Approved: 02/23/93
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairman Rochelle Chronister at 1:30 p.m. on February 17, 1993 in Room 514-S of the Capitol.

All members were present except: Rep. Wanda Fuller (excused absence)

Committee staff present: Alan Conroy, Legislative Research Department
Laura Howard, Legislative Research Department
Ellen Piecalkiewicz, Legislative Research Department
Jerry Cole, Committee Secretary
Sharon Schwartz, Administrative Assistant

Conferees appearing before the committee:

Rep. Barbara Allen, sponsor of HB 2188
Secretary Donna Whiteman, Department of Social and Rehabilitative Services
Gigi Felix, Kansas Chapter for National Association of Social Workers
Rep. Alex Scott, Committee on Public Health & Welfare
Robert Epps, Department of Social and Rehabilitative Services
Ann Elliott, Geary County Landlords
Dr. Nelda Kibby, Lindbergh Elementary School
Steve Stagner, Wichita Landlords Organization
Ed Jaskinia, Associated Landlords of Kansas
Rep. Bill Bryant, sponsor of HCR 5015
John Grace, Kansas Homes for the Aging
Secretary Joanne Hurst, Department on Aging
Sandra Strand, Kansans for the Improvement of Nursing Homes
Debbie Nickels, Jefferson County Health Department and Home Health Agency
Joe Kroll, Department of Health and Environment

Others attending: See attached list

Rep. Helgerson made a motion for the introduction of a bill dealing with municipal bonds. Rep. Kline seconded the motion. The motion was carried.

Rep. Barbara Allen appeared before the committee to brief the members about HB 2188. (See Attachment 1). She said that the bill basically encouraged teenage Aid for Dependent Children (AFDC) recipients to get their high school education. This bill would create a pilot project titled KanLearn which would be administered by SRS. Secretary Donna Whiteman, SRS, spoke in support of the bill saying that it was an incentive for the teenagers to stay in school. (See Attachment 2). She asked the committee to consider placing a time limit on the pilot project if the bill was to be recommended favorably. Gigi Felix, National Association for Social Workers also spoke in support of the bill. (See Attachment 3). She pointed out the increasing numbers of teenage mothers throughout Kansas and stressed the need for these mothers to finish their primary education. Chairman Chronister closed the hearing on HB 2188.

Rep. Alex Scott was first to appear for HB 2279. (See Attachment 4). Rep. Scott gave a brief synopsis of the bill and its goals. He said that the bill would facilitate and ensure the rental payments of tenants receiving state monetary assistance. Robert Epps, Department of SRS, spoke in opposition to the bill. (See Attachment 5). He said that not only did federal statute restrict the state in placing restrictions on AFDC payments, but that this bill undermined the basic goal of the agency-instilling self sufficiency in its clients. Ann Elliott, Geary County Landlords spoke to the committee in favor of the bill. (See Attachment 6). She stated many recipients cannot budget money and subsequently overspend, leaving no money for rent. Ms. Elliott said the bill would

Nelda Kibby - Attachment 7

school because of their transient status. Steve Stagner, Wichita Landlords Association, testified in support of the bill saying that the landlords could reduce rent if they were guaranteed payment. (See Attachment 8). Ed Jaskinia, Associated Landlords of Kansas offered the final testimony to the committee for the bill and was also in support. (See Attachment 9). Chairman Chronister closed the hearing on HB 2279.

Rep. Bill Bryant appeared to present HCR 5015 by offering some clarification for committee members as to the resolution's purpose and intent. (See Attachment 10). Secretary Donna Whiteman, SRS, testified in support of the resolution by telling the committee there were some services to the aging that were duplicated by other agencies. (See Attachment 11). She said the audits proposed in the legislation would help to weed out some of the overlapping services. Chairman Chronister turned the chair over to Vice Chairperson, Rep. Jo Ann Pottorff. Chairman Pottorff introduced John Grace, Kansas Homes for the Aging, who testified in support of HCR 5015. (See Attachment 12). Mr. Grace said that services to the aging definitely have a fiscal impact on the state and that this matter should be dealt with accordingly. Mr. Grace supported the resolution. Secretary Joanne Hurst, Department on Aging, testified to the committee. (See Attachment 13). Secretary Hurst said she had collaborated with Secretary Whiteman and that they both were in consensus as to the need for audits called for in the resolution. Sandra Strand, Kansans for the Improvement of Nursing Homes, offered testimony in support of the resolution. (See Attachment 14). Debbie Nickels, Jefferson County Health Department and Joe Kroll both testified to the committee in support to finish the hearing on HCR 5015. (See Attachments 15 & 16). Chairman Pottorff told the committee that Charles Oldfather and Marge Zakoura-Vaughan, both of the State Advisory Council on Aging were unable to appear but had offered written testimony. (See Attachments 17 & 18).

Chairman Pottorff adjourned the meeting at 3:10 p.m. The next meeting is scheduled for February 18, 1993.

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: FEB. 17, 1993

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO:
Becky Schwartz	Rt. 1 Hanover, KS 66945	Page
Danelle Stohs	Hanover, KS 66945	Page
[illegible]	SRS Topeka	
Robert Epps	Topeka	SRS
[illegible]	Topeka	K-NASW
Janet Schalansky	Topeka	SRS
Linda Ramirez Clanton	Topeka	KDHR
[illegible]	SRS Topeka	SRS
Marty Kennedy	Topeka	Budget
Dodie Lacey	Topeka	KCSL
Suzanne Southard	Ottawa University	
Jennifer Haupt	Ottawa University	
Cheri Goldendrich	Ottawa University	
Jodi Smith	Ottawa University	
Jan Penny	Washburn University	
Lyndon Dunn	Topeka	KDOT
Jeanne Hurst	Topeka/Lawrence	KDOT
[illegible]	Topeka	[illegible]
Laura Meyer	Overland Park	United Telephone
FRANK THACHER	TOPEKA	AARP-CCTF
Mildred Harkness	Lawrence	JDAA Advisory Board
Debbie Nikels	1012 Walnut Oskaloosa Hwy 59	Jefferson Co. Health Dept
Bonnie Brickhouse	3019 SE Starlite	Tayhawk Area Agency on Aging
Diane Stines	745 Vermont Lawrence	Dg Co. Senior Services
Kathryn LeMay	1214 Mac Vicar St	JAIA

Sandra Strand	Lawrence	KINH
Donald Jobson	McPherson	Intern
Preston Peth	Lawrence	Enter (Med)
Pam Brockus	Princeton	Ottawa University
Tonia Salvini	Ottawa	" "
ED JASKINIA	KCK	THE OSSCO LANDLORDS OF KANSAS
Craig Kammen	TOPEKA	Dept on Aging

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: FINANCIAL INSTITUTION & INSURANCE
MEMBER: TAXATION
RULES & JOURNAL
JOINT COMMITTEE SPECIAL CLAIMS
AGAINST THE STATE

February 17, 1993

Madame Chairman, Members of the Committee:

Thank you for the opportunity to appear before you today on **H.B. 2188** which establishes the KanLearn program.

The goal of KanLearn is to encourage teenage AFDC recipients to get a high school education, so that they can obtain a job and move off welfare. Specifically, financial incentives, and other support services such as child care, transportation, and tutoring and mentoring, would be offered to 13-19 year olds on public assistance.

Participants could either be parents themselves receiving payments under the Aid to Families with Dependent Children (AFDC) program, or they could be residing with their natural or adoptive parents who are receiving AFDC. The pilot program would be offered in three KanWork areas of the state. Assuming federal waivers are received, the program would be implemented in the fall 1993 school term.

The KanLearn pilot program should be structured so that the progress of participants is regularly evaluated, and so that the desired results of the program are objectively measured:

1) does school attendance improve for KanLearn participants?
2) are KanLearn participants more likely to stay in school and graduate?
2) are KanLearn participants more likely to get a job?
3) do KanLearn participants ultimately become productive adults and avoid long-term welfare dependency?

I believe the state **should** be in the business of providing special educational incentives for these kids, so that we can help reinforce the importance of a high school education. Most, if not all of them, need incentives to stay in school, because they come from homes where incentives to learn may not be present.

ATTACHMENT 1

The AFDC population in Kansas is **already** at a disadvantage for competing successfully in the job market because of racism, sexism, and the stigma of being on welfare. We should provide an added incentive through the KanLearn program for teenage AFDC recipients to learn, so that they can realize the connection between education and success.

Funding for KanLearn would be 59% federal and 41% state. **The Department of SRS estimates the fiscal note to the SGF for FY1994 to be $195,136, excluding child care.** This figure is based on a pilot project in three KanWork counties, and includes financial incentive payments at minimum levels, as well as auxiliary services such as transportation, tutoring, and special financial assistance payments. It excludes child care, as this service would already be provided for this population within the regular child care budget.

INCENTIVES RATHER THAN PENALTIES -- This is not the first time you have seen the KanLearn bill in Kansas. It was originally introduced in the form of a penalty, so that recipients who do not stay in school have their welfare benefits reduced. The bill before you provides incentives rather than sanctions for several reasons:

First, using punitive measures, although sometimes politically attractive, are not the answer to keeping kids in school. The states of Wisconsin and Ohio have "Learnfare" education/welfare reform programs, under which a family's AFDC grant is reduced if the child misses more than a designated number of days. In Wisconsin, the program withheld $3.4 million from welfare families in the first year of the program. However, the program failed to demonstrate improved school attendance among teens subject to Learnfare; and during the second year of the program, the number of sanctions did not decline.

Second, students are not going to learn the value of an education through financial sanctions. But they might learn the value of an education through positive incentives for returning to class, through mentoring and tutoring services, and through counseling to help resolve the personal or family problems that might be the cause of poor attendance.

Third, cutting a family's welfare grant may be a way to punish a child who refuses to attend school regularly, but it hurts innocent children and other family members, and may leave the family without sufficient income to pay the rent. In a family which is already struggling to survive, imposition

of financial sanctions on a child with poor school attendance will only serve to create adversaries between parent and child, and to increase tension and stress in the home.

CONNECTION of KANLEARN TO KANWORK -- The Department of SRS recently presented a review of the KanWork/JOBS program to the Appropriations SRS subcommittee. Testimony from Secretary Donna Whiteman stated, **"Either Kansas will continue to fund increases in the AFDC program, or it will develop a quality job training self-sufficiency program."**

Secretary Whiteman also told the subcommittee that, in her opinion, **one of the two biggest problems with KanWork was the education component**, and specifically, the failure of many KanWork clients to get their GED.

It's clear to me that **EDUCATION** is the key to developing a successful jobs program! **Although many circumstances often combine to force a family into welfare dependency, the underlying cause is most often lack of education**. Studies show there is a strong correlation between education and income.

In Kansas, we are facing an **education crisis** within our AFDC population. Many people on assistance don't receive schooling that will prepare them for the workforce. **In fact, only 59% of the adult AFDC population in this state has finished high school.** The Department of Labor estimates that the incidence of **learning disabilities** for the AFDC population in the JOBS program is between **25% and 40%**, and Secretary Whiteman believes the **actual percentage of learning disabled KanWork clients** is between **60% and 80%!**

The state of Kansas must expend 55% of the JOBS budget on a federally-mandated target group. It's interesting to note that **first priority is given to the target group population, which includes families in which the custodial parent is under age 24 and has not completed high school or is not enrolled in high school or an equivalent course.**

States **should** use their financial resources to strengthen the linkages between education and welfare. One of the goals of the KanWork/JOBS program is to slow the growth of cash assistance costs by increasing economic self-sufficiency for AFDC recipients. The KanLearn program is an effective

tool to help us reach that goal, because it will provide incentives for kids to graduate from high school, so that they can ultimately recognize the connection between education and success, and move off of welfare and into the workforce.

Thank you Madame Chairman. I will be happy to answer questions.

Possible Incentive Payments For KanLearn Participants
(as determined by the Secretary of SRS)
Three Pilot KanWork Counties

Completion of two semesters of high school, and enrollment to attend next semester -------- not less than $100

Graduation from high school, and receipt of a high school diploma --------- not less than $250

Other Possible Services/Payments -------- mentoring, tutoring, transportation to and from school, special financial assistance payments determined to be necessary for child to stay in school, subject to appropriations.

LEARNFARE PROGRAMS IN OTHER STATES

Several other states have adopted or proposed Learnfare programs involving both an incentive and a penalty. The following summarizes other state programs. In some cases these programs are already operating; in other cases, they are current proposals or reflect pending waiver requests:

CalLearn	Teen parents receive a $50 grant supplement each month if attending high school or GED, or a $50 reduction if not attending
Maryland	Grant is reduced by a maximum of 30 percent if certain behaviors including school attendance are not maintained
New York	GradFare -- Targets teens age 16 - 18 years of age; sanctions nonschool attendance; restores grant if child returns to school; as an incentive to return to school, the lost grant amounts are pain in a lump sum to the household upon graduation
Ohio	Teen parents receive a $62 grant supplement if attending school; $62 reduction if not attending school
Washington	Require parents under age 20 to show progress in completing high school or GED or grant terminates
Wisconsin	13 - 19 year old target group; sanctions for poor school attendance; grant reduced by the equivalent of one person

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

February 17, 1993

TO: Representative Barbara Allen

FROM: Laura Howard, Senior Fiscal Analyst

RE: Fiscal Note on H.B. 2188

Attached is the SRS response to the Division of the Budget on the estimated fiscal impact of the KanLearn bill. I thought it would be helpful to you if I summarized their assumptions since the total impact they estimate is greater than what we discussed. The significant difference is that the agency assumes that KanLearn participants will need child care services. As we have discussed earlier, these should be able to be absorbed within the regular child care budget.

