempt from local property taxation.

(e) A statement that the provider is required to have an annual certified audit by a certified public accountant and that a copy of such audit shall be made available upon request.

(f) If the operation of the home has not yet commenced, and with receipt of contract considerations as defined in **K.S.A. 40-2231** (a) and (b), the provider shall provide a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including but not limited to:

> (1) An estimate of such costs as financing expense, legal expense, land costs, marketing costs and other similar costs which the provider expects to incur or become obligated for prior to the commencement of operations;
>
> (2) A description of any mortgage loan or any other financing intended to be used for the financing of the facility, including the anticipated terms and costs of such financing;
>
> (3) An estimate of the total entrance fee to be received from or on behalf of residents at or prior to commencement of operation; and
>
> (4) An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.

(g) A statement as to whether the manager or any official or director of the provider, has been convicted of a crime or been a party of any civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property which resulted in a judgment against such person and whether any such person has had any state or federal license or permits related to care and housing suspended or revoked.

(h) A statement of the years of experience of the provider and manager in the operation of homes providing continuing care.

(i) A statement of the fiscal year of the provider.

History: L. 1989, ch. 73, § 2; July 1. Source or prior law: 16-1102.

K.S.A. 40-2233. Same; annual disclosure statement, contract and annual audit; filing with commissioner. A provider shall file with the commissioner within four months of completion of such provider's fiscal year the annual disclosure statement referred to in K.S.A. 40-2232, the continuing care contract referred to in K.S.A. 40-2234 and an annual audit certified by a certified public accountant.

History: L. 1989, ch. 73, § 3; July 1. Source or prior law: 16-1104.

K.S.A. 40-2234. Same; providing form to commissioner; contents and attachments. The provider shall provide the commissioner a copy of any continuing care contract form entered into on or after the effective date of this act or entered into between the provider and any resident which shall include or have attached thereto:

(a) A description of all fees and or charges required of residents, a description of all services to be provided or committed to providing in the future and a description of any services for which an extra charge is made over and above entrance fees and periodic charges that are provided for in the contract;

(b) A listing of the terms and conditions under which the agreement may be cancelled by either party to the agreement or by which any or all of the entrance fee or transfer of assets would be refunded, less the value of any services received; and

(c) A statement describing health and financial conditions required to continue as a resident, including any changes in either health or financial conditions of the resident.

History: L. 1989, ch. 73, § 4; July 1.

K.S.A. 40-2235. Same; certificate of registration, application, fee, renewal. No provider shall act as or hold themselves out to be a continuing care provider, as defined in this act, in this state, unless the provider shall hold a certificate of registration as a continuing care provider issued by the commissioner of insurance. Application for such certificate shall be made to the commissioner on a form prescribed by such commissioner and shall be accompanied by a filing fee of $50. Such certificate may be continued for successive annual periods by notifying the commissioner of insurance of such intent and payment of

a $25 continuation fee. Such certificate shall be issued to a continuing care provider or continued by the commissioner unless the commissioner after due notice and hearing shall have determined that the continuing care provider is not in compliance with this act.

History: L. 1989, ch. 73, § 5; July 1.

K.S.A. 40-2236. History: L. 1989, ch. 73, § 6; **Repealed**, L. 1997, ch. 24, § 7; July 1. Source or prior law: 16-1105.

K.S.A. 40-2237. Same; change of ownership or management of provider or home. If there is a change of ownership, or management of the provider or home, the new owners must file all required documents of this act within 90 days of change. History: L. 1989, ch. 73, § 7; July 1.

K.S.A 40-2238. Same; rules and regulations. The commissioner shall promulgate rules and regulations necessary to carry out the provisions of this act. History: L. 1989, ch. 73, § 8; July 1.

Resident days

Kan. Admin. Regs. § 30-10-28

(a) Calculation of resident days.

(1) "Resident day" shall have the meaning set forth in K.A.R. 30-10-1a.

(2) If both admission and discharge occur on the same day, that day shall be considered to

be a day of admission and shall count as one resident day.

(3) If the provider does not make refunds on behalf of a resident for unused days in case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day.

(4) Any bed days paid for by the resident, or any other party on behalf of the resident, before an admission date shall not be counted as a resident day.

(5) The total resident days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.

(6) In order to facilitate accurate and uniform reporting of resident days, the accumulated

method format set forth in data specifications in diskettes furnished by the agency shall be

used for all residents beginning January 1, 1999. The monthly reporting, using the diskette, shall be submitted to the agency as supportive documentation for the resident days shown on the cost report forms and shall be submitted at the time the cost report and required documents are submitted to the agency. Monthly census summaries shall include reporting for nursing facility or nursing facility-mental health, other residential days with shared nursing facility or nursing facility-mental health costs, and day care hours. Each provider shall keep these monthly records for each resident, whether a Kansas medical assistance program recipient or a non-recipient. If the provider fails to keep accurate records of resident days in accordance with the accumulated method format, the assumed occupancy rate shall be 100 percent.

(7) The provider shall report the total number of Kansas medical assistance program resident days in addition to the total resident days on the uniform cost report form.

(8) The provider shall report the total number of other residential days with shared nursing

facility or nursing facility-mental health costs on the uniform cost report form.

(b) Respite care days shall be counted as resident days and reported on the monthly census

forms.

(c) Day care and day treatment shall be counted as one resident day for 18 hours of service.

The total hours of service provided for all residents during the cost reporting year shall be divided by 18 hours to convert to resident days.

