

Long-Term Care Services Task Force

YEAR FOUR REPORT

CONCLUSIONS AND RECOMMENDATIONS

The Task Force reaffirms the six broad goals and the policy directions and strategies adopted in its first year of existence. The Task Force believes progress is being made on providing greater freedom of choice for recipients of long-term care services. Year four stands out as a year where major progress was made on compiling needed demographic and other statistical information for informed decision making regarding long-term care services.

Proposed Legislation: None

BACKGROUND

Long-Term Care Task Force Created

HB 2780 enacted by the 2000 Legislature and codified at KSA 65-6206 created a 20-member Task Force on Long-Term Care Services to study: “. . . state and federal laws and rules and regulations which impact on the services provided by the government and the private sector to citizens who are consumers of long-term care services, the financing of these services, both public and private, the effectiveness of partnering activities between state agencies and long-term care providers, and such other matters as relating thereto the Task Force deems appropriate.”

The bill later defines long-term care as including a broad spectrum of supports, ranging from skilled nursing services to assistance with activities of daily living or help with instrumental activities of daily living.

Seven members of the Task Force are appointed by the Legislative Coordinating Council (LCC). Three of these appointees must be consumers of long-term care, three providers of long-term care, and one a trustee or board member of a long-term care facility.

Of these seven, no more than two members may reside in any one congressional district.

The Chairperson and Vice Chairperson of the Task Force are appointed by the LCC from among the members of the Task Force. The Chairperson is to be a legislative member. Two members are appointed by the President of the Senate and the Speaker of the House. Of the two appointments, one is to be a member of the Senate Committee on Ways and Means and one a member of the House Committee on Appropriations. The appointees must be from different political parties.

An additional two members are appointed by the Senate President, and the Minority Leader of the Senate is to appoint two members. In each case, one appointee must be a member of the Senate Committee on Public Health and Welfare and one a member of the Senate Committee on Financial Institutions and Insurance.

Two members are appointed by the Speaker of the House and two members are appointed by the Minority Leader of the House. In each case, one appointee must be a member of the House Committee on Health and Human Services and one a member of the House Committee on Insurance.

The Secretaries of Social and Rehabilitation Services (SRS), Aging, and Health and Environment (KDHE) or their designees make up the remaining members of the Task Force.

The Task Force is required to submit a report and recommendations to the Governor and Legislature on or before the second Monday of January each year through 2005, the year in which the statute creating the Task Force will expire. In developing recommendations, the Task Force is to consider creative, common sense solutions and approaches to problems that do not necessarily require additional expenditures.

Membership of the Long-Term Care Task Force

Legislative Members	
Rep. Bob Bethell, Chairperson	Sen. Larry Salmans, Vice Chairperson
Sen. Henry Helgerson	Rep. Nancy Kirk
Sen. Janis Lee	Rep. Jim Morrison
Sen. Chris Steineger	Rep. Judy Showalter
Sen. Susan Wagle	
Nonlegislative Members	
Mark Baily, Via Christi Services	Bob Smith, Alzheimer Association
Evie Curtis, Kansas Advocates for Better Care	Sister Beth Stover, North Central Flint Hills AAA
Linda Lubensky Kansas Home Care Association	Ray Vernon, Wesley Towers
Carol Moore, ANP (Gerontology)	Janis DeBoer (Aging)
Mennonite Friend- ship Manor	Margaret Zillinger (SRS)
	Charles Moore (KDHE)

TASK FORCE ACTIVITIES

The Task Force met for nine days during calendar year 2003. A one day meeting was

held in April to discuss home and community based services waiver waiting lists and review possible solutions implemented by the states of Maine and Oregon.

The Task Force met for one day in July to discuss workforce issues in long-term care. The specific concern to be addressed was the shortage of staff for the physically disabled, developmentally disabled, home health and nursing facilities. Conferees who appeared included representatives of the Kansas Association of Homes and Services for the Aging, the Kansas Department on Aging, Kansas Association of Centers of Independent Living, Kansas Council on Developmental Disabilities, Kansas Home Care Association, Kansas Area Agencies on Aging Association and the Department of Social and Rehabilitation Services.