SRS Fiscal Impact

Staffing and OOE (4.0 FTE)	$135,097	
System Modifications	24,840	
Staff Training	4,000	
Subtotal - Admin	$163,937	
Incentive Payments	$58,350	
Special Payments	74,400	
Transportation	108,000	
Tutoring	11,520	
Transportation Payment	162,000	
Child Care	344,640	
Total -- Assistance	$650,910	
TOTAL PILOT -- ALL FUNDS		$814,847
STATE FUNDS		338,162
EXCLUDING CHILD CARE :		
ALL FUNDS		$470,207
STATE FUNDS		195,136

As we have discussed, child care can be funded from existing dollars in the SRS budget; presumably if these children are in school they already have child care arrangements which may include subsidized child care.

Please call if you have questions.

COMPARISON OF AVERAGE WAGES EARNED

MEN

	1 – 3 Years of High School	4 Years of High School
1970		
WAGES	$8,514	$9,567
% OF HIGH SCHOOL GRADUATE	89.0%	--
1990	$20,902	$26,653
% OF HIGH SCHOOL GRADUATE	78.4%	--

WOMEN

	1 – 3 Years of High School	4 Years of High School
1970		
WAGES	$4,655	$5,580
% OF HIGH SCHOOL GRADUATE	83.4%	--
1990	$14,429	$18,319
% OF HIGH SCHOOL GRADUATE	78.7%	--

of Dropouts

l dropouts in the year that they dropped out:

umbers in thousands]

Civilian labor force status[2]				Number not employed and not looking for work
mber in or force	Labor force participation rate	Percent employed	Percent unemployed[3]	
427	60	74	26	285
455	63	66	34	272
471	64	68	32	268
450	63	64	36	264
421	63	58	42	247
377	63	68	32	220
387	64	67	33	214
413	67	64	36	199
359	64	72	28	203
333	66	62	38	169
327	59	73	27	225
292	65	72	28	154

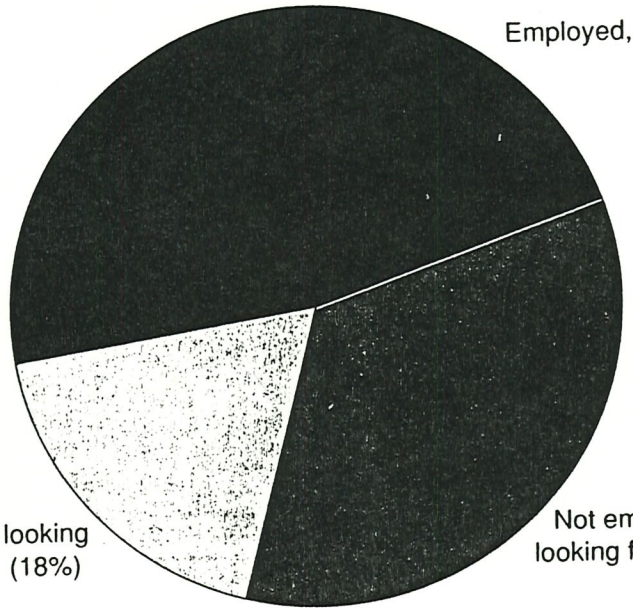
) dropped out from any grade without completing high school during r).

plus those seeking employment. The labor force participation rate is eking employment.

se in the labor force who are not working and are looking for employ-

Labor Statistics, *Employment of School-Age Youth, Graduates, and*

Employment status of 16- to 24-year-olds who dropped out of school in 1988-89



Total persons who dropped out between October 1988 and October 1989 = 446,000

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *Employment of School-Age Youth, Graduates, and Dropouts*, various years; and unpublished tabulations.

The job outlook for high school dropouts is generally dismal. In October of 1989, only about one-half of those who had dropped out in the previous 12 months were employed. Some of those not working were looking for jobs, but many more were neither employed nor looking for work. A much larger proportion of dropouts (35 percent) than noncollege-enrolled high school graduates (15 percent) were not in the labor force (see Indicator 38).

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna Whiteman, Secretary

Testimony before the House Appropriations Committee
H.B. 2188 - KanLearn
February 17, 1993

****

SRS MISSION STATEMENT

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."
****

The Department of Social and Rehabilitation Services wishes to express support for House Bill 2188 which establishes the KanLearn pilot project. We believe this action will give teens a clearly understandable and monetarily tangible reason to pursue their education and reduce the likelihood of their future dependence on public assistance. Our experience has been that the lack of education among Aid to Families with Dependent Children (AFDC) recipients is their greatest barrier to achieving self-sufficiency. This is illustrated in the data and experience we have gained in the KanWork program. Our data shows 40% of the clients entering the KanWork program have not completed high school or obtained a GED. This project has the potential to reverse the downward spiral of chronic, generational welfare dependency and give teens on assistance the keys to a better future.

Currently teenagers receive cash assistance as a member of a family unit. If the child drops out of school and is 16 years of age or older he/she becomes a mandatory KanWork participant. There are no stipulations if the child is under 16. Should a teenager become pregnant, the baby would become part of the assistance plan of the family. As long as the teen parent stays in school the only service available would be child care, if needed. If the teen parent drops out of school and becomes mandatory for KanWork, then he/she would be eligible for all the KanWork support services, i.e., transportation, child care, special allowance, and education or training funds if needed. HB 2188, KanLearn, would provide some of these services prior to the teen dropping out of school and thus would encourage some teens to stay in school.

As indicated earlier, some AFDC teenagers, sixteen years of age and older, are already being served through the JOBS program in Kansas. SRS has estimated that 35% of 16 to 19 year old dropouts are returning to high school or an equivalent education as a result of conciliatory efforts mandated by the JOBS program. The remaining 65% are sanctionable under JOBS and their needs can be removed from the cash assistance payments. The KanLearn project could provide good incentives to help these teens choose to stay in school.

We would propose the KanLearn project be administered as part of the Job Opportunities and Basic Skills Training Program (JOBS) as an educational

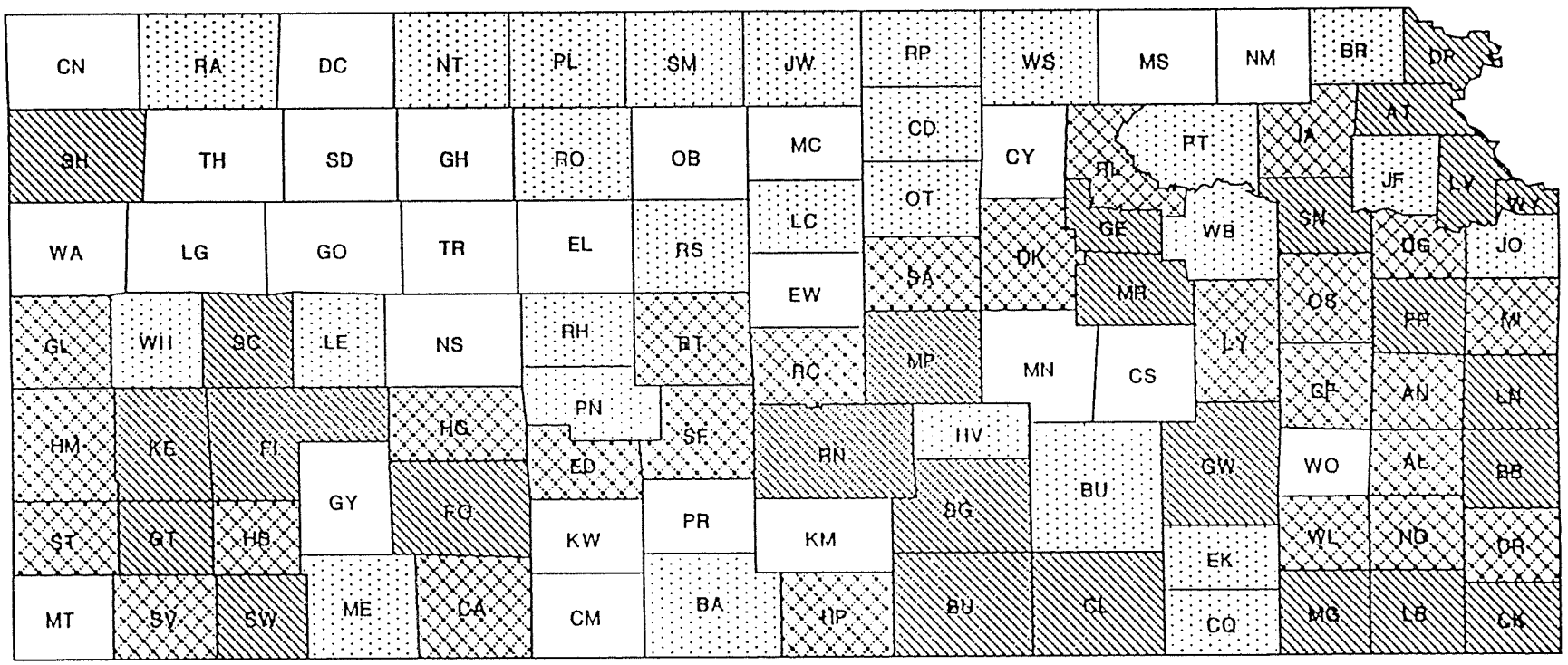
ATTACHMENT 2

component to target adolescents. We suggest piloting the program for two years in Harvey, Montgomery, and Saline counties. Although it will be necessary to obtain federal waivers to exempt the incentive payments as countable income in a family's public assistance case, many of the changes will only require state plan modifications. We would not anticipate any problems in getting federal approval, as similar programs have been implemented in other states.

As written, the bill allows only AFDC recipients to participate in KanLearn. We believe the eligibility guidelines should be expanded to include teens receiving General Assistance. There are many families in Kansas who, for one reason or another, are not eligible for AFDC but are receiving nearly identical assistance through the state-funded GA program. Teens in these families are equally as vulnerable to long-term welfare dependence and should be included in KanLearn.

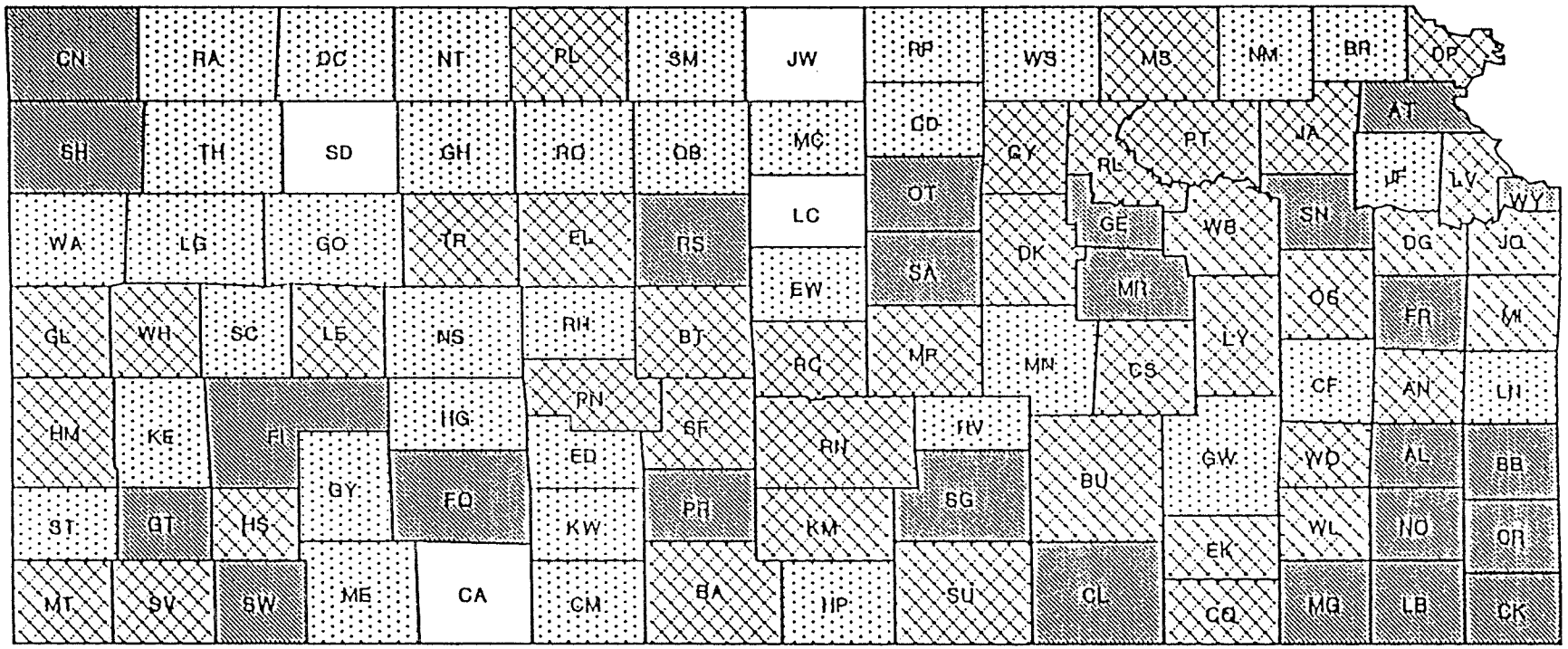
The KanLearn program will require extensive coordination among all levels of SRS and the Kansas Board of Education in the development and maintenance of accurate and efficient reporting tools. We feel this effort will be justified by the future savings that will be realized through diverting teens from long term dependence on public assistance.