(d) This regulation shall take effect on and after January 1, 1999.

Kan. Admin. Regs. § 30-10-28

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Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985;

amended May 1, 1987; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-

90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Jan. 1, 1999.

Kan. Admin. Regs. § 30-10-1a

Section 30-10-1a - Nursing facility program definitions

(a) The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(1) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active treatment for individuals with mental retardation or a related condition" means

a continuous program for each client, which shall include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the following:

(A) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(3) "Agency" means the department of social and rehabilitation services.

(4) "Ancillary services and other medically necessary services" means those special services or supplies, in addition to routine services, for which charges are made.

(5) "Case mix" means a measure of the intensity of care and services used by a group of residents in a facility.

(6) "Case mix index" means a numeric score with a specific range that identifies the

relative resources used by a particular group of residents and represents the average resource consumption across a population or sample. Two average case mix index scores are considered in setting rates for nursing facility program participants. These indexes are the following:

(A) "Medicaid average case mix index," which means the average case mix index calculated using case mix scores for only the medicaid residents in a population; and

(B) "facility average case mix index," which means the average case mix index calculated using case mix scores for all the residents in a nursing facility.

(7) "Change of ownership" means a transfer of rights and interests in real and personal property used for nursing facility services through an arm's-length transaction between unrelated persons or legal entities.

(8) "Change of provider" means a change of ownership or lessee specified in the provider agreement.

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(9) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility or in a company engaged in business with the provider facility.

(10) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(11) "Cost and other accounting information" means adequate financial data about the nursing facility operation, including source documentation, that is accurate, current, and sufficiently detailed to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if the documentation originated at the time and near the place of the transaction. In order to provide the required cost data, the provider shall maintain financial and statistical records in a manner that is consistent from one period to another.

This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(12) "Cost finding" means recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(13) "Costs not related to resident care" means costs that are not appropriate, necessary, or

proper in developing and maintaining the nursing facility operation and activities. These costs shall not be allowed in computing reimbursable costs.

(14) "Costs related to resident care" means all necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate

and helpful in developing and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27, and K.A.R. 30-10-28.

(15) "Cost report" means the nursing facility financial and statistical report (MS-2004).

(16) "Educational activities" means an approved, formally organized, or planned program of study usually engaged in by providers in order to enhance the quality of resident care in

an institution. These activities shall be licensed when required by state law.

(17) "Educational activities net cost" means the cost of approved educational activities less any grants, specific donations, or reimbursements of tuition.

(18) "Hospital-based nursing facility" means a nursing facility, as defined in this regulation, that is attached to or associated with a hospital.

(19) "Inadequate care" means any act or failure to act that may be physically or emotionally harmful to a recipient.

Section 30-10-1a - Nursing facility program definitions Kan. Admin. Regs. § 30-10-1a

(20) "Level of care" means the type and intensity of services prescribed in the resident's plan of care as based on the assessment and reassessment process.

(21) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function. Relevant diagnoses shall be limited to schizophrenia, recurrent and severe major

affective disorders, atypical psychosis, bipolar disorder, paranoid disorders, schizoaffective disorder, psychotic disorder, obsessive-compulsive disorder, or borderline personality disorder.

(22) "Mental retardation" means subaverage general intellectual functioning that originates in the developmental period and is associated with an impairment in adaptive behavior.

(23) "Nonworking owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(24) "Nonworking related party or director" means any related party, as defined in this regulation, who does not perform a resident-related function for the nursing facility.

(25) "Nursing facility (NF)" means a facility that conforms to these criteria:

(A) Meets state licensure standards;

(B) provides health-related care and services, as prescribed by a physician; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision to residents for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(26) "Nursing facility for mental health" means a nursing facility that meets these criteria:

(A) Meets state licensure standards;

(B) provides structured mental health rehabilitation services, in addition to healthrelated care, for individuals with a severe and persistent mental illness; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision. The

nursing facility shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(27) "Ongoing entity" means that a change in the provider has not been recognized for Kansas medical assistance program payment purposes.

(28) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of legal business entity. These costs shall be considered to be intangible assets representing expenditures for rights and privileges that have value to the business.

(29) "Owner and related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a five percent or greater interest

in the provider or any related party, as defined in this regulation, whether the payment is from a sole proprietorship, partnership, corporation, or nonprofit organization.

(30) "Owner" means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(31) "Plan of care for nursing facilities" means a document completed by the nursing facility staff that states the need for care, the estimated length of the program, the methodology to be used, and the expected results for each resident.

(32) "Prescription drug" means a simple or compound substance or mixture of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that is prescribed by a licensed physician or practitioner and dispensed by a licensed pharmacist.

(33) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report shall be based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(34) "Provider" means the operator of the nursing facility specified in the provider agreement.

(35) "Recipient" means a person determined to be eligible for the Kansas medical assistance program in a nursing facility.

(36) "Related parties" means two or more parties with a relationship in which one party has the ability to influence another party to the transaction in the following manner:

(A) When one or more of the transacting parties might fail to pursue the party's or parties' own separate interests fully;

(B) when the transaction is designed to inflate the Kansas medical assistance program costs; or

(C) when any party considered a related party to a previous owner or operator becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations.

(37) "Related to the nursing facility" means that the facility is significantly associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(38) "Representative" means either of the following:

(A) A legal guardian, conservator, or representative payee as designated by the social security administration; or

(B) any person who is designated in writing by the resident to manage the resident's personal funds and who is willing to accept the designation.

