KANSAS INSURANCE DEPARTMENT
Vicki Schmidt, Commissioner

MEMORANDUM

DATE: June 15, 2023
TO: Representative Brenda Landwehr; Secretary Laura Howard
FROM: Kansas Insurance Department
RE: Continuing Care Providers

Jurisdiction of the Kansas Insurance Department

House Bill No. 2381 became effective July 1, 1989, and was subsequently codified as K.S.A. 40-2231 through K.S.A. 40-2238. This bill initiated a formal registration process for certain providers of continuing care. It replaced 1986 House Bill No. 2251 (K.S.A. 16-1101 through K.S.A. 16-1105) and was designed to more clearly define the type of contract or agreement form pursuant to which providers undertake to furnish continuing care. It applied to any *provider* using a *continuing care contract*, as defined in the Bill or in K.S.A. 40-2231, as well as a contract or agreement form used by *any provider who voluntarily applies* for a Certificate of Registration.

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

K.S.A. 40-2231(a) defines a "continuing care contract" as an agreement to which a provider undertakes to furnish to a person 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 as defined in K.S.A. 40-2235, which states 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."

The Insurance Department's jurisdiction concerning continuing care providers is the registration of such providers and the annual renewal of the certificate of registration for said providers. The initial registration consists of an application, disclosure statement and applicable exhibits, continuing care contracts, fee schedules, a certified financial audit, and the payment of a $50 registration fee.

The annual renewal for each provider is based upon the month and day of their initial registration. Renewal requirements are the same except the renewal fee is $25. The certified

financial audit is required within four months of completion of the provider's fiscal year. Upon receipt of all required materials, an acknowledgment letter is emailed to the provider stating that the certificate has been renewed until the next renewal date which is stated in the letter.

Providers are required to provide the Commissioner a copy of any continuing care contract forms in use, 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.

The applications for new and renewal continuing care provider registration can be found at https://insurance.kansas.gov/accident-health-life-insurance/

Jurisdiction of the Kansas Department on Aging and Kansas Department of Health and Environment

On June 3, 2010, Senate Substitute for Senate Substitute for Substitute for House Bill No. 2320, became effective. It was codified as K.S.A. 75-7435 and the enforcement of its requirements is the responsibility of the Kansas Department on Aging and the Kansas Department of Health and Environment.

K.S.A. 75-7435 establishes an annual assessment per licensed bed, also known as a quality care assessment, on each skilled nursing facility licensed in Kansas. Although the amount of the assessment is changed through legislation every few years, the assessment for 2023 is $4,908 annually per licensed bed. However, the assessment for skilled nursing facilities that are part of a continuing care retirement facility, small skilled nursing facilities and high Medicaid volume skilled nursing facilities does not exceed 1/6 of the actual amount assessed for all other skilled nursing facilities. Thus, these facilities are assessed at a rate of $818 per bed rather than $4,908 per bed.

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

The Insurance Department is not involved with the quality care assessment for certain types of skilled nursing facilities as defined in statute. It is the provider's responsibility to properly notify KDADS if they have a current certificate of registration on file with the Insurance Department. However, KDADS, as well as some of the providers, do contact the Insurance Department to ask for a copy of the acknowledgment letter that was previously sent to them.

Federal Jurisdiction

The Centers for Medicare and Medicaid Services (CMS) require a number of forms to be completed in order to enroll in the Medicare program including an application, "Skilled Nursing Facility Application for Medicare and Medicaid." Question F27 asks, "Is the facility part of a continuing care retirement community (CCRC)?" In the General Instructions and Definitions of the application, instructions for F27 state, "Check yes if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." As defined on the form, a CCRC is "any facility which operates under State regulation as a continuing care retirement community."

If a provider should answer "no" to question F27, it would affect the amount of the quality care assessment imposed pursuant to K.S.A. 75-7435(b)(1). If, for example, the 2023 assessment is $4,908 per bed, rather than the lower assessment afforded to certain facilities, then the amount of monies deposited in the Quality Care Fund would be much higher than if the facilities obtained the lower assessment rate of $818 per bed.

The CMS website defines a continuing care retirement community (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 they charge monthly fees.

As stated earlier, K.S.A. 40-2231(a) defines a continuing care contract as an agreement requiring a minimum $5,000 entrance fee. But it also contains a rather confusing definition stating, "Continuing care contract shall also mean an agreement of any other provider who voluntarily applies for a certificate as defined in K.S.A. 40-2235", which states 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." It's possible that the inclusion of this definition may be the cause of some of the current issues.

Conclusion

The Insurance Department's jurisdiction regarding CCRCs is the initial registration and annual renewal of these providers. The Department is not involved with the quality of care assessments performed through KDADS nor with the Federal aspect of Medicare or Medicaid. Because of a lack of a substantial nexus to insurance, the Insurance Department supports exploring moving the registration requirement to an agency that more closely regulates these providers. This would reduce the number of agencies a provider must interact with and would create efficiencies.

Since the requirements for registration began long before the quality care assessments, some legislative change may need to be considered to bring things into sync. Further, the Insurance Department has received communications from registrants that the timing of the annual audit requirement submission is burdensome. The Insurance Department is open to a legislative solution to that issue.