TEEN PREGNANCY RATES PER 1000 POPULATION



High School Dropout Rate 1990

2-4

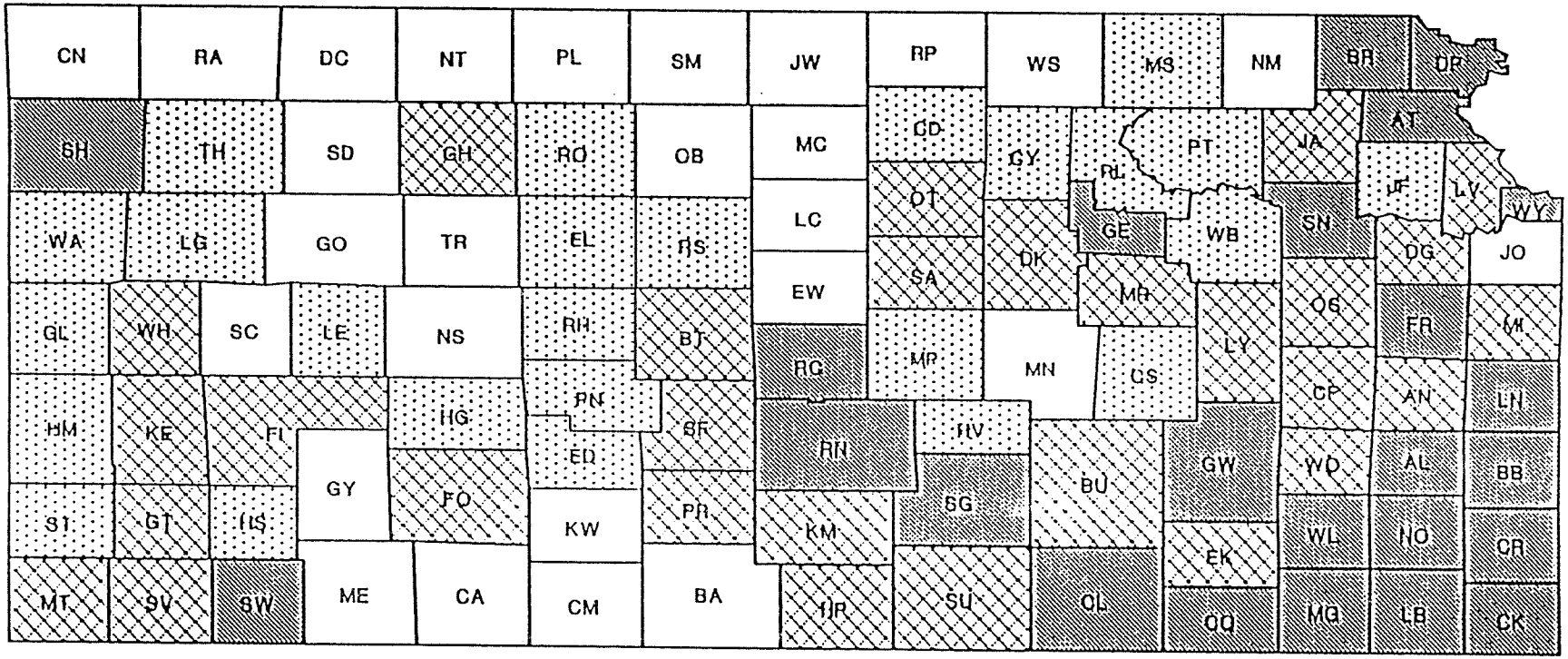


Maximum: 7.7 Minimum: 0.0 Average: 3.0 Median: 2.8

- 0.0
- 0.1 to 2.2
- 2.3 to 4.0
- 4.1 to 7.7

Source: Kansas Board of Education
Graphics by: KSU Extension DIRECT Program

Aid to Families with Dependent Children
Fiscal Year 1991 per 1000 Population



Maximum: 76.8 Minimum: 0.3 Average: 23.4 Median: 20.4

- 0.3 to 12.5
- 12.6 to 20.0
- 20.1 to 32.0
- 32.1 to 76.8

Source: Kansas Department of Social and Rehabilitation Services
Graphics by: KSU Extension DIRECT Program

THE TOPEKA CAPITAL-JOURNAL
IN THIS SECTION
Kansas 2-D
Classified 3-D
Wednesday, February 17, 1993

Teen moms rural, too

■ A day care has opened at Shawnee Heights to help keep students in school

By KRISTEN L. HAYS
The Capital-Journal

Teen pregnancy and parenthood don't stop at the city limits.

Ask Michelle Gibson. As the 18-year-old senior at Shawnee Heights Senior High School cradled her 5-month-old daughter, Roneisha, on her lap Tuesday, she said it isn't a situation any school district — rural or urban — can ignore.

Gibson is the only student so far in Shawnee Heights Unified School District 450 to take advantage of a new infant and toddler care center for teen parents.

The two-room center, across the street from Shawnee Heights Senior High in Shawnee Heights United Methodist Church at S.E. 44th and Shawnee Heights Road, opened last month thanks to a $2,600 grant from United Way of Greater Topeka and other donations.

Shawnee Heights Senior High teacher Karen Mead teaches child development and parenting classes. Diane Rawson, director of Heights of Learning day care and preschool at the church, provides the laboratory as well as day care.

USD 450 pays nothing for it.

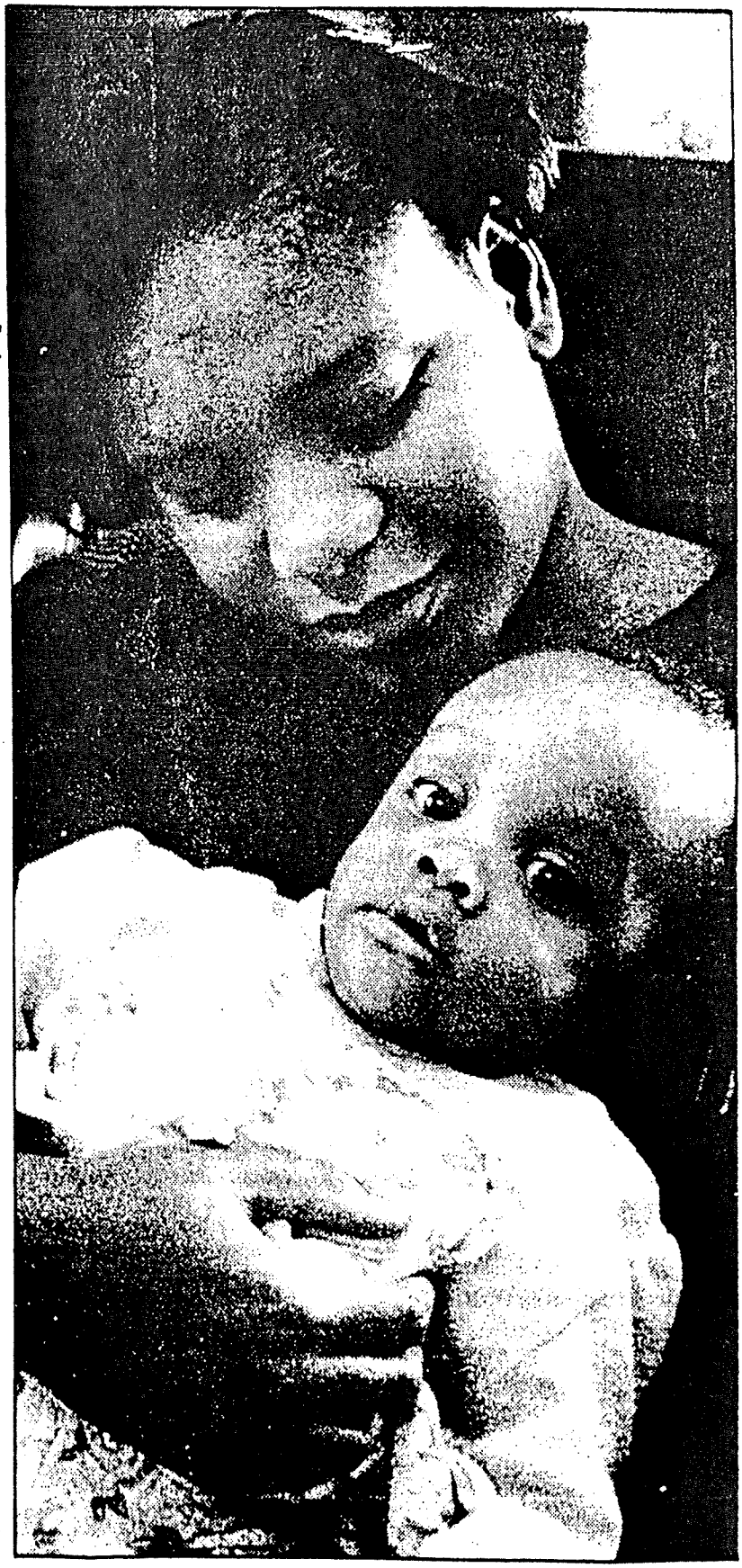
Gibson used to miss school to take care of her daughter. Now she is learning baby basics and preparing for Wichita State University.

That is the idea, said Rawson — to keep teen mothers in school and give them a boost in parenting skills so they can graduate with an eye to the future.

"I think it's needed everywhere," she said, "but it may take a little longer in rural areas."

Tuition for Rawson's center is $110 a week for infants up to a year old and $95 a week for toddlers 1 to 2½ years old. High school students get financial help from the Kansas Department of Social and Rehabilitation Services.

Pat Cardwell, one of Rawson's employees, expects a baby boom in the next few months. She knows four pregnant Shawnee Heights teens with due dates in the summer or fall. A baby born two weeks ago to another high school mother will arrive at the center this month.



—Brett Garland/The Capital-Journal

Michelle Gibson took time recently during a school day to visit her 5-month-old daughter, Roneisha. Michelle attends Shawnee Heights Senior High School, and Roneisha stays at the Heights of Learning Preschool and Child Care Center across from the high school.

ATTACHMENT 3

TESTIMONY IN SUPPORT OF HB2188

Good Afternoon. My name is Gigi Felix, and I am the executive director of the Kansas Chapter of the National Association of Social Workers. I am here today to support the KanLearn Program as proposed in HB2188. In attachments to my testimony are pages from the "Kansas Kids Count" report put out by Kansas Action for Children. The statistics for Kansas are startling. Cowley County showed an increase of 189% in the years 1980-1990. In our state the teenage birth rate has increased 40% in just those 10 years, while the national average has increased only 14%. In 13 Kansas Counties there were over 50 births to single teenage mothers in 1990 alone. That's frightening. The problem is occurring in every corner of the state as shown in today's Topeka Capitol Journal. The problem is neither rural nor urban - it is universal.

I bring these statistics to your attention to show that Kansas is not only not exempt from the single teen parenting problem, we are way above the national average which includes places usually associated with the issue - places like New York or Los Angeles.

What will happen to these teen parents' education? If they are lucky, there is a parent or family member who can assist with the care of the infant while the parenting teen finishes high school. But, what if there is not? There is little chance for a teenager without an education, and an infant to care for, to find work and secure an income - or if there is a job, how much of the minimum wage would be left to buy food, clothes, etc.

ATTACHMENT 3-2

after the child care is paid? Obviously, there are few options other than to quit school, and go on public assistance FOR YEARS.

This legislation gives the teenage parent a way to stay in school, get an education, become a taxpayer in Kansas within only a few years, and know that the child is secure. The services are doled out on a need basis, not universally. The financial rewards are small - only $100 for completing 2 semesters of high school, and $250 for earning the high school diploma. The support systems that are in the legislation, address the very real needs of a teenager to complete their high school education. Transportation, mentoring and tutoring are also provided <u>if determined necessary</u>. And even more importantly, child care; a place to leave the child in safety, and in capable hands allowing the parent to concentrate on learning.

There are several other assets in this plan. One is that only teens who are actually interested in completing high school would avail themselves of these services. There is not enough money, or service involved to enroll just to take advantage of the plan. It wouldn't be worth their while. Another is that it sunsets in 1996, and it is set up to be piloted in only 3 counties in the state so it can be evaluated with a more limited fiscal impact.

I have been intentionally brief, but I hope you will take a minute to look at the attached information, and hope you will support this important step to securing a future for the teens of Kansas.

Thank you for your consideration!