(39) "Resident assessment form" means the document that meets these requirements:

(A) Is jointly specified by the Kansas department of health and environment and the

agency;

(B) is approved by the health care finance administration; and

(C) includes the minimum data set.

(40) "Resident assessment instrument" means the resident assessment form, resident assessment protocols, and the plan of care, including reassessments.

(41) "Resident day" means that period of service rendered to a resident between census taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas medical assistance program or non-Kansas medical assistance program resident who was not in the nursing facility. Census-taking hours shall consist of 24 hours beginning at midnight.

(42) "Resident status review" means a reassessment to identify any nursing facility resident who may no longer meet the level of care criteria.

(43) "Routine services and supplies" means services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies shall be included in the provider's cost report.

(44) "Sale-leaseback" means a transaction in which an owner sells a facility to a related or nonrelated purchaser and then leases the facility from the new owner to operate as the provider.

(45) "Severe and persistent mental illness" means mental illness as defined in this regulation, but shall include both of the following additional requirements:

(A) The individual meets one of the following criteria:

(i) Has undergone psychiatric treatment more intensive than what could have been provided through outpatient care more than once in a lifetime; or

(ii) has experienced a single episode of continuous, structured, supportive residential care other than hospitalization for a duration of at least two months.

(B) The individual meets at least two of the following criteria, on a continuing or

intermittent basis, for at least two years:

(i) Is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) requires public financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;

(iii) shows a severe inability to establish or maintain a personal social support system;

Section 30-10-1a - Nursing facility program definitions Kan. Admin. Regs. § 30-10-1a

(iv) requires help in basic living skills; or

(v) exhibits inappropriate social behavior that results in a need for intervention by the mental health or judicial system.

(46) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services that provide ongoing treatment for mental health problems and that are aimed at attaining or maintaining the highest level of mental and psychosocial wellbeing. The specialized rehabilitative services shall include the following:

(A) Crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(47) "Specialized services" means inpatient psychiatric care for the treatment of an acute episode of mental illness.

(48) "State licensing agency" means the department of health and environment for hospital-based nursing facilities and the department on aging for all other nursing

facilities.

(49) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital bed or nursing facility bed.

(50) "Twenty-four-hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(51) "Working trial balance" means a list of the account balances in general ledger order that was used in completing the cost report.

(b) This regulation shall be effective on and after May 1, 2005.

Kan. Admin. Regs. § 30-10-1a

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1,

1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May

1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994;

Section 30-10-1a - Nursing facility program definitions Kan. Admin. Regs. § 30-10-1a amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended May 1, 2002; amended May 1, 2005.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey

From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

Appendix III - Acronyms

Assisted Living Facility (ALF)

Centers for Medicare & Medicaid Services (CMS)

Certification and Survey Provider Enhanced Reports (CASPER)

Certified Public Accountant (CPA)

Code of Federal Regulations (CFR)

Continuing Care Provider (CCP)

Continuing Care Retirement Community (CCRC)

Doing Business As (DBA)

Federal Financial Participation (FFP)

Federal Medical Assistance Percentage (FMAP)

Fee-For-Service (FFS)

Government Accountability Office (GAO)

High Medicaid Volume (HMV)

Kansas Department for Aging and Disability Services (KDADS)

Kansas Department of Health and Environment (KDHE)

Kansas Department of Insurance (KDOI)

Kansas Medical Assistance Program (KMAP)

Kansas Organization Tracking Application (KOTA)

Kansas Statutes Annotated (KSA)

Long Term Care Unit (LTCU)

Long-Term Support Services (LTSS)

Managed Care Organization (MCO)

Medicaid Bed Days (MBD)

National Provider ID (NPI)

Nursing Facility for Mental Health (NFMH)

Office of the Medicaid Inspector General (OMIG)

Potentially Preventable Readmission (PPR)

Provider Assessment Loss (PAL)

Provider Assessment Revenue (PAR)

Quality Care Assessment (QCA)

Quality Care Improvement Panel (QCIP)

Skilled Nursing Facility (SNF)

State Fiscal Year (SFY)

State General Funds (SGF)

Survey, Certification and Credentialing (SCC)

Within-Stay (WS)

New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404

Kansas
Department for Aging
and Disability Services

Phone: (785) 296-4986
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kdads.wwwmail@ks.gov
www.kdads.ks.gov

Laura Howard, Secretary

Laura Kelly, Governor

March 15, 2024

Mr. Steven D. Anderson
Medicaid Inspector General
Memorial Hall
120 SW 10th Avenue
Topeka, KS 66612-1597

Dear Mr. Anderson,

Thank you for providing the draft findings, recommendations, and conclusions from your audit of Continuing Care Retirement Communities (CCRC) program performance. My staff have reviewed the report. We have no comments or suggestions for changes in the background information provided about the Medicaid program, Quality Care Assessment program, or the descriptions of nursing facility rate setting. Our comments are focused on the recommendations within the report directed to the Kansas Department for Aging and Disability Services (KDADS).

Finding 1: Kansas Department of Insurance, Non-Compliance with State Statutes.
This finding does not specifically mention KDADS in the analysis, but the recommendations do specifically direct actions at KDADS.

Recommendation 1: The report recommends reassigning responsibility for Continuing Care Providers (CCP) registration from the Department of Insurance (DOI) to the Survey Certification and Credentialling Commission (SCC) within KDADS. As the report mentions, moving responsibility would require a statute change. HB 2784 in this session would change the statute and has passed the House of Representatives and was scheduled for a hearing on March 12, 2024 by the Senate Public Health and Welfare committee.