Conferees indicated that adequate staffing for long-term care is a critical issue. Factors that affect staffing include: how the job is valued by society, the workplace, the economy and labor market, and policy. The Task Force heard testimony that recruitment and retention are critical long-term care staffing concerns and about methods employers can use to target these concerns, including the nursing home climate; training initiatives and opportunities; financial incentives; career ladders; and leadership opportunities.

The Kansas Department on Aging addressed culture change in nursing facilities and presented information about an awards program, *Promote Excellent Alternatives in Kansas Nursing Homes (PEAK)*, which was created to support, promote, and recognize the nursing homes in pursuing “nontraditional” models of care with progressive environments. The award recognizes excellence in four areas: resident choice, staff empowerment, home-like environment and community involvement. The Task Force addressed these culture change issues with testimony from the 2003 PEAK award winners in its August and

September meetings: Kansas Veterans Home, Winfield; Lakeview Village Health Center, Lenexa; Lyons Good Samaritan Center, Lyons; Pleasant View Home, Inc., Inman; Rossville Valley Manor, Rossville; Sandstone Heights, Little River; Schowalter Villa, Hesston; Valley View Professional Care Center, Junction City; Wichita County Health Care Center, Leoti; and Windsor Place, Coffeyville.

Conferees expressed concern about the availability of direct support workers for the disabled. Working shortages in the home health care industry were also noted, with concern about the shortages in rural areas. The Task Force heard testimony that shrinkage of the long-term care workforce is at a crisis level and healthcare insurance and benefits need to be addressed. The Department on Social and Rehabilitation Services presented information on a grant application through the Centers for Medicare and Medicaid to target workforce issues in long-term care, including health insurance, recruitment and training of Direct Support Professionals (DSP) and the development of a statewide insurance pool for DSPs.

The Task Force met for two days in August to further address workforce issues in long-term care services, including nursing shortages, availability of liability insurance in group pools, and job skills and training for the industry. The Task Force heard from additional PEAK award winners about culture change in Kansas nursing homes.

Conferees who appeared included representatives of The Healthcare Center at Larkfield Place, the Coalition for the Advancement of Careers in Health Care, the Kansas Insurance Department, The Kansas State Nurses Association, the Kansas State Board of Nursing, the Kansas Department on Aging, Lakeview Village, Lyons Good Samaritan Center, Schowalter Villa, Valley View Professional Care Center, Pleasant View Home, Inc., Rossville Valley Manor, Sandstone Heights Nursing Home, Mennonite Friendship Manor, Kansas

Department of Commerce, Kansas Department of Social and Rehabilitation Services, the Kansas Association of Homes and Services for the Aging, and the Kansas Foundation for Medical Care.

One conferee presented information about the working relationship between a nonprofit facility and a technical college. The conferee noted the measure of success in the partnership is that residents are seen as unique individuals and students are encouraged and paid while working in their home community, which has resulted in a lower turnover rate when coupled with senior staff mentoring. A conferee expressed concern that the critical nursing shortage warrants immediate attention, noting the supply will not be able to meet demand and that education programs are unable to grow due to the lack of faculty, facilities, and clinical sites. One conferee highlighted Kansas' nursing shortage noting that the current vacancy rate in Kansas hospitals is 11.3 percent for Registered Nurses. Another conferee provided recommendations to improve the number of nurses: increase recruitment efforts; improve the image of a nurse's role in health care; increase the number of faculty; increase scholarships; improve working conditions; and improve compensation. The Task Force heard from recipients of the PEAK award, where recipients addressed the culture change at their facilities including: a joint effort among all employees; neighborhoods for residents; staff empowerment; the addition of a child care center; cross-training of staff; a change from sterile white units to a colorful facility; and resident involvement in the changes that were made.

The Task Force met for two days in September to discuss estate recovery, group funded insurance pools, and worker recruitment. The committee further discussed the President's Task Force on Medicaid Reform, and culture change in other states and the use of the Civil Monetary Penalty Fund.