3-3

• TEL (913) 354-4804 • FAX (913) 354-1456

1 9 9 3

Kansas Kids Count is a partnership of:

Johannah Bryant
Kansas Action for Children

Dr. Tom McDonald
The University of Kansas

Rob McKnight
The Ceres Group

Jennie Adams Rose
Project Director

A Road Map For Our Future

...s Action for Children, Inc., made possible by a grant from the Annie E. Casey Foundation, 1993.

Kansas Kids Count Data Book

Percent All Births That Are To Single Teens

Over a ten year period, births to single teens in Kansas have increased nearly 40%, from 2289 to 3024 in 1990. Nationally, births to single teens have increased at just 14%.

Sharp increases in births to single teens can be found all over Kansas. Thirteen counties had 50 or more births to single teens in 1990, and each experienced an increase between 1980 and 1990.

Cowley County's births to single teens jumped 189%. Other counties with large numbers of births to single teens, as well as high rates of increase, include Ford, Geary, Montgomery, Reno and Saline counties.

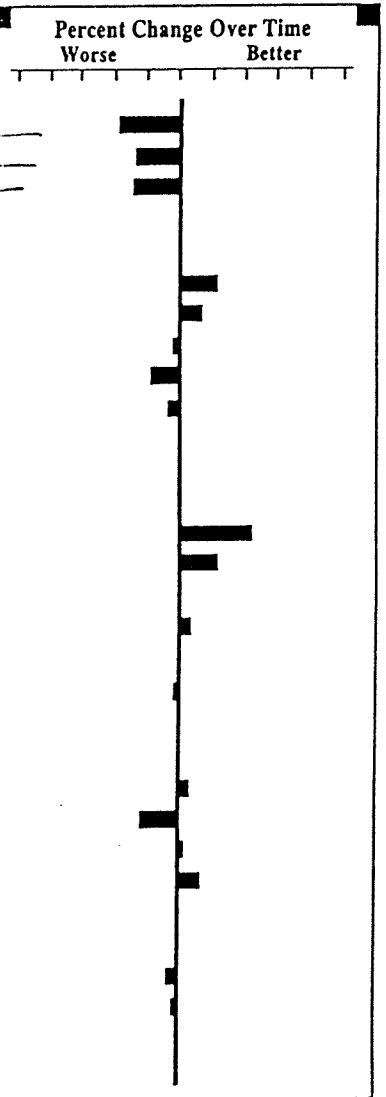
The chances of being poor increase substantially when a child lives in a single parent family. When that single parent is a teenager, the risk is increased. Delaying pregnancy until youths are past their teen years has a positive economic effect on both generations.

COUNTY	#1980 TEEN BIRTHS	PERCENT TEEN BIRTHS 1980	1980 DECILE RANK	#1990 TEEN BIRTHS	PERCENT TEEN BIRTHS 1990	1990 DECILE RANK	PERCENT CHANGE 1980-90
ALLEN	15.00	5.49	9	11.00	7.05	6	28.33
ANDERSON	7.00	4.76	7	4.00	4.49	4	-5.62
ATCHISON	20.00	7.41	10	27.00	12.05	10	62.72
BARBER	1.00	.94	2	7.00	8.97	8	851.28
BARTON	23.00	4.23	7	24.00	5.38	5	27.28
BOURBON	13.00	5.02	8	22.00	10.28	9	104.82
BROWN	11.00	5.85	9	7.00	4.09	4	-30.04
BUTLER	30.00	3.98	6	44.00	5.97	6	49.85
CHASE	2.00	4.55	7	0.00	0.00	1	-100.00
CHAUTAUQUA	2.00	3.17	5	2.00	5.26	5	65.79
CHEROKEE	13.00	4.25	7	40.00	14.49	10	241.14
CHEYENNE	1.00	2.27	3	1.00	3.03	3	33.33
CLARK	3.00	10.00	10	1.00	4.35	4	-56.52
CLAY	1.00	.69	1	2.00	2.35	2	241.18
CLOUD	8.00	4.52	7	5.00	4.42	4	-2.10
COFFEY	2.00	1.24	2	9.00	7.63	7	513.98
COMANCHE	0.00	0.00	1	1.00	3.57	3	.
COWLEY	25.00	4.17	6	62.00	12.09	10	189.58
CRAWFORD	29.00	5.39	8	37.00	9.34	9	73.34
DECATUR	1.00	1.67	3	0.00	0.00	1	-100.00
DICKINSON	9.00	3.59	5	12.00	4.88	5	36.04
DONIPHAN	7.00	3.87	6	12.00	12.37	10	219.88
DOUGLAS	40.00	4.15	6	53.00	4.98	5	19.93
EDWARDS	0.00	0.00	1	4.00	11.11	10	.
ELK	3.00	8.33	10	0.00	0.00	1	-100.00
ELLIS	14.00	2.92	4	15.00	4.84	4	65.90
ELLSWORTH	6.00	5.94	9	5.00	7.25	6	21.98
FINNEY	41.00	6.95	10	69.00	9.40	9	35.28
FORD	27.00	5.30	8	57.00	9.95	9	87.53
FRANKLIN	17.00	5.23	8	21.00	6.12	6	17.05
GEARY	50.00	3.93	6	69.00	5.53	5	40.77
GOVE	0.00	0.00	1	0.00	0.00	1	0.00
GRAHAM	1.00	1.72	3	1.00	2.44	2	41.46
GRANT	11.00	6.11	9	14.00	10.85	9	77.59
GRAY	4.00	4.00	6	2.00	2.86	2	-28.57
GREELEY	1.00	2.38	3	4.00	14.29	10	500.00

A project of Kansas Action for Children, Inc., made possible by a grant from the Annie E. Casey Foundation, 1993.

Kansas

	Base Year	Current Year	Decile Rank	Percent Change
Economic Well-Being				
Percent All Births That Are To Single Teens	5.60	7.80		39.30
Percent Children In Poverty	11.46	14.35		25.22
Percent Children In Single-Parent Families	13.47	17.15		27.32
Physical Health and Safety				
Childhood Death Rates, Ages 1 to 14	40.60	31.20		-23.15
Infant Mortality Rate	10.10	8.40		-16.80
Percent Births With Early Prenatal Care	80.80	80.60		-.20
Percent Kindergartners Fully Immunized By Age 2	64.44	51.67		-19.82
Percent Low Birth Weight Babies	5.80	6.20		6.90
Academic Achievement				
Head Start Participation Rate		28.71		
High School Graduate Unemployment Rate	2.77	1.60		-42.24
High School Graduate Post-Secondary Education Rate	60.00	73.20		22.00
Percent All Births That Are To Mothers With Less Than A High School Degree	18.50	17.00		-8.10
Percent Graduating High School	83.74	83.60		-.17
Emotional Well-Being				
Confirmed Child Abuse/Neglect Rate	388.44	363.50		-6.42
Out-Of-Home Placement Rate	678.00	823.00		21.40
Reported Child Abuse/Neglect Rate	3372.96	3345.75		-.81
Teen Violent Death Rate	84.50	72.60		-14.08
Social Behavior And Social Control				
Juvenile Arrest Rate	3306.30	3526.98		6.67
Juvenile Incarceration Rate	227.50	231.80		1.88

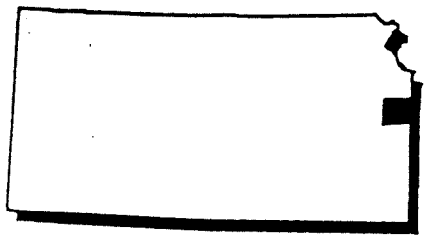


Demographics

	State
Population Size	2,477,574
Percent Population Under Age 18	26.7%
Ethnicity	
White	88.4%
Black	5.7%
American Indian, Eskimo or Aleut	0.8%
Asian or Pacific Islander	1.2%
Hispanic Origin (All Races)	3.8%
Median Family Income	$32,966

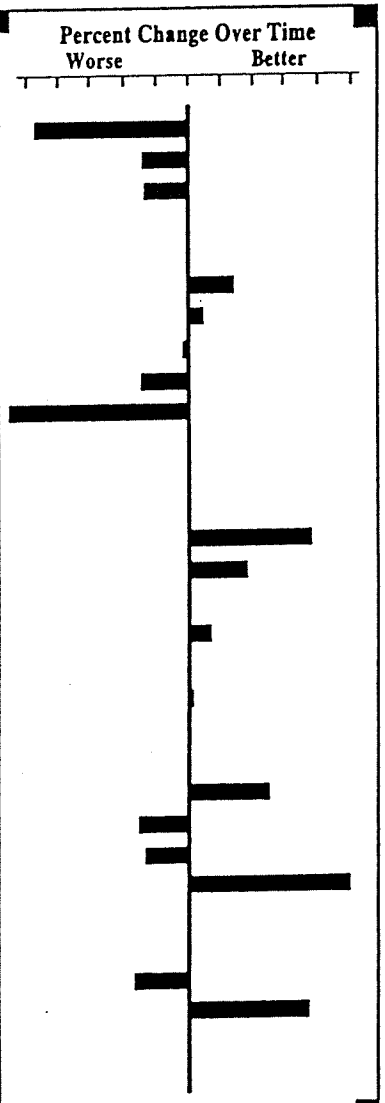
Children under 18 represent slightly more than one-fourth of the population in Kansas, 26.7%, compared to 28.1% nationally. Of the 19 Kansas Kids Count indicators, the state shows a decline in ten from the base year and an improvement in eight (no percent change is recorded for Head Start Participation Rate). The High School Graduate Unemployment Rate shows the most improvement, dropping -42.24% or from 2.77 in the base year to 1.60 in the current year. Showing the greatest decline is the Percent All Births That Are To Single Teens which has increased 39.30% from a rate of 5.60 to a rate of 7.80.

 A project of Kansas Action for Children, Inc., made possible by a grant from the Annie E. Casey Foundation, 1993.



Miami

	Base Year	Current Year	Decile Rank	Percent Change
Economic Well-Being				
Percent All Births That Are To Single Teens	2.18	4.26	4	95.41
Percent Children In Poverty	7.00	8.79	1	25.61
Percent Children In Single-Parent Families	10.23	12.84	5	25.43
Physical Health and Safety				
Childhood Death Rates, Ages 1 to 14	107.53	76.83	8	-28.54
Infant Mortality Rate	6.20	5.70	3	-8.06
Percent Births With Early Prenatal Care	85.67	84.90	3	-.90
Percent Kindergartners Fully Immunized By Age 2	55.00	39.00	8	-29.09
Percent Low Birth Weight Babies	3.12	7.10	8	127.98
Academic Achievement				
Head Start Participation Rate		49.03	2	
High School Graduate Unemployment Rate	4.95	1.12	5	-77.29
High School Graduate Post-Secondary Education Rate	49.12	67.04	9	36.49
Percent All Births That Are To Mothers With Less Than A High School Degree	14.95	12.54	3	-16.17
Percent Graduating High School	87.18	87.67	6	.56
Emotional Well-Being				
Confirmed Child Abuse/Neglect Rate	398.90	184.11	5	-53.85
Out-Of-Home Placement Rate	468.73	615.20	5	31.25
Reported Child Abuse/Neglect Rate	3958.27	4924.82	10	24.42
Teen Violent Death Rate	120.85	0.00	1	-100.00
Social Behavior And Social Control				
Juvenile Arrest Rate	1841.06	2470.08	7	34.17
Juvenile Incarceration Rate	162.07	40.52	4	-75.00

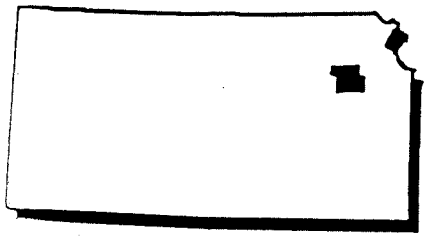


Demographics

	County	State
Population Size	23,466	2,477,574
Percent Population Under Age 18	27.8%	26.7%
Ethnicity		
White	95.7%	88.4%
Black	2.4%	5.7%
American Indian, Eskimo or Aleut	0.5%	0.8%
Asian or Pacific Islander	0.1%	1.2%
Hispanic Origin (All Races)	1.2%	3.8%
Median Family Income	$34,424	$32,966

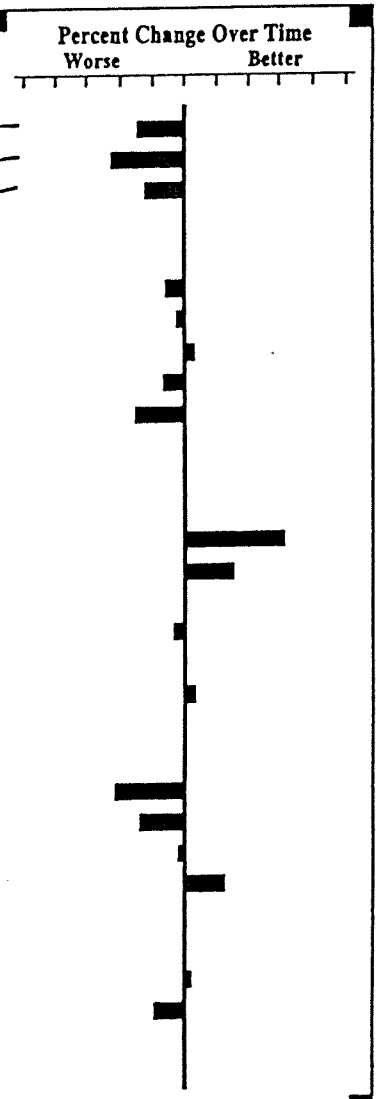
Miami County has one of the highest median family incomes in the state and has one of the lowest rates of children in poverty. There were no teen violent deaths in the current year in the county. However, it has a very high rate of reported child abuse/neglect, and a large increase in the number of low birth weight babies.