Recommendation 2: The report recommends having a CPA or a staff with equivalent accounting background review CCP registration applications. KDADS did not include an accountant in its estimate of fiscal impact for HB 2784. SCC does not have positions with accounting requirements as part of the staff but KDADS does have access to KDADS audit staff that review financial documentation related to initial licensure and changes of ownership. KDADS revised estimate of fiscal impact for HB 2784 would require hiring 2.00 new FTE positions for a Licensure Program consultant and a Program Manager to take on the additional responsibilities. If HB 2784 is passed, KDADS will evaluate the need for the number of staff to approve the registration applications and assess the skills needed to fulfill the statutory requirement.

Recommendation 3: The report recommends updating the change of ownership procedures to identify Skilled Nursing Facilities that operate as part of a CCRC. KDADS does not agree with this recommendation. Skilled nursing facility is a certification designation and not a category of adult care home licensure. The decision to operate as a CCRC is made by the facility owners. We require all long-term care facility operators to be knowledgeable of required notifications and registrations as part of licensure. KDADS can add the additional instructions to the change of ownership and initial licensure process.

Recommendation 4: The report recommends having sufficient staff to process registrations and verify that CCRCs have services across the continuum of care. KDADS revised estimate of fiscal impact for HB 2784 would require hiring 2.00 new FTE positions for a Licensure Program consultant and a Program Manager to take on the additional responsibilities. These positions would have access to all relevant systems and databases to evaluate the types of care provided within approved CCRCs.

Recommendation 5: The report recommends starting quality control steps on 285 incomplete applications for CCRCs and then put quality controls in place to ensure each CCRC is appropriately registered. The report does not specifically direct these recommendations at KDADS. If HB 2784 passes, KDADS will implement procedures to review CCRC applications during the annual renewal process and any new facilities that request to become a CCRC.

Recommendation 6: The report recommends aligning CCP registration dates to align with cost reporting deadlines. HB 2784 imposes an April 1 requirement for renewals to make all requests and updates due on the same date. If the bill passes, the dates would be aligned with the single effective date.

Finding #2: Missed Opportunity by KDADS to verify NFs that were claiming to be a CCRC but did not offer a continuum of care.

The report suggests that KDADS did not verify whether a CCRC had continuing care provided to residents. The statute requires KDADS to use the approved CCP registration provided by the Department of Insurance to identify facilities that receive the lower Quality Care Assessment (QCA) rate. KDADS is fulfilling the requirement of the statute by accepting the DOI certificate of registration. No additional verification is required by statute enacting the QCA and rate setting.

Recommendation 1: The report recommends updating the statutory definition of a CCRC and that KDADS be required to verify the continuum of care services. HB 2784 includes a definition of continuing care retirement community. In the House passed version, "Continuing care retirement community means any place or facility that combines a range of housing and services to encompass the continuum of aging care needs provided at an independent living facility, an assisted living facility, a residential healthcare facility and or a skilled nursing care facility within a single place or facility to avoid the need for residents to relocate to a separate place or facility. The provision of community care includes the multiple levels of care provided within as part of a continuing care retirement community." If the bill passes, KDADS will implement procedures to verify the different types of services included within the CCRC.

Recommendation 2: The report recommends staff verifying whether a NF is part of a CCRC to have access to information about independent living services that are available. If HB 2784 passes, that will be included in the KDADS registration process.

Finding #3: SNFs reporting to KDADS as a CCRC, yet not reporting to CMS as a CCRC.

The report found 29 NFs in 2023 that had CCRC status for the QCA calculation did not submit information on Form CMS - 671 as part of their provider enrollment application.

Recommendation 1: The report recommends KDADS share data between the licensing database with the CASPER survey reporting database. Facilities are not required to report to CMS that they operate as CCRC. That field is available on the form used for enrolling, but that form is not audited by KDADS. The CMS-671 form isn't used by KDADS for our survey oversight or rate setting. CASPER is a federal system, and the Kansas licensing database is home grown. KDADS has no way to automatically send an update from the state system to CASPER. Federal status as a CCRC is irrelevant to the Kansas Statutory requirement to be certified by the Kansas DOI. Not all CCRCs have skilled nursing as a level of care within their community and would never fill out a CMS-671 form.

Finding #4: A SNF assessed for QCA at $4,908 per bed pays an average of $296,752.65 more annually than a SNF assessed for QCA at $818 per bed.

The QCA per bed rates were set in statute by the 2010, 2012, 2013, 2016, and 2020 Legislatures. Those rates have been agreed to by prior legislatures, stakeholders, and advocates. CMS must approve the provider tax rates based on statistical tests and analysis of the revenue and expenditure across the Medicaid program. The QCA rates meet all statutory and regulatory requirements from CMS.

Recommendation 1: The report recommends a rate study to close the gap between the standard and reduced QCA rates to "encourage NFs to keep beds open and for the bed taxes to be affordable for those beds to stay open." KDADS must seek CMS approval for the provider tax rates and payment methodologies and defend the taxes and payments for compliance with federal regulations. The current QCA rates have been through that review process and meet CMS requirements. Other changes to the QCA rates are a policy decision to be made by the Legislature. KDADS will take the recommendation under advisement for discussion with long term care stakeholders, the Legislature and Governor's office in preparation for the 2025 Legislative Session.