Conferees who appeared included representatives of the Department of Social and Rehabilitation Services, the Kansas Insurance Department, the Kansas Association of Home and Services for the Aging, Inc., the Kansas Department on Aging, Windsor Place, Meadowlark Hills, Kansas Veterans Home, the Kansas Foundation for Medical Care, Inc., and the Wichita County Health Center, Leoti.

The Task Force reviewed HB 2415, regarding group pools for liability insurance for long-term care providers. The Kansas Insurance Department noted that a Long-Term Care Liability Insurance Task Force had been created to help address the liability coverage for facilities. The conferee noted that in mid-2000 premiums, in some cases, were increasing in excess of 300 percent.

The Department of Social and Rehabilitation Services provided information about the process of estate recovery and actions that it takes after the death of a Medicaid recipient to recover property. The discussion focused on legislation at the federal and state level to address changes to the current recovery system, including the eligibility process and the disregard of assets. Medicaid spend down requires a person cannot own resources or assets in excess of \$2,000. However, there are resources exempted from this spenddown - the home in which the individual or spouse lives or intends to return, one vehicle per family, personal effects and keepsakes (e.g. furniture, clothing, household goods), burial funds and merchandise (limits apply), and small life insurance policies. These are the items that may exempted from estate recovery by the long-term care insurance credit, based on the amount of long-term care that was paid for by the insurance policy.

Another conferee spoke to the four fundamental principles of new models for nursing facilities as seen in the Greenhouse Model: the elder is the decision-maker; front-line care givers are empowered to be

responsive to elders and each other; an attitude and atmosphere of home prevail; and the organization, residents, and staff are integral and vital part of their community.

In a discussion regarding the use of Civil Monetary Penalty funds, a Task Force member inquired about the use of these funds for capital improvement changes. One conferee noted that there is a need to define the model of the foundational base of resident-directed services through policies and procedures, quality improvement systems, and human flow systems. Items requiring continued discussion, the conferee noted, are the use of demonstration projects and curriculum and licensing requirements for administrators.

The Task Force met for two days in October to discuss the issues relating to the availability of foreign pharmaceuticals in the United States and Kansas, a program that addresses prescription medications for low-income Kansans, and training of long-term care workers.

Conferees who appeared included representatives of the Department of Social and Rehabilitation Services, the Kansas Pharmacists Association, Pat Hubbell Associates, Inc., Wichita Medical Services Bureau, and the Friends of the Johnson County Nursing Center, Inc.

Conferees discussed concerns about the availability of foreign pharmaceuticals. Two factors, one conferee noted, seemed to drive this interest in obtaining foreign pharmaceuticals: the high cost of prescription medication in the United States and the electronic age, and the ease of ordering products all over the world. One conferee noted that importation of drugs from any other country is illegal; no efforts have been taken to purchase medications for Medicaid beneficiaries through Canada. Concern was expressed by one conferee about the creation of a lucrative market for counterfeit medication in the United States. The cost of prescription medication for

seniors was addressed before the Task Force. One conferee presented information about a program designed to ease the burden of high cost medication in Wichita, through the Wichita Medical Services Bureau. The pharmacy programs provide assistance to individuals who qualify based on residency, not having any other prescription insurance or enrollment in any government program that provides access to medications, and meeting income guidelines. The Department of Social and Rehabilitation Services provided information about a three-year Real Choices Systems Change Grant, noting its primary goal of making home and community-based services as accessible to individuals with disabilities or long-term illnesses as institutional care. One conferee spoke to the high turnover rates in direct care positions. The conferee expressed concern that without sufficient growth to address the shortfall in direct care, there will be a crisis in this country if a solution is not found to meet the needs of the aging population. Employees, the conferee noted, do not have formal training and orientation to their work in long-term care. The conferee went on to discuss the Geriatric Education Research and Training Institute, or GERTI. The program is developed to educate long-term care workers by discussing different concepts in culture change in long-term care, communication skills, different conditions affecting long-term care patients and how to work with them, safety issues, inspection processes and many other aspects of long-term care giving. The Task Force discussion concluded with preparation of recommendations for the Task Force report.