A project of Kansas Action for Children, Inc., made possible by a grant from the Annie E. Casey Foundation, 1993.



Shawnee

	Base Year	Current Year	Decile Rank	Percent Change
Economic Well-Being				
Percent All Births That Are To Single Teens	7.77	10.04	9	29.22
Percent Children In Poverty	9.74	14.10	4	44.79
Percent Children In Single-Parent Families	17.56	21.68	10	23.46
Physical Health and Safety				
Childhood Death Rates, Ages 1 to 14	38.03	42.18	6	10.90
Infant Mortality Rate	9.70	10.00	6	3.09
Percent Births With Early Prenatal Care	83.62	86.47	2	3.40
Percent Kindergartners Fully Immunized By Age 2	67.00	58.00	3	-13.43
Percent Low Birth Weight Babies	5.29	6.95	7	31.19
Academic Achievement				
Head Start Participation Rate		43.36	2	
High School Graduate Unemployment Rate	3.63	1.35	5	-62.90
High School Graduate Post-Secondary Education Rate	52.61	68.13	8	29.48
Percent All Births That Are To Mothers With Less Than A High School Degree	15.13	16.32	6	7.91
Percent Graduating High School	72.08	76.68	10	6.38
Emotional Well-Being				
Confirmed Child Abuse/Neglect Rate	307.01	438.92	8	42.97
Out-Of-Home Placement Rate	910.11	1161.65	9	27.64
Reported Child Abuse/Neglect Rate	2894.97	3038.88	7	4.97
Teen Violent Death Rate	85.60	66.58	4	-22.22
Social Behavior And Social Control				
Juvenile Arrest Rate	4441.99	4324.47	9	-2.65
Juvenile Incarceration Rate	327.34	387.47	10	18.37



Demographics

	County	State
Population Size	160,976	2,477,574
Percent Population Under Age 18	25.9%	26.7%
Ethnicity		
White	85.3%	88.4%
Black	8.1%	5.7%
American Indian, Eskimo or Aleut	1.0%	0.8%
Asian or Pacific Islander	0.7%	1.2%
Hispanic Origin (All Races)	4.8%	3.8%
Median Family Income	$35,987	$32,966

Shawnee County is one of the more populous counties and has one of the highest median income levels in the state. The county does well in providing early prenatal care, child immunizations and Head Start slots. Older children seem to fare more poorly. Births to teen mothers are among the highest in the state and are rising as are out-of-home placement rates and incarceration rates. The high school graduation rate is among the lowest in the state.

A project of Kansas Action for Children, Inc., made possible by a grant from the Annie E. Casey Foundation, 1993.

STATE OF KANSAS

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REPRESENTATIVE, SIXTY-FIFTH DISTRICT
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(913) 238-3760

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ELECTIONS
JUDICIARY
PUBLIC HEALTH AND WELFARE

TESTIMONY HB 2279

by Rep. Alex Scott

February 17, 1993

This piece of legislation, HB 2279 has several goals. It is a mechanism which may improve the relationship between the Social & Rehabilitation client to the benefit of both parties. Some of the benefits are the following:

* The rental will be secured, and eviction for non payment of rent eliminated.
* Homelessness should be reduced.
* Rent may be negotiated at a lesser amount if payment is assured.
* Cost savings can accrue to S.R.S.
* Residential stability will mean fewer school transfers so the children may share the stability of housing usually associated with ownership.
* Social workers of Social & Rehabilitation Services will more readily locate their clients.

In the Public Health and Welfare Committee on Feb. 2, 1993, Secretary of S.R.S. Donna Whiteman stated that one of the problems of follow up of Kan-work clients was the inaccuracy of addresses and lack of a telephone number. This single measure should improve the efficiency of the departments' social workers.

Homelessness has in some cases been a result of a renter getting a bad reputation as a renter. Dwellings have been trashed, and a midnight move made by the renter in some cases. Sooner or later this catches up and no one will rent to them hence homelessness.

In some cases there is an absolute inability to handle finances so that the rent money is squandered before payment of the rent.

All Americans have to make some concessions unless possessed of considerable financial resources. It is probably right for a paternalistic government to act like a parent. If this is emotionally burdensome, it is no more burdensome than paying rent out of a paycheck earned on the job.

ATTACHMENT 4

This will not be in effect until January 1, 1994 and a report to the Governor is to be made in one year. The report should show very positive results including significant monetary and personnel savings.

Department of Social and Rehabilitation Services
Donna L. Whiteman, Secretary

Committee on House Appropriation
House Bill No. 2279

February 17, 1993

****

The SRS Mission Statement:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

****

Madam Chairwoman, I want to thank you for providing me with the opportunity to present this testimony regarding House Bill 2279, a plan for the direct remittance of the shelter allowances of public assistance recipients to their landlords. The agency does not support this bill for the reasons discussed below.

The mandatory placement of restrictions on the use of assistance payments made to recipients of Aid to Families with Dependent Children (AFDC) is contrary to federal law. Federal statute and regulations prohibit states from placing restrictions on the monetary payments made to AFDC families unless the agency determines that the caretaker has misused funds to such an extent that allowing him or her to continue to manage the AFDC grant would be a threat to the health and safety of the children (Section 406(b) of the Social Security Act; 45 CFR 234.11(a), 45 CFR 234.60). Because this is in statute, it is not waiverable. Therefore, adoption of this bill would be prohibited. If the State chooses to proceed in the face of this prohibition the State could lose more than $78 million in federal matching funds for the AFDC program. Michigan does operate a voluntary program that is permissible under federal regulations; however, after reviewing the results of that program, I would not recommend it's adoption in Kansas. A review of the pros and cons of Michigan program are detailed in Attachment A.

Currently, cash assistance payments are intended to cover much more than rent. They must also be used to pay for utilities, food, clothing, transportation, school expenses, personal care items, laundry, etc. In Junction City, for example, a family of 3 receives $92 as a shelter allowance and $294 for other monthly basic needs of utilities, food, clothing, transportation, etc. Because the assistance payment will rarely stretch to cover all these needs, the recipient is in the position to judge the family's most pressing needs each month. However, if a parent consistently makes poor choices to the detriment of the children, the state has the authority to appoint a payee to pay the family's bills or to pay the bills by vendor while teaching the parent responsible household budgeting. This is a client responsive approach which promotes self-sufficiency and does not put the state in the middle of landlord/tenant disputes.

ATTACHMENT 5

Should this legislation be passed, the work of Income Maintenance staff would increase dramatically. Income Maintenance workers would have to gather detailed information from landlords in order to set up the separate payments. As there are currently 35,263 public assistance cases, this could potentially be 35,263 contacts at the outset with new information with every change of landlord. Staff would also have to handle numerous complaint calls and complete fair hearing summaries as clients attempted to settle their landlord/tenant disputes through that process. A substantial number of new staff would be required to support this proposal.

An additional problematic issue in attempting to implement this proposal is the state's low shelter allowance. The shelter allowance is that portion of the AFDC/GA grant provided for rent or mortgage obligations. The monthly shelter allowances range from $92 - $135 depending upon the county of residence. These amounts are reduced even further when a family shares its residence, resulting in shelter allowances which may be as minimal as $18 for a disabled adult who lives with others. (See Attachment B.) These shelter allowances are inadequate to obtain suitable housing anywhere in the state except in HUD subsidized housing units, which have waiting lists of 2 - 3 years in most communities.

Paying bills for the clients seriously undermines the agency's goal of promoting client self-sufficiency in order to reduce long-term welfare dependency. To be self-sufficient, clients must learn to manage their money and pay their bills. Paying client's bills by vendor is treating them as though they were some how innately irresponsible. Again, for clients who consistently make poor choices in managing their money to the detriment of their children, the agency has the authority to appoint a payee to pay the family's bills while the parent is learning responsible household budgeting. This approach provides the clients with the tools for managing their finances and promotes self-sufficiency without involving the agency directly in landlord/tenant affairs.

Donna L. Whiteman
Secretary

Attachment A

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Income Support/Medical Services

M E M O R A N D U M

TO: Donna L. Whiteman **DATE:** February 16, 1993

FROM: Robert L. Epps **SUBJECT:** Michigan Vendor Program

Michigan has had a voluntary shelter vendoring program of shelter payments in operation for ten years. About 40% of the AFDC families utilize this option. Many are forced to do so by landlords who will not rent to welfare recipients who do not elect the vendor payment option. The Michigan Department of Social Services reports the following pros and cons of vendor payments to landlords:

PROS:

1. It provides a service to clients and landlords. It is a convenience to them in much the same way as the direct deposit of wages.

2. Because Michigan does not allow vendoring of any housing unit that does not meet local housing codes, it is easier to enforce the housing codes. However, this only works in the communities which have a local housing authority; many do not. It is up to the client to turn the landlord in for violations.

CONS:

1. Paying bills for the clients seriously undermines the agency's goal of promoting self-sufficiency. To be self-sufficient, clients must learn to manage their money and pay their bills. Paying clients' bills by vendor is treating them like irresponsible children.

2. It costs approximately $73,000 extra each month to mail vendor payments to landlords. (Checks are mailed semimonthly in Michigan.) There is also double the opportunity for lost or stolen warrants, which increases the administrative costs even more. In addition, each local office must have a coordinator to oversee the program. This is a full-time position in large offices; part-time in others.

3. Landlords expect the agency to be a rent enforcer. Local and central office staff spend valuable time explaining to landlords that the agency is not a party to a contract with a renter and is not responsible for the renter's bills. The agency is under constant pressure from the Landlord Association lobby to become responsible for the clients' bills.

4. This is very work intensive for IM staff who must handle all client requests to discontinue or transfer vendor payments. HHS has told Michigan that because this is a voluntary program, vendoring must be stopped promptly if the client requests it. When Michigan wanted to limit vendor changes to once each fiscal year in order to reduce administrative costs, HHS would not

allow it. IM staff are also responsible for handling the numerous complaint calls from landlords and clients regarding the vendoring system and completing fair hearing summaries when clients try to settle their landlord/tenant disputes through that medium.

5. Although the vendor payment method is supposed to be voluntary, landlords have taken the option away from clients by refusing to rent to them unless they have their rent payments vendored. It has become a weapon for landlords to use to discriminate against welfare recipients.

6. Once a program like this is put in place, it is almost impossible to get rid of. Michigan has tried twice to terminate the shelter vendoring program because it negates the promotion of client self-sufficiency and because it is administratively costly. Both of those efforts have been successfully blocked by a strong Landlord Association lobbying effort. The agency's Secretary may initiate legislation again this year to terminate the program.

Please let me know it you need additional information or want to discuss these issues in more detail.