Recommendation 2: The report recommends increasing the number of beds in a small NF from 45 to 55 to reduce the QCA rate for smaller NFs and encourage them to reopen beds. KDADS will take the recommendation under advisement for discussion with long term care stakeholders, the Legislature and Governor's office in preparation for the 2025 Legislative Session.

Finding #5: One KDADS Staff Member Responsible for All Bed Counts for the State.

Recommendation 1: The report recommends that an onsite inspection be completed by KDADS within 30 days of the requested change and document the bed change in KOTA. The KDADS process of approving and reviewing changes in bed count requests meets federal requirement for that activity. In most cases, changes in bed capacity are requested because of construction or renovation and that would require an in-person inspection. Reductions in bed capacity are facility choices that would not justify the travel and personnel time to verify. KDADS will take the recommendation under advisement but does not agree an in-person review is required for all requests to change bed capacity.

Finding #6: Unnecessary processing of CCP applications due to current language in state statutes K.S.A. 40-2231 and K.S.A. 40-2235.

The report identified 97 CCP applications from facilities that did not need to be a CCP to receive the lower QCA rate.

Recommendation 1: The report recommends changing the statute to only require CCP registrations from NFs that would already qualify for the lower QCA rate by meeting other criteria. This recommendation is not directed at KDADS, but a facility can decide whether they want to seek a CCP registration based on their own business needs. The federal definition of CCRC that uses the CCP registration is not related to a provider tax. The federal definition identifies facilities that provide multiple levels of care across the continuum that want to market themselves as a CCRC. KDADS disagrees with the recommendation to put a narrow focus on the CCP registration thereby limiting facilities seeking a CCRC designation.

Finding #7– Use of SGF Increases as QCA Declines

Recommendation 1: The report recommends conducting a yearly analysis of QCA revenue and expenditures to identify trends that should be addressed by the Quality Care Improvement Panel (QCIP) and included in the

annual QCIP reports. KDADS agrees with the recommendation. At the request of the committee, the revenue and expenditure data for State FY 2023 was added to the QCIP report submitted to the Legislature in 2024. KDADS will continue to incorporate that analysis into agendas for the QCIP and in the annual reporting to the Legislature.

Finding #8: Quality Care Improvement Panel (QCIP) annual reports have not been provided to the committees named in K.S.A. 75-7435(5)(k) since 2020.

The report indicates that KDADS did not provide annual report of the QCIP to required legislative committees. KDADS did provide annual reports in all the years and distributed copies electronically to the appropriate legislative committees although some of these reports were available as draft copies that were not fully reviewed by the QCIP for the years indicated.

Recommendation 1: The report recommends KDADS provide the require report annually. KDADS will ensure the annual reports will be reviewed by the QCIP and provide to the Legislative Committees indicated in the statute.

Recommendation 2: The report recommends that the QCIP should meet quarterly to discuss areas of concerns within the QCAs, the QCA fund, or any other nursing facility issues. KDADS will take the recommendation under advisement. Quarterly meetings when rates are updated annually would be excessively burdensome on the panel members.

Recommendation 3: The report recommends adding a representative from the Office of Inspector General to the QCIP. The report contains no rationale for this recommendation. That would a policy choice by the Legislature to add the Inspector General or a representative to the membership of the QCIP.

Finding #9: Legal advice from KDOI's General Counsel led to non-compliance with K.S.A. 40-2233.

This finding and the associated recommendations are exclusive to the KDOI. KDADS has no response to Finding #9.

Thank you for the opportunity to review the draft report. There are several recommendations KDADS will review to improve our processes working with KDOI and as the CCP registration are used to calculate QCA amounts. Thank you for you and your team's thorough review.

Sincerely,

Laura Howard

Laura Howard
Secretary

March 18, 2024

GENERAL RESPONSE TO FINDINGS AND RECOMMENDATIONS PERTAINING TO THE KANSAS INSURANCE DEPARTMENT

The draft report provided by the Office of the Medicaid Inspector General ("MIG") to the Kansas Department of Insurance ("Department") on March 1, 2024, lacks foundation in fact, reaches flawed conclusions based upon unreliable extrapolations, demonstrates a lack of understanding of the realities of the senior care market, misinterprets and misapplies the law, demonstrates a lack of understanding of the authority of the Department, is overreaching in scope, and should be discounted nearly in its entirety. Rather than exhaustively respond to each problematic element of the draft report, the Department provides the following comments to illustrate why the report should be disregarded and not be published.

The Department believes that the MIG's audit was initiated following a memorandum dated June 15, 2023 ("Memo"), sent by the Commissioner of Insurance to Representative Brenda Landwehr and Laura Howard, the Secretary for the Kansas Department for Aging and Disability Services ("KDADS"), outlining concerns with certain aspects of the CCP registration statutes, which were first enacted in 1989. In the Memo, which is available in its entirety for public inspection, the Department identified inadequacies in the definition of continuing care contract, as well as the ability of providers to *voluntarily* apply for registration as a CCP to be potential issues when considered in light of statutes enacted in 2010 establishing quality care assessment ("QCA") or bed tax rates for skilled nursing beds. Subject to a few exceptions, the QCA rates differ significantly for those operated by registered CCPs and those operated by non-CCPs. Because of the definitional ambiguities and incongruity between the CCP registration statutes and the intent of the QCA taxation scheme, the Department suggested in the Memo, "some legislative change may need to be considered to bring things into sync." The Memo also noted a legislative solution to the timing of the submission of the required annual audit might be appropriate, in that many registrants found the timing to be difficult to achieve and burdensome.