YEAR FOUR CONCLUSIONS AND RECOMMENDATIONS

Civil Monetary Penalty Funds

The Task Force encourages the development of grants to access civil monetary penalty funds for quality improvement and educational purposes at

various locations in the state for all long-term health care providers, and specifically those who have recognized problems. The Task Force recommends programs like those offered through GERTI , which provide comprehensive training to long-term care workers and have experienced, to date, demonstrable success. While education programs for nursing facilities are voluntary, the task-force recommends the development of incentives to persuade facilities to participate. Suggestions included increasing the time between facility inspections, which are currently done on an annual basis, for those facilities with exceptionally high standards of care. The Task Force encourages to the State Medicaid Director to utilize civil monetary penalty funds in accordance with the letter received from the Center for Medicare and Medicaid Services. (See attached) In addition, the Task Force notes that the Department on Aging is forming a task force to address nursing facilities with chronically low performance rates.

The Civil Monetary Penalty (CMP) fund is administered by the Department on Aging. Revenue is derived from penalties assessed to Medicare/Medicaid certified nursing facility providers that are found to be out of compliance with federal regulations. Aging surveyors that are able to document incidents of "immediate jeopardy to resident health or safety" recommend penalties between \$1,000 and \$10,000 per incidence, depending on the seriousness of the infraction and the facility's history of noncompliance. As a general rule, recommendations for penalties are imposed and collected. Federal regulation 42 CFR 488.442(g) requires that "Civil money penalties collected by the State must be applied to the protection of the health or property of residents of facilities that the State or HCFA finds non compliant, such as:

- (1) payment for the cost of relocating residents to other facilities;
- (2) state costs related to the operation of a facility pending

correction of deficiencies or closure; and (3) reimbursement of resident for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents.”

The CMP has a balance of approximately \$1.7 million currently, with \$200,000 committed to a two-year contract with the Kansas University Medical Center to evaluate the consistency of the nursing home review process and to evaluate what organizational characteristics are related to resident care. SFY 2004 CMP Fund revenue is anticipated to be approximately \$50,000. The agency cautions, however, that revenues for the fund have declined due to the use of sanctions other than fines for non-compliance.

Vaccinations

The Task Force recommends the introduction of legislation to require vaccinations for influenza and pneumonia for all nursing facility residents, with an exception for those who are allergic to the shots. Pneumonia vaccinations are necessary only once—if you are 65 and have never had one, or between 60 and 65 and have not had one in five years. Influenza vaccinations are necessary annually. The Task Force anticipates no additional state costs for the mandatory vaccinations. The cost will be covered through Medicaid, Medicare or personal resources, depending on the consumers. The average cost for an influenza shot is \$20; the average cost for a pneumonia shot is \$30.

Change From Case Management to Care Management

According to the Senate President’s Medicaid Task Force, one of the most important topics they covered was care management. Don Muse, a health care consultant invited to address the Task Force, pointed out that certain high cost Medicaid clients whose care, if managed by a team of

health professionals, could result in better quality care at lower cost, like those with diabetes.

Medicaid serves two primary groups - poor women and children and the aged, mentally ill, and disabled. Women and children make up 75 percent of all Medicaid recipients, while the cost of providing service to them is only about 32 percent of total Medicaid expenditures. Meanwhile, the aged, mentally ill and disabled are only 25 percent of all Medicaid consumers, but account for approximately 68 percent of the costs.

Managed care describes a system where a trained person assists those who need additional guidance as to their own medical care. Medical care management moves away from the concept of capitated managed care guided by clerks and program benefit limitations to an understanding that a trained person, where necessary will interact with the medical professionals to arrange the proper and appropriate care to address psycho-social, physical, and mental needs of the client - in short, to treat the whole person, not just their disease.

The problem already being faced by the Department of Social and Rehabilitation Services is the question of who is to provide the care management. If the agency and the state are to be assured of the best possible use of budget dollars, according to the task force report, then there has to be an evaluation as to whether the service is best provided by a professionally trained medical person or by an attendant. It would seem that if the care management system is to work in the best interest of the consumer, then the initial medical evaluation needs to be done by a medically trained professional. The implementing of the medically prescribed program, hopefully, could be done by an attendant.