RLE:DD:jmm

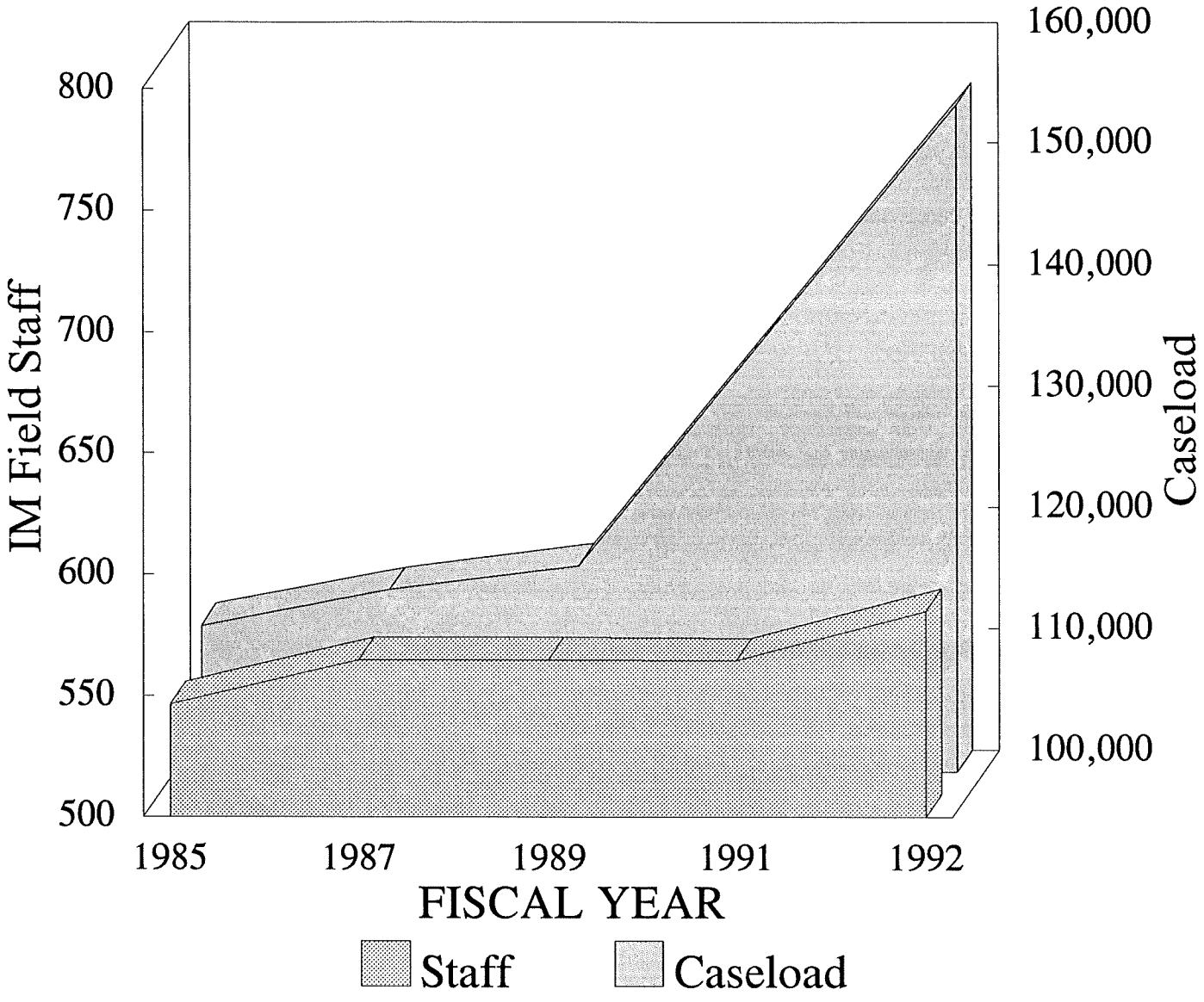
Attachment B

SHELTER ALLOWANCES FOR AFDC & GA FAMILIES
AND FOR GA DISABLED ADULTS
By Shelter Groups

	I & II		III		IV		V	
# Persons	Non-Shared Living	Shared Living	Non-Shared Living	Shared Living	Non-Shared Living	Shared Living	Non-Shared Living	Shared Living
Family of 3	$92	$55	$97	$58	$109	$65	$135	$77
Disabled Adult	$73	$36-$18*	$77	$38-$19*	$ 87	$43-$21*	$108	$54-$27*
	Allen	Gove	Ness	Franklin	Butler		Douglas	
	Anderson	Graham	Norton	Gray	Jefferson		Harvey	
	Atchison	Grant	Osborne	Kiowa	Leavenworth		Johnson	
	Barber	Greeley	Ottawa	Morton	McPherson			
	Barton	Greenwood	Phillips	Pawnee	Miami			
	Bourbon	Hamilton	Pottawatomie	Seward	Osage			
	Brown	Harper	Pratt	Sherman	Reno			
	Chase	Haskell	Rawlins		Rice			
	Chautauqua	Hodgeman	Republic		Riley			
	Cherokee	Jackson	Rooks		Sedgwick			
	Cheyenne	Jewell	Rush		Shawnee			
	Clark	Kearny	Russell		Wyandotte			
	Clay	Kingman	Saline					
	Cloud	Labette	Scott					
	Coffey	Lane	Sheridan					
	Commanche	Lincoln	Smith					
	Cowley	Linn	Stafford					
	Decatur	Logan	Stanton					
	Dickinson	Lyon	Stevens					
	Doniphan	Marion	Sumner					
	Edwards	Marshall	Thomas					
	Elk	Meade	Trego					
	Ellis	Mitchell	Wabaunsee					
	Ellsworth	Montgomery	Wallace					
	Finney	Morris	Washington					
	Ford	Nemaha	Wichita					
	Geary	Neosho	Wilson					
			Woodson					

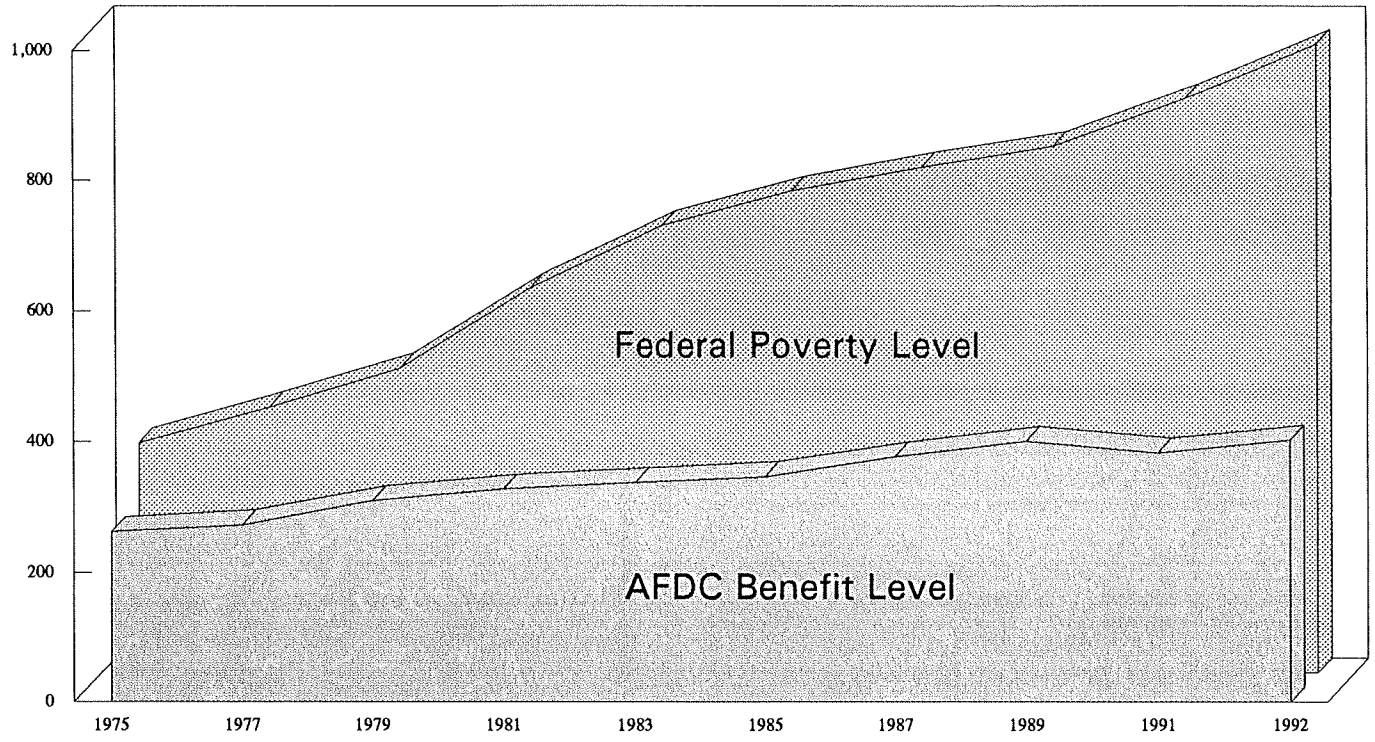
* The exact amount of the shelter allowance is determined by the number of persons in the household.

CASELOAD / STAFFING COMPARISON



Comparison of Kansas AFDC Benefits vs Poverty Level

Summary for 1975 - 1992



	1975	1977	1979	1981	1983	1985	1987	1989	1991	1992
Federal Poverty Level	352	407	466	589	685	738	775	807	880	965
Kansas AFDC Benefits	263	273	310	328	338	347	377	401	383	403
% Federal Poverty Level	75%	67%	67%	56%	49%	47%	49%	50%	44%	42%

NOTE: Figures shown are based on standard for a family of 3

GEARY COUNTY LANDLORDS ASSOCIATION
364 Grant Avenue
JUNCTION CITY, KANSAS 66441
913/238-1894

HOUSE APPROPRIATIONS COMMITTEE
February 17, 1993

Testimony on HB 2279 - Shelter Payments for Public Assistance
By - Ann Elliott

Food and shelter are known basic necessities of today's society. For the SRS recipient, food is provided by the use of Food Stamps. Shelter and necessities currently must come out of the assistance the SRS recipient receives.

Because many recipients have never had to budget or have never learned to budget, they occasionally over spend or spend unwisely and cannot pay their rent. Christmas, birthday's, alcohol and drugs are prime examples of where this money goes. Or, the recipient will rent, not taking into consideration that the rent and utilities will take more than they can afford.

In some cases recipients will share a home and share costs to make ends meet. This situation leads to more destruction of the home, zoning problems (such as single family zoning), neighborhood complaints and landlord-tenant problems.

Landlords must screen prospective tenants carefully. If the prospective tenant has a history of not paying rent, destruction or landlord-tenant problems, they soon will become "homeless".

Landlords have had to compensate for the loss of rent and the destruction by raising rents to all tenants to cover the money lost by tenants who don't pay rent, the court costs to evict and the cost of repairs. As the rent raises the recipient can no longer afford to rent.

SRS has an Emergency Assistance program that will pay the landlord $135.00 once a year toward rent if the landlord will not evict the recipient. The tenant is to make up the difference. However, this does not always happen and the landlord is out the money due. The recipients know this program exists and tend to take advantage of the program each year. Many landlords are hesitant to accept the emergency assistance, because they are not guaranteed the balance due.

ATTACHMENT 6

Rental assistance programs are available in Kansas, such as HUD Section 8 and Farmer's Home Section 515/8. The Needs Assessment protion of the State CHAS compiled by The Dept. of Commerce and Housing states "communities are unwilling to build additional public housing, and instead prefer to use Section 8 certificates or vouchers because housing remains in private ownership and local governments thus avoid building and maintaining units." Waiting lists for these programs are long and finding landlords to participate is difficult due to the regulations.

Direct payment from SRS to the landlord could work in the same manner as the certificate program, the landlord would be paid the rent by SRS and the tenant would be establishing a good rent paying record. More landlords would be willing to rent to recipients and rents could stay on a more affordable level.

The Emergency Assistance program for evictions due to non-payment of rent could be eliminated. The "stolen" checks from the recipients home or mailbox would no longer be an excuse to not pay rent. Drug and alcohol problems of recipients could be reduced because a substantial portion of the assistance would go to rent.

The children of recipients would have a more stable home life and could do better in school. Many times when the recipient can't pay rent, they move. Each time the household moves, the children must adjust to a new home, new friends and sometimes a new school and a different teacher.

Understandably there will be expense involved to implement a Direct Pay program, however the cost savings will outweigh that expense. Safeguards and regulations will also have to be implemented to protect SRS, the landlords and the recipients.

There are landlords in our state who are willing to work with SRS to establish a Direct Pay program.

I would also like to point out that recipients on federal rent assistance programs receive the same amount of assistance as does a recipient who has to pay rent. If an amount is set for rent for each recipient, the assistance for recipients on federal assisted programs should be dropped the same amount as is being paid to landlords.

On February 2nd, President Clinton in his speech to the National Governors Assn., pledged to transform the welfare program by allowing Governors broad freedom to experiment with welfare change. This is an opportune time to implement a Direct Pay program.

6-2

To: Members of the Appropriations Committee
From: Dr. Nelda Kibby
Re: House Bill 2279
Date: February 17, 1993

I strenuously support HB2279 for the following reasons.

First, one of my greatest frustrations as principal of an inner city school in Kansas City, Kansas is the constant turnover of students. Last year, out of 280 students, approximately 200 moved in and out of Lindbergh School between August and January. It is almost impossible to effectively teach students who are with us only a few weeks or months during the year.

Several years ago, when I taught children with Learning Disabilities, I concluded that the state should create another category for children with "Moving Disabilities." More recently, I have tried to get the school district to bus students who are out of our attendance area and who are high risk back to Lindbergh School. That, it seems, is a very difficult task for the transportation department. For example, a second-grade student enrolled who had 13 times since kindergarten. He was emotionally disturbed, hyper active and depressed. Twice last year we talked the mother out of moving. However, this year, she has moved three times. I was able to obtain special transportation arrangements the first two moves, but the last move took him too far away. With two semesters in the same place and a lot of extra effort on our part, he was beginning to show some improvement both in attitude and abilities.

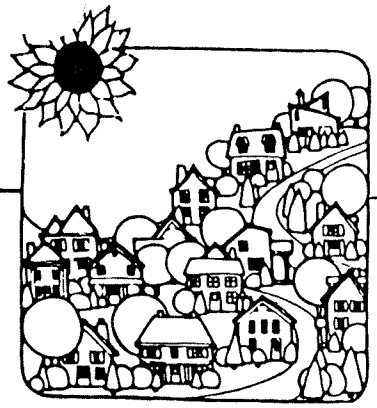
Often, when students move, they may miss several days of school. Not only is it difficult to help the student build meaningful relationships with teachers and peers, parent involvement in the school is nonexistant.

I am also concerned about the lessons children are learning about the value and care of property. Most of the students from my school live in rental property. I am amazed at the number of times the property is distroyed and redecorated. It appears that parent become angry with the landloard when they are urged to pay the rent. Consequently, they demonstrate their discontent by leaving the porperty in shambles.