Rather than recognizing the issues and solutions offered by the Department by looking for entities that were registered as CCPs contrary to the perceived legislative intent regarding facility type or provision of services, the MIG did a 100% review of CCP registration files and conducted such review through the lens of strict compliance for technical requirements like timely submission of an annual audit. The MIG's February 15, 2024, testimony before the House Committee on Health and Human Services

committee suggests the audit's conclusions were already reached at that time – before the Department had seen the audit or was afforded an opportunity to respond. Upon receiving a copy of the audit draft on March 1, 2024, the Department learned the MIG somehow now places $88 million in blame on the Department for the statutory problems which the Department first identified. The number entirely lacks reasonableness.

The audit lists the first objective as: "Are there currently issues within the legislative language that are allowing these facilities to falsely claim they are part of a CCRC?"[1] The Department objects to this characterization of the issue. The issue is not whether an entity *falsely* claims to be a part of a CCRC. This assumes there is always a "correct" claim to be a CCRC. Assigning falsity of any given registration is conclusory and portrays an assumption of ill-intent on behalf of the registrants. This is especially the case because of the ambiguity in current law. A better statement of the issue is "Does current law allow for an entity to obtain a registration as a continuing care provider in contravention of what is commonly understood as a CCRC, thereby allowing entities to pay lower QCA assessments?" The Department also disagrees with the MIG's summary to the audit's second objective, "Are there currently proper procedures in place to monitor compliance within the CCRC and CCP registrations?" The Department disagrees that proper procedures are not being followed. The MIG's assertion that procedures were not being followed is founded on an unduly harsh and unreasonable interpretation and application of the CCP registration statutes.

The executive summary quickly reveals the absurdity of the MIG's main, headline-seeking conclusion. The MIG incredulously claims the State lost more than $88 million in QCA revenue and interest over the course of four years because CCP registrations were incorrectly issued to Skilled Nursing Facilities, mainly because the entities lacked an annual audit report from a CPA. There are several problems with the MIG's simplistic, yet overly harsh approach used to reach this conclusion. Under the MIG's strict methodology and analysis, if an audit was provided to the Department on the 121st day after the end of a Provider's fiscal year end – meaning one day late, the entity should not have been initially registered as a CCP or had its registration renewed. As a consequence of this draconian change in status, the entity would be subject to the 6x QCA bed tax of $4,908 instead of the lower $818 rate applicable to skilled nursing beds which are part of an entity operated by a registered CCP.

[1] The acronym "CCRC," is not defined or used anywhere in Kansas statutes or regulations. Instead, statutes in Chapter 40 refer to Continuing Care Providers ("CCPs"). The term "Community Care Retirement Facilities" is utilized in K.S.A. 75-7435 and regulations pertaining to the QCA (K.A.R. 129-10-31(b)(1)(A)).

Many of the entities identified by MIG as noncompliant were simply late in providing the audit. Providing the audit within 4 months of the completion of the entity's fiscal year is a challenge. The problem is further complicated by the fact that many providers are part of a larger holding company or management structure involving several registered providers with different fiscal years. In these instances, the holding or management company has consolidated financials reflecting complex accounting and organizational structures, and the audit takes longer than what is contemplated by the statute.

More often than not, the Department's files reflect a CPA audit was provided with the renewal application, or within the extension granted by the Department to the applicant who sought additional time due to incongruity between annual renewal dates and the end of the provider's fiscal year.

The MIG identified a large, well-known not for profit facility in Topeka, Kansas as being incorrectly registered as a CCP. The entity is a 240-unit independent living facility, 28-unit assisted living facility, 97-bed health care facility where short-term rehab and nursing care are provided. The entity was first registered as a CCP in 1989. As an illustration of the process for registration, the following occurred:

o October 17, 2022- Department issues letter to Entity for Continuation of Certificate of Registration through August 29, 2023.

o August 29, 2023 – Entity submits Application for Renewal for annual period ending August 29, 2024, and pays $25 renewal fee. The entity also submits the required materials, including the annual disclosure statement and an Independent Auditor's Report and Combined Financial Statements for December 31, 2022, and 2021. According to the MIG, the entity should not have been allowed to renew its CCP registration and instead paid $396,730 more in bed taxes for 2023.

Admittedly, there are a few instances of applications being approved without a CPA audit. But that has not deprived the State of $88 million. Further, the Department recognized this as an issue prior to the MIG audit. CCP registrations date back to 1989, and, as the industry would testify, previous administrations had not enforced the annual audit requirement. In recent years, however, the Department – under the direction of this Commissioner – has more closely scrutinized applications and have required CPA audited financials to be provided as a condition of new and renewal applications. Indeed, as the MIG points out, the Department has issued administrative action against entities that have failed or refused to provide CPA audited financials.

Recognizing, however, that CPA audits often cannot be completed as quickly as the MIG claims is strictly required by K.S.A. 40-2233, and many entities had been

registered for years without providing CPA audits, the Department does exercise forbearance and latitude to the heavily regulated industry to allow time to come into compliance. In a few instances, as a pathway to compliance, the Department accepted less formal financial statements, but has also required proof of an engagement to obtain a CPA audit. The MIG's standard of strict compliance on the other hand, would cause serious disruption to the industry, would drive up the cost of care, and would reduce the supply of critically needed care for Kansas seniors. To assign a 68%, $88 million error rate is astronomically unreflective of reality. The MIG audit's overly broad assignment of error ignores the nuances of each registrant's application history.