By the blending of these two functions, the hope is that there can be a medically sound program which is guided day-to-day

by an attendant but under the watchful eye of the health professional.

According to the American Association of Retired Persons report "Before the Boom: Trends in Long-Term Supportive Services for Older Americans with Disabilities," as the baby boomers reach retirement age and beyond, the types of services they will be accessing is widely varied. Although nursing homes have been the primary health provider for the aged in the past, nursing home utilization has decreased by one quarter since 1974. The growth of long-term care options, from assisted living to home care services, as well as decreasing disability rates seem to have fueled this trend.

The Task Force notes the continued need for the public to be made aware of the services available to them, especially as SRS changes its delivery system by closing and consolidating offices. In addition, the Task Force recognizes the integral role played by the area agencies on aging in directing Kansans to services and providers.

Waivers

The Task Force encourages a resolution to the federal government to attempt to affect change in the mandates regarding home and community based services (HCBS) waivers. The Task Force encourages the pursuit of HCBS waivers as an entitlement, like nursing facilities. The federal government does not currently treat HCBS waivers as entitlements for funding purposes and does not require the state to provide waiver services to all who request them. The result in the last fiscal year has been the growth of waiting lists for all of the waivers. It is undisputed that waiver services are less costly, on the average, than nursing home services.

In addition, the Task Force encourages the Department on Aging to request various types of waivers, to better meet the needs of Kansans accessing long-term care.

The Task Force also recommends the continuation of the proviso that requires funds follow consumers as they move from nursing facilities into the community. The Task Force is, however, concerned that there be sufficient funds to continue the community-based services following the transition year period. There are seventy-five opportunities for persons, as of July 1, 2003, to begin moving from nursing facilities on the physically disabled and frail elderly waiver. The Task Force encourages the Department on Aging to collaborate with providers to seek out persons who would be appropriately placed in a less restrictive setting and take advantage of the cost savings of having the funding follow the consumer. While they have experienced the typical barriers to de-institutionalization of housing and transition costs, the Area Agencies on Aging and Centers for Independent Living are working to pick up these costs. The estimated time to complete the transition is approximately one year.

The Task Force encourages the pursuit of grants through the New Freedom Initiative - the President's program to: increase access to assistive and universally designed technologies, expand educational opportunities, promote home ownership, integrate Americans with disabilities into the workforce, expand transportation options and promote full access to community life. These grants are one time money, so continuing funding would be needed be identified. The State of Texas implemented Rider 37, which has allowed approximately 2,200 disabled persons to move from nursing facilities to the community without additional state appropriations.

Insurance

The Task Force recommends continued review of insurance risk pools for nursing facilities, in recognition of the rising cost of insuring nursing facilities. For example, premiums have reached nearly \$1,000 per bed and increases as high as 300 percent have been reported. Providers have been hit

with very high rates. There are several contributing factors - high claims in other states, 9-11, and the poor performance of the stock market limiting the liquid assets of insurance facilities. The Task Force members are concerned that the rising cost of insurance for facilities leaves some providers with only two choices - close their doors or operate without insurance. It has been estimated as high as 25.0 percent of nursing facilities in Kansas go without insurance each year.

Group funded insurance pools have worked for larger organizations to address these issues. The Task Force requests the Insurance Committee to study this issue further, and give additional attention to including other health care providers in these insurance pools and/or allowing providers to form pools.

In addition, the Task Force recommends the Legislature and agencies work hard to address liability issues in the long-term care industry to relieve the pressure of high insurance costs. The Task Force notes the nursing facility liability insurance does not operate like auto insurance—there is no reward for operating with few or no violations, because premiums continue to rise, despite having one of the lowest tort claims liability caps in the nation.

The Task Force requests the House and Senate Insurance Committees review the inclusion of health care workers in the state health insurance plan.