I am convinced that if we could reduce the inordinate number of moves some families make, the schools could be much more successful. At this time, because of the mobility of students, it is difficult to measure any success of our schools because we are not measuring the same students from one year to the next.

Anything you can do to address the concerns listed above will be appreciated.

ATTACHMENT 7



RENTAL OWNERS, Inc.

P. O. BOX 1614
WICHITA, KANSAS 67201
(316) 755--3331

Member:
The Associated Landlords of Kansas
Credit Bureau of Wichita

February 17, 1993

DIRECT PAY BY SRS

Representing Rental Owners, Inc. of Wichita, Kansas, a non profit organization of landlords that provides education of landlords and tenants of their rights and responsibilities.

I. Rental Owners Inc. supports HB2279 SRS direct payment to landlords because:

   A. Landlords can supply homes at lower cost when payment is guaranteed by state or local agencies.

   B. Section 8 Housing has proven to be a viable way to provide good housing by using direct payment to the landlord and having home inspections to determine habitability and recommending changes needed by the landlords or the tenant to keep the home up to standards.

   C. Direct pay by SRS will make more housing available, thus provide shelter for persons who might otherwise be homeless.

II. Rental Owners Inc., believes that the state of Kansas should follow the lead of the federal government standards and make direct payment to landlords and thus saving funds for all concerned.

Presented by Steven L. Stagner
Board of Directors

ATTACHMENT 8

Ed Jaskinia
President
(913) 299-8383

Tess Raydo
Vice President (Zone 1)
(913) 236-5334

TALK

Bill Nelson
Vice President (Zone 2)
(913)827-1865

Pat McBride
Vice President (Zone 3)
(316) 331-4379

The Associated Landlords of Kansas
P.O. Box 2025 • Topeka, Kansas 66601
(913) 232-0507

The Associated Landlords of Kansas (TALK) was created in 1975 by a group of people from across Kansas to "Promote a strong voice in the legislature, a high standard of ethics, and provide educational opportunities for landlords." Some of our members helped create "The Landlord-Tenant Act of 1975, a model of fair law for both landlords and tenants. Our organization has several thousand members in 11 cities across the state, and new chapters are in the process of being formed.

In this 1993 legislative session, we are working in a number of different arenas, some of which we have listed below.

1) SRS Direct Pay to Landlords - Discussion about direct payment from SRS to landlords has been picking up steam from last year. Several individual cities in the United States are doing this, and we believe that Kansas should adopt this policy as well. In addition, we feel that natural gas, electric and water utilities should be included in this program. There are many benefits to the tenants, local communities, and school districts. For example, tenants would not have to move over and over again after being evicted for non-payment of rent. Children could stay in school without the fear of new teachers and friends every few months, and local communities could be assured that very little welfare money is used for drug and alcohol addictions.

Money for food is being given to SRS recipients in the form of food stamps in order to ensure that basic nutritional needs are met. We believe that the need for shelter deserves the same type of consideration.

2) Small Claims Court - Small claims court in Kansas is an excellent tool for both tenants and landlords to settle minor and not so minor differences. The law allows both parties to save money by allowing us to represent ourselves in cases of non-payment of rent, evictions, and failure of the landlord to perform. The law currently allows small claims court to be used 10 times a year, with a $1,000 limit per case.

We will be working toward increasing these limits to 20 appearances a year with a $1,500 per case limit. The effects of this change will be minimal on most people who use small claims, but for those who need it in a particular year, the difference in cost savings for both tenant & landlord could be dramatic.

3)Small Claims Court: Appeals - While the small claims court system is very "user friendly," the appeals process out of small claims to district court can be devastating. Currently the law says that the party that loses the appeals is ***required*** to pay the winning attorneys expense. We have no objection to the court having ***the right*** to order doing this, but we feel that ***to require*** the judge to order this is taking from the judge the ability to look at all pertinent information and allowing the court to decide what is best.

We will be working towards eliminating the mandatory language of this law and replacing it with language that allows the judge more freedom of decisions.

If we can be of help to you in these or any other areas concerning property, tenants, or landlords, please feel free to contact us.

Ed Jaskinia
President

ATTACHMENT 9

Kansas City, Kansas Board of Education

625 Minnesota Avenue • Kansas City, Kansas 66101 • (913) 551-3200

Sylvia L. Robinson
President

George Gray Breidenthal Jr.
Vice President

William W. Boone

Norma Kelso

Richard J. Kaminski

Jo-Anne Meditz

Peter C. Pomerenke

Jerry P. Franklin
Interim Superintendent
of Schools

February 15, 1993

To the Honorable members of the Kansas House of Representatives Appropriations Committee

Though I am unable to be with you today I am pleased to be able to share my interest in House Bill 2279 with you by letter. On the surface this bill seems mostly to affect rental property owners, of which I am one, and their tenants. My concern with this bill is how it may affect children.

Unfortunatly some Kansans who are in need of public assistance can't or won't meet their obligation to use assistance in a manner that lends to a stable environment for children. When assistance funds are used for things other than food or shelter many times a child goes without those necessities. As rental obligations are not taken care of families tend to continualy be on the move and the childs environment is even more unstable. Children are shuffled from town to town or from school to school within our State. These mobile children seldom are able to have roots in any school and are apt to drop behind and eventually withdraw from school with skill deficiencies. In the long term the cost to all of us for these neglected children is too much.

I ask that you give this bill your consideration so that our children will no longer have to live like nomads because as we know there's no place like home.

Thank you,

George Breidenthal

Kansas City, Kansas Public Schools

Prevention Services • 800 Barnett • Kansas City, Kansas 66102 • (913) 551-3495

Cathy Stillman, M.S.
Director of
Prevention Services

Kelli Mather
Program Specialist
Comprehensive Drug Education

John Rios
Program Specialist
Drop Out Prevention

MEMORANDUM

TO: Members of the House Appropriations Committee

FROM: Mr. John D. Rios
Dropout Prevention Specialist

DATE: February 17, 1993

RE: **HOUSE BILL 2279 SRS DIRECT PAYMENT TO LANDLORDS**

At the request of Ed Jaskinia, I am writing to express my point of view on your consideration of House Bill 2279. In my experience as a Dropout Prevention Specialist, I have come across many students who are continuously on the move from one house to another. They do not settle in any one place long enough to have a home, in the true sense of the word. This is in the majority of the cases the root of the child's at-risk behaviors - poor attendance, poor academic performance, poor standardize test scores (if the student has any scored recorded), poor self-esteem and poor social skills.

Former President George Bush's plan "America 2000" points out that children spend 91 percent of their lives from birth through age 18 in places other than school, "America 2000" throws into sharp relief the paramount importance of home and community in promoting learning and shaping children's values. Though this legislature can not legislate laws that make parents responsible, it can assist in the nurturing of children and retreat from the widespread complacency that's embedded in the mistaken belief that "the Nation is at risk, but I'm o.k.". We are not o.k. Even those parents who try the hardest often need support and direction when it comes to doing what's best for their children.

House Bill 2279 is not the definitive cure, but it may be an important start toward that direction.

FEBRUARY 15, 1993

SANDRA F. WATSON
WATSON RENTALS
1221 CENTRAL AVE
KANSAS CITY, KANSAS
66102

DEAR LADIES AND GENTLEMEN OF THE LEGISLATURE:

I AM WRITING THIS IN SUPPORT OF DIRECT PAYMENT OF RENT TO LANDLORDS BY THE SRS.

MY NAME IS SANDRA WATSON. I HAVE BEEN A LANDLORD FOR 10 YEARS IN KANSAS CITY KANSAS. I HAVE 70 UNITS PREDOMINANTLY IN THE INNER-CITY AREA. IN ANY GIVEN YEAR 60 TO 75 PERCENT OF MY TENANTS RECEIVE SRS ASSISTANCE.

IN THESE TEN YEARS I HAVE SEEN THINGS THAT I WOULD NOT HAVE BELIEVED POSSIBLE. THE SUFFERING OF THE CHILDREN BECAUSE OF CERTAIN IRRESPONSIBLE PARENTS IS BEYOND COMPREHENSION.

I HAVE SEEN THESE PARENTS DRINK THEIR RENT MONEY, USE IT FOR DRUGS, GIVE IT TO THEIR BOYFRIENDS TO FRONT DRUGS, AND NUMEROUS OTHER ILLEGAL OR FOOLISH ACTIVITIES. I HAVE SEEN THE SAME FAMILIES LIVE IN 3 TO 4 DIFFERENT PLACES IN A YEARS TIME. EACH MOVE CAUSES THE CHILDREN TO MOVE FROM SCHOOL TO SCHOOL, NEVER REALLY HAVING A CHANCE TO GET A MEANINGFUL EDUCATION. MAKING FRIENDS EITHER WHERE THEY LIVE OR IN THEIR SCHOOL BECOMES AN IMPOSSIBILITY.

I HAVE SEEN BABIES ACTING AS LOOKOUTS FOR THE LANDLORD, OR SHERIFF, AS THE CASE MAY BE. THESE SAME BABIES WATCH THEIR ADULT ROLE MODELS SNEAK OUT OF THEIR HOME IN THE MIDDLE OF THE NIGHT, BECAUSE THE SRS CHECK FOR THEIR HOUSING NEEDS HAS BEEN SPENT FOR OTHER THINGS.

NEEDLESS TO SAY, ACTIONS LIKE THESE PERPETUATE THE CYCLE OF POVERTY, GENERATION AFTER GENERATION. THEY BREED CONTEMPT FOR THE SYSTEM, AND OFTEN PROVIDE THE DRUGS THAT ARE DESTROYING THEIR LIVES, HOMES, AND MAY EVEN SOME DAY CAUSE THEIR DEATHS.

DIRECT PAYMENT OF RENT WOULD HELP SOLVE THESE PROBLEMS IN THE FOLLOWING WAYS;

1. CHILDREN WOULD HAVE A BETTER CHANCE FOR A DECENT EDUCATION.

2. IT WILL LOWER THE INDIGNITIES THAT THE YOUNG MUST SUFFER BY THE CONSTANT MOVING ABOUT.

3. IT WOULD DRAIN THE MONTHLY SUPPLY OF AVAILABLE DRUG MONEY, AND PRAYERFULLY REDUCE THE NUMBER OF DRUG RELATED EXPERIENCES TO WHICH THESE CHILDREN ARE SUBJECTED.

4. NEIGHBORHOODS SHOULD SEE A STABILIZING EFFECT WITH LESS MOVING.

5. AVAILABLE HOUSING SHOULD IMPROVE WITH TENANT STABILITY. (LESS LOST INCOME SHOULD ALLOW LANDLORDS TO KEEP UP THEIR PROPERTY, PAY THEIR REAL ESTATE TAXES, AND NOT SUFFER AS MANY LOSSES TO VANDALS PREYING UPON VACANT UNITS).

6. MINIMIZE THE NUMBER OF EVICTIONS.

7. IMPROVED FAMILY STABILITY WILL RESULT IN A MORE EFFECTIVE EDUCATIONAL PROCESS. IN TURN THIS STABILITY WILL INCREASE NEIGHBORHOOD IDENTITY AND COMMUNITY AWARENESS.

8. LOWER THE LEVEL OF FRAUD IN THE STATE SRS.

RESPECTFULLY SUBMITTED,

SANDRA F. WATSON
(913) 342-7740

STATE OF KANSAS

WILLIAM M. BRYANT, D.V.M.
REPRESENTATIVE, 106TH DISTRICT
WASHINGTON, REPUBLIC, MARSHALL,
RILEY AND GEARY COUNTIES
RURAL ROUTE 2
WASHINGTON, KANSAS 66968

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: FINANCIAL INSTITUTIONS AND INSURANCE
MEMBER: AGRICULTURE AND SMALL BUSINESS
LOCAL GOVERNMENT
JOINT COMMITTEE ON HEALTH CARE DECISIONS FOR THE 1990S
HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

Testimony on HCR 5015
Presented to the House Appropriations Committee
Feb. 17, 1993
By Representative Bill Bryant

Madam Chairman and members of the Committee, thank you for the opportunity to testify on HCR 5015. I believe that the intent of this resolution is very straight forward, and is well summarized in the opening statement which requests the Legislative Post Audit Committee to direct a review of agencies providing services to the aging to discover overlapping or duplication of services and to determine the cost effectiveness and efficiency of such services.

The request for such a study recognizes the statewide concerns about overregulation of residential housing for aging Kansans. Operators, residents and families of residents believe rising costs are due, in part, to triple agency oversight by 1) the Kansas Department of Health and Environment, 2) the Kansas Department of Social and Rehabilitation Services and 3) the Kansas Department on Aging.

While it can be shown that several studies have been done in the area of coordination of benefits among these agencies in the past, none have resulted in any cost savings. In fact, most have brought forth proposals for new programs.

It is the feeling of myself and the other sponsors of this resolution that if there are inefficiencies or cost saving measures to be discovered in the delivery of services to our aging population, that considering the track record of the Legislative Post Audit Division, they would be the proper agency to conduct such a study.

In closing, I ask for your favorable consideration and passage of HCR 5015. Thank you.