There is an additional, fundamental weakness with MIG's conclusion in that it fails to consider that Kansas law recognizes a constitutional, due-process protected property interest in a license, of which a CCP registration is closely analogous. Because an entity that possesses a registration is entitled to a due process hearing prior to deprivation of that registration, both in terms of the 14th Amendment to the United States Constitution, Section 18 of the Bill of Rights of the Kansas Constitution, and explicitly in K.S.A. 40-2235, it is inaccurate to assert that a CCP loses its registration automatically upon the slightest of technical violations. Instead, once issued a registration, the operative statute requires that upon payment of the $25 continuation fee and notification of intent to renew, such certificate *shall* be issued to a continuing care provider or continued by the Commissioner *unless* the Commissioner after due notice and hearing shall have determined that the continuing care provider is not in compliance with this act. See also, *Kansas Racing Mgmt., Inc. v. Kansas Racing Comm'n*, 244 Kan. 343, 354, 770 P.2d 423, 431–32 (1989)(applying Constitutional due process principles to an agency's licensing decisions once an entity possesses a license).

The MIG's audit findings fail to consider the procedural reality that an entity would have at least 18 days after notice of nonrenewal to request an administrative hearing to challenge the Department's decision. Under the Kansas Administrative Procedures Act, the nonrenewal of the entity's registration would not become final until after a hearing was conducted and a final order imposing a nonrenewal was rendered by the presiding officer. The MIG audit is premised largely on the position that the Department has no authority to renew a registration if the entity does not provide an audit within 120 of the entity's fiscal year end. In essence, this position means there is no mechanism or possibility for the entity to cure an untimely filing, even if the required audit is provided prior to the hearing. If this is true, it renders meaningless the due process notice and opportunity for a hearing set forth in K.S.A. 40-2235, even though the audit has been provided.

It is a long-standing maxim of statutory construction that where the application of statutes would produce an absurd result even if they are otherwise clear, they are to be construed to avoid the absurd result.[2] The due process and hearing requirements of the CCP Act are rendered meaningless and produce an absurd result under the MIG's interpretation that there is no remedy or cure available for an untimely filed audit. The same absurd result occurs under the MIG's position that the Department staff do not have implied authority to grant extensions of time for filing audits when the registrant's annual renewal date is badly out of sync with the timely filing of an audit.

Taking the foregoing example further, if the entity provided the audit prior to the requested hearing, and the hearing officer issued a Final Order denying the registration or renewal in accordance with the position espoused by the MIG, the registrant would have the right to appeal the decision under the Kansas Judicial Review Act. In such a situation, the Department asserts a court would overturn the agency decision under K.S.A. 77-621(c)(8) as being unreasonable, arbitrary or capricious. Kansas courts have held agency action to be unreasonable if it is: "taken without regard to the benefit or harm of all interested parties which is so wide of the mark that its unreasonableness lies outside the realm of fair debate." *In re Emporia Motors, Inc.,* 30 Kan. App. 2d 621, 624, 44 P.3d 1280, 1282–83 (2002).

Alternatively, the entity could avoid the MIG's proposed imposition of more than $4,000 per bed tax by simply converting its renewal application to a new application and paying the $50 registration fee. When considering the history of CCP registrations and the practical realities of the industry, i.e., incongruity between renewal dates and timing of fiscal years and the number of consolidated entities, it is reasonable and fair for the Department to grant entities flexibility in the timeliness of submitting audited financials. Conversely, it is unreasonable to assume $88 million in fictious or hypothetical bed tax revenue because the Department exercised discretion and fairness in determining it was in the best interest of the residents of continuing care facilities to allow flexibility in the timeliness of filing of audited financial statements.

MIG's claim that $32 million in tax revenue is missing because certain registrants did not offer a continuum of care is flawed for multiple reasons. First, as the MIG recognizes, the definition of continuing care as it relates to registered entities is ambiguous. K.S.A. 40-2235 requires that no "provider" shall act as or hold themselves out to be a continuing care provider, as defined in this act, in this state, unless the provider shall hold a certificate of registration as a continuing care provider issued by the Commissioner of Insurance. "Provider" or "continuing care provider" means the

[2] *N. Nat. Gas Co. v. ONEOK Field Servs. Co.,* 296 Kan. 906, 918 (2013).

person, corporation, partnership, association or other legal entity which agrees to provide *continuing care* to residents in a home. K.S.A. 40-2231(d).

What constitutes "continuing care" is not defined in Kansas statute or regulation.[3] Thus, it is improper to conclude a Skilled Nursing Facility ("SNF") is not a continuing care provider and thus not eligible for the reduced CCP bed tax, because the entity does not offer a "continuum of care", which the MIG contends – without statutory support – means different levels of care. It appears to be improper to assign error based upon a failure to provide something that is not clearly defined in statute.

Assuming, however, that continuing care equates to different levels of care, it appears MIG's conclusion is still wrong because it assumes a provider has to have skilled nursing and some other level of care in order to be a CCP. This is wrong because there are different levels of care within skilled nursing. MIG does not appear to have considered this, instead concluding that a CCP that MIG found to only have a SNF license could not be a CCP eligible for the reduced QCA rate.

MIG's analysis is also off track because it further assumes that each level of care requires a different licensure. But this is also not in line with Kansas licensing laws. Independent living, for example does not require licensure by KDADS. Thus, a provider could provide non-licensed independent living and skilled nursing, and thus, only show up as skilled nursing on the KDADS website, yet still be a CCP under the MIG standard.