Provider Rates

The Task Force encourages Kansas Department on Aging to examine the rate setting process to see if there is a need to adjust the reimbursement rates earlier than originally intended. The 2003 Legislature changed the rate setting methodology for nursing facilities by setting FY 2001 as the base year for rate setting initially, adjusted by data collected in ensuing years. The Department is given some flexibility in

selecting base years as data are collected. Providers have expressed concern that higher insurance premiums in 2002 and 2003 are not reflected in the new methodology, placing financial strain on providers. The use of a pass through of funding to recognize those increased costs for insurance not only for liability, but employee health insurance, was suggested by the Task Force.

Inspections

The Task Force recommends that the Department on Aging and Bureau of Health Facilities increase the length between surveys for facilities that perform better to not more often than the allowable fifteen months. Instead of an inspection every twelve months, surveys of the good performing homes should be extended to the maximum allowable time between inspections and poorly performing homes be surveyed more frequently thus giving the average of every 12 months for federal law.

The Task Force encourages Aging and the Bureau of Health Facilities to work with the federal government to meet those standards while rewarding the facilities that are providing good care.

In addition, the Task Force recommends a Legislative Resolution to request the federal government review the inspection standards.

Workforce Issues in Long Term Care

The Task Force recommends the study of workforce issues across the state. According to the Kansas Association of Homes and Services for the Aging, the biggest concern for providers is workforce. Long term care health workers are faced with a variety of issues regarding their job, including how society values the job, the workplace, the economy and labor market and policy.

In regard to long term care health workforce retention, the root issue is the

climate of the facility. Since the workforce of a long-term care facility is primarily the front line contact in caring for residents, they should be empowered to be an integral and honored part of all “resident-first, resident-directed” care giving at a facility. The climate is a direct result of the model of service utilized by care providers. The traditional efficiency-driven institutional model does not provide a climate of empowerment and honor for the workforce.

The Task Force believes it is time for the era of the traditional model to pass away. It must be replaced by a resident-directed service model where residents are first and foremost in all parts of their care, i.e. give them choices: when and what to eat, when to get up, when to go to bed, bathing alternatives and recreational activities, to mention a few. This new model is called the Deep Culture Change Model.

In order to address the workforce issues, as well as to provide a better level of care for long term care residents, the Task Force recommends the creation of a demonstration site, at a facility with demonstrated success in implementing culture change, funded by the Civil Monetary Penalty (CMP) fund.

This site will also be a training site. It will develop training materials and systems for the description, understanding and implementation of the Deep Culture Change Model. Furthermore, upon success at the first demonstration site, other sites should be established across the state near community colleges and vocational technical schools. The methodology for implementing the change from demonstration/development site to full blown training site should be an integral part of the first demonstration project.

The first Demonstration Site would be specifically responsible to:

- 1) Develop a “train the trainer” curriculum for 1 to 5 subsequent Demonstration Sites. The subsequent sites would be

learning sites for others.

- 2) Develop a complete “tool chest” of systems designed to support and sustain the Deep Culture Change Model, i.e. policies and procedures, model description/change processes, human flow system, culture change quality assurance (QA) systems, etc.

Community colleges and vocational technical schools will be able to interconnect with the demonstration sites so as to determine needed curriculum changes for various disciplines to be consistent with deep culture change concepts. These disciplines include:

- ! Registered Nurse (RN);
- ! Licensed Practical Nurse (LPN);
- ! Certified Nursing Assistant (CNA);
- ! Social Worker;
- ! Social Service Designee;
- ! Long term care service providers (Administrators-in-Training [AIT] program along with Preceptor training);
- ! Long term care health workforce;
- ! Home and community based care services providers; and
- ! Other areas of expertise as needed.

The Task Force encourages the collaboration between community colleges and vocational technical schools in the provision of training for long term care service providers, long term care staff development, as well as the various disciplines such as mentioned above. Strategies to address these issues range from culture change in facilities, as implemented by the PEAK Award winners and the recipients of the exemplary care award, to additional educational opportunities for staff.

The Task Force also encourages training in deep culture change for home and community based services providers.

In addition, the Task Force encourages the use of technology to provide educational

opportunities for facilities not located in urban centers. The location of subsequent demonstration sites can greatly aid in this matter.