The MIG's unfounded assertion that KDADs and the Department lacked appropriate oversight because of a perceived failure to confirm each provider provided a continuum of different levels of care is also off the mark because there is no clear statutory requirement the Department independently verify an entity's levels of care. There is a more than fair probability that the industry would not support MIG's conclusion on this, and it is an unreasonable expectation that is not contemplated by the CCP registration statutes or administrative law, for the Department conduct inspections to verify services providers provide. Indeed, the MIG's position is contrary to well-established principle of administrative law that agencies are creatures of statute and their power is dependent upon authorizing statutes; therefore any exercise of authority must come from within the statues either expressly or by clear implication.[4] There is absolutely no authority in the statutes governing the CCP registration process which conveys on the Department the requirement or authority to confirm levels of care or verify services offered by a CCP.

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[3] See footnote 1, *supra.*

[4] *Pork Motel, Corp. v. Kansas Dept. of Health & Environment*, 234 Kan. 374, 378, 673 P.2d 1126 (1983)

The MIG's solutions for identifying "real" CCPs aren't fool proof. The MIG identifies three ways it attempted to, and therefore suggest the Departments use, to verify an entity is providing multiple levels of care. None of which are actually determinative. First, the MIG suggests a review of an entity's financial statements. But there is no requirement an entity identify each level of care it provides in its financial statements. The absence of evidence in financial statements is not evidence of absence of multiple levels of care.

Second, review of floor plans provided by KDADS would not necessarily identify multiple levels of care. Entities are not required to submit floor plans to the Department, and even if they were, the Department would not be able to identify different levels of care. The Department understands that a floor plan would reflect licensure, not levels of care. As indicated earlier, multiple levels of care can be provided within one class of license, i.e. skilled nursing. Floor plans, while possibly helpful, are not conclusive evidence to establish whether a provider is providing multiple levels or continuing care.

As a whole, the MIG's findings and conclusions regarding providers' duties and abilities to register as a CCP would have a devastating effect on the critical senior care industry. Many providers would not be able to afford the 6-fold bed tax increase MIG believes is warranted and would be forced to close. Removing options for seniors to obtain the residential care they need because of a bureaucratic technicality is not good public policy. It is difficult to conceive the industry or the Legislature desire the result suggested by MIG.

Finally, MIG suggests a review of providers' websites. There are several problems with this approach. Providers aren't required to have a website, nor keep it updated. Providers aren't required to list all their services on a website. An entity can have a website that simply says, "We are a skilled nursing facility." But if the provider also provides a different level of care, the website could be true, accurate, but not complete. Thus, a website cannot conclusively demonstrate whether a provider is a CCP.

Nevertheless, the Department asked the MIG to identify the entities MIG claimed provided what it considered only a single level of care, i.e., skilled nursing. The Department reviewed available websites for many of those entities and found that the websites tended to show that the providers did, in fact, provide multiple levels of care. For example, an entity in Emporia claims it "offers a full continuum of care, from temporary respite stays, to short-term rehabilitation, to long-term skilled nursing

care, as well as a broad array of specialty programs and services." The MIG would also impose the $4900 per bed tax on an award winning, non-profit senior living community in Johnson County that, according to its website, provides short term rehabilitation, long-term care, and respite care. The MIG asserts this facility should have paid nearly $1,000,000 in QCA assessments.

Finally, with respect to the definitional issues, K.S.A. 40-2231 also permits that a continuing care contract shall also mean an agreement of any other provider who *voluntarily applies for a certificate* pursuant to K.S.A. 40-2235. Thus, under current law, a provider does not even have to provide different levels of care. It can voluntarily apply for a certificate. This is a public policy issue requiring statutory revision; the Department did not commit fraud, waste, or abuse by allowing such voluntary applications.

RESPONSE TO FINDING #6

Finding # 6 is also uncalled for. MIG claims that state resources were wasted on processing unnecessary applications. This claim assumes that an entity's only reason to register is to get a lower QCA. However, Kansas law requires registration if an entity acts as or wants to hold itself out as a CCP. The services encompassed within continuing care are not necessarily synonymous with those in a skilled nursing facility. A provider could provide continuing care, but not be subject to the QCA if the provider is not a skilled nursing facility. They would, however, still be required to be registered as a CCP. The MIG's claim of waste here also ignores the fact that providers may want a CCP registration for marketing purposes. And, importantly, it is not the province of the MIG to weigh in on the efficiency of the Department's processes if there is no nexus to Medicaid.

RESPONSE TO FINDING # 9

The MIG continues its peripheral pursuits by recommending the Commissioner of Insurance review other decisions made by the General Counsel to ensure other statutes have not been ignored. MIG has no justification or jurisdiction suggesting review of other decisions not pertaining to Medicaid. The Department, based upon the General Counsel's advice, has made many difficult decisions to correctly apply the law, contrary to prior administrations' practices. That will continue.

CONCLUSION:

The Department asserts the MIG audit was misguided and does not reflect the practicalities of administrating a flawed registration scheme. To the extent registrants were not incompliance with the law, as reasonably interpreted and applied by the

Department, the Department had already begun processes to enforce the CPA audit requirement prior to the MIG audit and report, contrary to the practice of previous administrations. Those efforts continue.

The Department disagrees with the ultimate conclusion that more than $88 million in bed tax revenue was lost by the state.