The Task Force recommends that SRS pursue grant opportunities through the Centers for Medicare and Medicaid and elsewhere that target workforce issues in long-term care. While the task Force recognizes that the grants are short-term solutions, they encourage SRS to pursue plans to continue the programs started by the grants through development of the appropriate infrastructure.

The Task Force also recommends that nursing school accreditation include a long-term care module and encourages the nursing associations to pursue this inclusion.

The Task Force requests the House Health and Human Services committee introduce legislation to update the Administrators-in-Training (AIT) program for adult care homes. The program is a 480 hour practicum to help administrators be successful in leading their facility teams and providing a long-term professional relationship for them while ensuring quality care of seniors. The significant decline in the number of licensed administrators of adult care homes in the last several years and the recommendation of the Board of Adult Care Home Administrators (BACHA) have convinced the Task Force that the AIT program is in need of review and should also be funded from the CMP fund.

Re-Entry of Older Persons into the Workforce

The Task Force recommends that the Department of Human Resources work to address the unique needs of older persons re-entering the workforce under the Workforce Investment Act (WIA). The Task Force

recommends that specific funds be set aside to address these needs.

Overview of Long-Term Care Services and Responsibilities

The Task Force requests that the Department of Health and Environment, Department on Aging, and Department on Social and Rehabilitation Services, for those areas that are referred to as long term care, provide a report outlining the functions under state and federal control, to give the Task Force better direction in affecting change. In addition, the report should include information regarding which programs are mandated by the federal government and which ones are optional to states and how changes might affect federal funding streams. Finally, information regarding the process for changing federal regulations, where it applies, should also be a part of the report. It is the expectation of the Task Force that this information not necessarily be all inclusive, but that it be accurate, reflecting the precise language in federal and state regulations whenever possible, to give the Legislature a better understanding of what regulations they control or have an opportunity to change. The Task Force requests reporting of the information to the Legislature no later than February 1, 2004.

Foreign Pharmaceuticals

The Task Force requests the House Health and Human Services Committee review the quality and cost of foreign pharmaceuticals. The Task Force recognizes that Kansans continue to search for ways to make pharmaceuticals more affordable. However, concerns about the content and quality of drugs imported from other countries, not regulated by the Food and Drug Administration, lead the Task Force to believe that further study is necessary.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Ref:S&C-02-42

Date August 8, 2002

From: Director
Survey and Certification Group
Center for Medicaid and State Operations

Subject: Use of Civil Money Penalty (CMP) Funds by States

To: Associate Regional Administrator
Divisions of Medicaid & State Operations
Regions I-X
State Survey Agency Directors

The purpose of this memorandum is to provide information regarding how states may use CMP funds collected from nursing homes that have been out of compliance with Federal requirements. It has come to our attention that guidance is needed to ensure that states use CMP funds in accordance with the law and in a consistent manner, while maintaining some flexibility in the use of those funds.

Background - States collect CMP funds from Medicaid nursing facilities and from the Medicaid part of dually-participating skilled nursing facilities (SNFs) that have failed to maintain compliance with Federal conditions of participation. CMP funds collected from Medicare-participating SNFs and the Medicare part of dually-participating SNFs are Federal funds and are returned to the Medicare Trust Fund.

Section 1919(h)(2)(A)(ii) of the Social Security Act (the Act) provides that CMP funds collected by a state as a result of certain actions by nursing facilities or individuals must be applied to the protection of the health or property of residents of nursing facilities that the state or the Secretary finds deficient. These actions include CMPs assessed against:

- (1) A nursing facility that is not in compliance with Federal requirements in sections 1919(b), (c), (d) of the Act;
- (2) An individual who willfully and knowingly certifies a material and false statement in a resident assessment (section 1919(b)(3)(B)(ii)(I) of the Act);
- (3) An individual who willfully and knowingly causes another individual to certify material and false statement in a resident assessment (section 1919(b)(3)(B)(ii)(fl) of the Act); and
- (4) An individual who notifies (or causes to be notified) a nursing facility of the time or date on which a standard survey is scheduled to be conducted (section 1919(g)(2)(A)(i) of the Act).

The Act cites three examples of uses for CMP's:

- (1) Payment for the costs of relocation of residents to other facilities;
- (2) Maintenance of operation of a facility pending correction of deficiencies or closure;
and
- (3) Reimbursement of residents for personal funds lost.

The regulations, at 42 CFR 488.442(g), contain similar language with some very minor wording changes that make it clear that the costs of relocation of residents to other facilities are for state costs. The regulations also indicate that the personal funds lost at a facility are the result of actions by the facility or by individuals used by the facility to provide services to residents. Section 7534B of the State Operations Manual (SOM) contains similar language, but specifies that the funds must be used to protect the health or property of residents of deficient facilities.

In the preamble to the final enforcement regulations published on November 10, 1994, we indicated that the law suggests that CMP revenues be applied to administrative expenses rather than direct care costs although it is clear that states have broad latitude to determine which of these types of expenses best meet the needs of their residents (page 56210 of the Federal Register, Volume 59, No. 217). Further, the preamble is very clear that the Act permits each state to implement its own procedures with respect to the use of CMPs. Our previous direction to CMS regional offices has been that the specified uses of CMP funds in the Act and section 488.442(g) are not exhaustive, that states need flexibility in determining the appropriate use of funds, and that regional offices have some oversight responsibility. Beyond this, we have not provided general guidance to all states and regional offices on what is considered appropriate use of these funds within the scope of the law and regulations. Due to the lack of guidance, a number of states have been reluctant to use a majority of the money. As result, some states have a significant amount of money on deposit and this amount is continuously growing.

Flexibility in Use of CMP Funds -- While the Act provides states with much flexibility to be creative in the use of CMP funds, this flexibility is limited by the requirement that CMP funds are to be focused on facilities that have been found to be deficient. However, the law does not specify when a facility must have been determined to be deficient to qualify for benefits under state project funded by CMPs. Most nursing facilities have had one or more deficiencies either recently or in the past. Rather than setting forth rigid criteria on when it is that facility must have been deficient to be an eligible target for the application of CMP revenues, we believe that the best course is to offer states maximum flexibility to make this determination. Apart from this, we believe that projects funded by CMP collections should be limited to funding on hand and should be relatively short-term projects.

Each state is responsible for ensuring that CMP funds are applied in accordance with the law. Regional oversight should be general in nature, responding to questions from states or commenting on the occasional project proposal submitted for regional office input, but there is no requirement that a regional office review and approve each state project before it is implemented.

Appropriate CMP Fund Use —As we stated in the preamble to the 1994 final enforcement regulations, CMP revenues should be spent on administrative expenses, rather than direct care costs, as applied to deficient facilities. If the purpose of the state project is related to deficient practice, the CMP funds could be used to prevent continued noncompliance by nursing facilities through educational or other means. For example, to address particular areas of noncompliance, a state could develop videos, pamphlets, or other publications providing best practices, with these educational materials being distributed to all deficient nursing facilities. Other uses could include, for example, the development of public service announcements on issues directly related to the identified deficient area, and employment of consultants to provide expert training to deficient facilities. North Carolina and other states have issued grants to several nursing facilities to fund Eden Alternative Projects, which provide training and other services necessary to support the use of animals in nursing facilities for therapeutic purposes. Because CMP funds collected by a state are state funds, the state may use the money for any project that directly benefits facility residents, in accordance with section 1919(h)(2)(A)(ii) of the Act, including funding an increase in ombudsman services.

Inappropriate CMP Fund Use — We believe that it is not appropriate for states to use CMP funds for a loan to a deficient facility that is having financial difficulty meeting payroll or paying vendors. As pointed out in the preamble, if the CMP is used by the facility to correct the noncompliance that led to its imposition, it is, in effect, not a remedy.

If you believe that a state is not spending collected CMPs in accordance with the law or regulations, or not at all, you should refer this matter to your regional office account representative so that he or she may discuss this matter with the State.

Effective Date: This guidance is effective on the date of issuance.

Training: This policy should be shared with all survey and certification staff; surveyors, their managers and the state/regional training coordinator.

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Steven A. Pelovitz