ATTACHMENT 10

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

House Appropriations Committee
Testimony on House Concurrent Resolution No. 5015
February 17, 1993

****

The SRS Mission Statement:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

****

Madam Chairman and members of the committee, I appreciate the opportunity to present you with testimony regarding House Concurrent Resolution 5015 regarding post audit review of services to the aged.

Responsibility for adult care home regulation in Kansas is shared by several State agencies. The Department of Social and Rehabilitation Services is responsible for determining reimbursement rates. The Department of Health and Environment is responsible for licensing adult care homes, for issuing rules and regulations for operation, and for certifying providers to receive Medicaid and Medicare payments. In addition, the State Fire Marshal, county and city health departments, and local fire and safety authorities share a role in the licensing process, and the Department on Aging is responsible for an advocacy role on behalf of adult care home residents through its ombudsman program.

As of January, 1992 there were 355 nursing facilities with a total of 25,948 beds certified as participating in the Title XIX Medicaid Program. During the first six months of FY 1993, 12,500 persons were served. The FY 93 budget is $187 million. Kansas has the nation's highest number of licensed skilled nursing and intermediate care facility beds per 1,000 population age 65 and older.

The Home and Community-Based Nursing Facility Program is currently serving 1,391 persons over the age of 65 or persons with disabilities over age 16 who require care in a nursing facility. An average of $492 is saved each year for each individual served by this waiver. In FY 92, $6.3 million was expended.

Income Eligible Home Care Program provides services to individuals who are able to reside in a community-based residence if some services are provided. Through the month of November almost 5,000 persons were served. SRS serves those persons whose income does not exceed $852/month. The Department on Aging serves persons with incomes of $852/month or more (150% of poverty or above).

Donna L. Whiteman
Secretary

ATTACHMENT 11

LONG TERM CARE FOR THE ELDERLY

OFFICE OF SOCIAL POLICY ANALYSIS
SCHOOL OF SOCIAL WELFARE OF THE
UNIVERSITY OF KANSAS

AND

KANSAS DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

FOR INFORMATION REGARDING THIS PUBLICATION, WRITE:

Department of Social and Rehabilitation Services (SRS)
Division of Medical Services
Docking State Office Building
Room 628-S, 915 SW Harrison
Topeka, Kansas 66612-1570

This publication was developed by Dr. Rosemary Chapin, Ms. Rachel Lindbloom, and the Kansas Department of Social and Rehabilitation Services, Division of Medical Services staff. We gratefully acknowledge help provided us by other agencies including the Kansas Department on Aging (DOA) and the Kansas Department of Health and Environment (KDHE).

March, 1992

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Introduction

Background

This fact book on long term care for physically disabled and elderly citizens in Kansas has been developed jointly by faculty of the Kansas University School of Social Welfare and Kansas Department of Social and Rehabilitation Services (SRS) staff. The purpose for this work is to provide policy makers with basic data to help inform their long term care decisions, especially in relation to programs funded under Medicaid. This creates a common base of facts from which to begin discussion and can help to develop understanding of the need for increased emphasis on alternatives to nursing home care.

Long term care for the elderly and physically disabled includes a range of medical and supportive services for individuals who have lost some capacity for self care due to a chronic illness or condition and who are expected to need care for a prolonged period. Long term care services can be provided in a variety of settings including in-home care as well as care in a nursing facility. The information contained in this book explains how our current long term care system developed, presents demographic information about our elderly population, describes current programs and provides information on cost. It concludes with a discussion of future long term care options. The following section provides a brief overview of long term care in Kansas.

- In 1965, the Social Security Act was amended to include Title XIX. Title XIX (Medicaid) provides medical coverage that includes care in nursing facilities, based on income eligibility as well as medical need and categorical eligibility. Medicaid is state administered within federal regulations. Medicaid is an entitlement program for which federal match is received for all state expenditures meeting federal requirements.

- In 1968, Kansas began participation in the Medicaid program. Medicaid is administered in Kansas by SRS. Given the fiscal incentive for institutional care created by the availability of federal matching funds to pay for such care under Medicaid, Kansas experienced dramatic growth in its nursing facility population.

- The Income Eligible Home Care program was established under Public Law 93-47 which became effective October, 1975. This community-based long term care program, originally called the Homemaker Program, is also administered by SRS. The program is not funded through Medicaid, but rather with state funds and with federal Social Services Block Grant money. Currently, the Income Eligible Home Care Program targets elderly people who are not eligible for the Medicaid waiver program because they are not completely impoverished. Services include homemaker services, non-medical attendant care and home services. It serves people with incomes up to 150% of poverty.

- In 1981, the U.S. Congress passed Section 2176 of Public Law 97-35 of the Social Security Act which established the Home and Community-based Services (HCBS) waiver component of the Medicaid program. The intent of the HCBS Waiver was to be a cost savings program. Costs for the HCBS Waiver were not to exceed costs for institutionalization. This allowed the states to use federal matching funds to develop innovative ways of providing home and community-based services to Medicaid eligible persons who would otherwise require nursing facility care.

- Kansas applied for and was granted a Home and Community-based Services Waiver which began operation in July 1982. Kansas developed a broad based program that serves the elderly, the physically disabled, and the mentally retarded. This program is administered by SRS, the state Medicaid agency.

- In November 1982, nursing facility preadmission screening for Medicaid recipients was instituted. The 1992 legislature is considering mandatory prescreening for all nursing facility applicants.

- The Kansas Department on Aging (DOA) also has responsibility for community-based long term care programs. The Department on Aging was established by the Kansas Legislature in 1977 to receive and disburse federal funds available through the Older Americans Act, to advocate for older Kansans, and to provide information and referral. Title III of the Older Americans Act provides limited federal funds for services which include: housekeeping services, homemaker services, chore services, attendant care, personal care, and home delivered meals. A 15% state match is required for these funds.

- The Kansas Department of Health and Environment (KDHE) has responsibility for regulation of nursing facilities, personal care homes, home health agencies, and other health related services for the elderly. Their work also shapes the long term care system. Since all three agencies have responsibilities for community-based

long term care services, there have been repeated attempts to coordinate efforts, and to reduce fragmentation, redundancy, and gaps.

- In December 1986, KDHE, SRS and DOA submitted a comprehensive plan for developing home and community-based long term care services to the Legislature as mandated by the 1986 Kansas Legislature. The plan built on previous work by the three state agencies. In 1984, the three agencies with the Kansas Medical Society had adopted a Joint Position Statement on Long Term Care. This Statement became a part of the 1986 Comprehensive Plan. The Long-Term Care Continuum Model from the 1984 State Health Plan also became part of the 1986 Comprehensive Plan. Implementation of the 1986 Plan has been uneven.

- In 1989, the Kansas Legislature adopted the Kansas Senior Care Act. The Act incorporated the 1986 Comprehensive Plan's concept of targeting core home and community services for funding. The Senior Care Act authorized the Secretary of Aging to establish a program of in-home support services for residents age 60 or older. This program is funded with state and local dollars. However, only three pilot projects are currently funded.

- In 1989, a Federal division of assets law was passed to protect a spouse from impoverishment due to use of jointly held resources to pay for nursing facility care.

- In 1991, the Kansas Legislature placed a cap on eligibility for Medicaid coverage of nursing facility care. The cap limits eligibility to people with incomes of less than 300% of Supplementary Security Income. That limit increased to $1,266 when the SSI benefit level for one person increased to $422/month effective January 1, 1992.

- Currently, the Long Term Care Action Committee, composed of representatives from SRS, KDHE, and DOA is meeting to develop a comprehensive statewide action plan for the cost effective delivery of long term care. Their intent is to develop a less fragmented system, to recommend expansion of community-based programs with a proven track record, and to close current gaps.

Demographic Trends: The Elderly

- One out of 9 persons in the US is age 65 or older. The elderly will represent approximately 15% of the nation's population by the year 2000.
- The Kansas population aged 65 and over is expected to expand by 44,880 persons between 1980 and 2010 (1980 Census Information).
- In 1989, Kansas ranked 13th among the states in percentage of the population 65 years and over. One out of 8 Kansans were 65 years and over.
- The majority of Kansans over 65 live in non metropolitan counties. Approximately 44% of elderly Kansans live in metropolitan counties and 56% live in non-metropolitan areas.
- Although approximately 4.5% of the Kansas population over 65 is non-white, a smaller proportion of nursing facility residents is from racial minority groups.
- More women use formal home and community-based care services than men, since women live longer and are more likely to live alone. Nationally, elderly women are twice as likely to reside in nursing homes as men. In Kansas, 75% of nursing home residents in 1991 were female.
- The risk of becoming disabled and in need of long term care increases with age.
- In the US the "older-old" (age 85+) are growing at a faster rate than the "younger-old" (age 65-84). In Kansas, over the next twenty years, the number of "older-old" are expected to increase by 15%.
- The Kansas population 85+ has increased by 26% since 1980.
- The poverty rate of Kansans over the age of 85 was 74% higher than the overall Kansas rate in 1980. As is the case with other retirement age groups, the 85+ group has a large number of persons just above the poverty level (Kansas Coalition on Aging, 1990).
- Kansas has the 7th highest rate of institutionalization for people over the age of 85 in the US (Kansas Coalition on Aging, 1990).

POPULATION STRUCTURE OF KANSAS, 1990 - 2010

Age	Population		Change (Percent)	Percent Total Population	
	1990*	2010†	1990 to 2010	1990	2010
<65	2,135,003	2,347,933	+10.0	86.1	87.0
65 - 74	184,664	185,235	+0.3	7.5	6.9
75 - 84	115,666	117,201	+1.3	4.7	4.3
>85	42,241	48,707	+15.3	1.7	1.8
Total	2,477,574	2,698,976		100.0	100.0

* Based on 1990 Census Data
† Based on 1980 Census Projections

METROPOLITAN AND NON-METROPOLITAN DISTRIBUTION OF THE ELEDERLY IN KANSAS, 1990

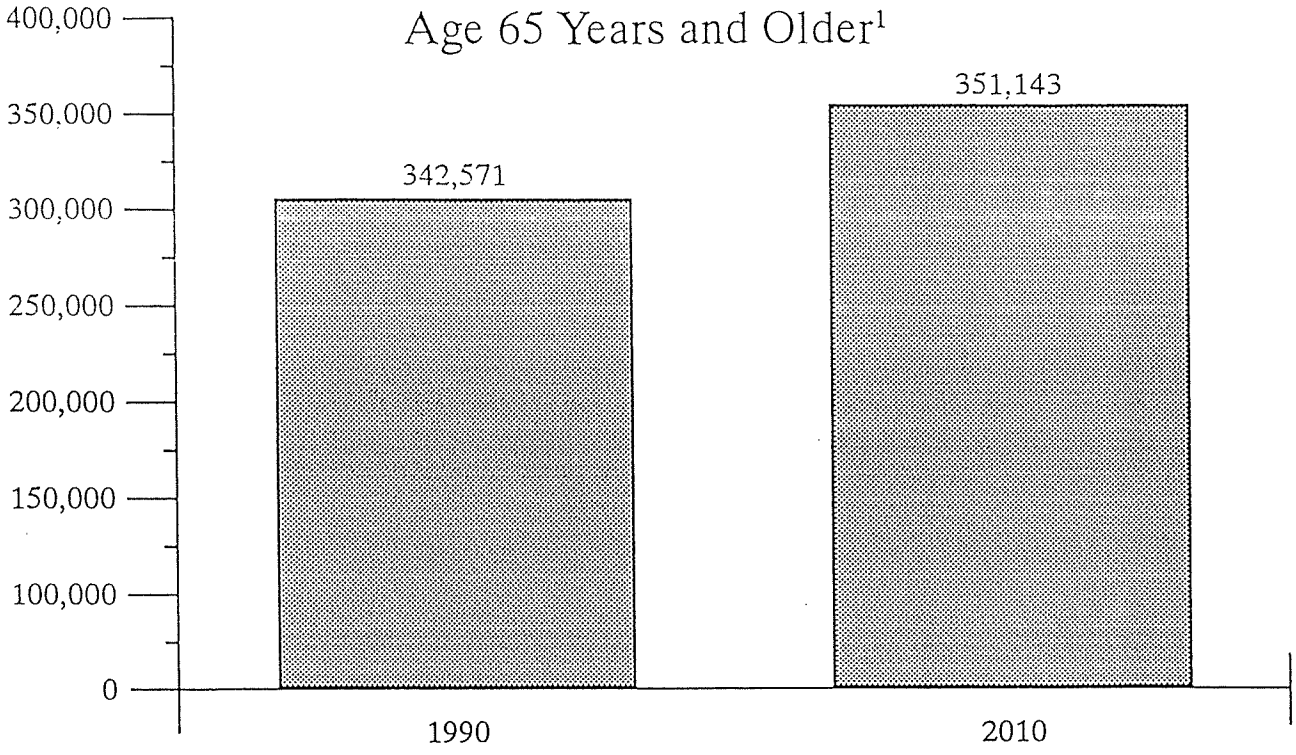
	Population Over 65	Percent	Percent of Total Area Population
Metropolitan Counties *	149,399	43.6	11.2
Non-Metropolitan Counties **	193,172	56.4	13.9
State Total	342,571	100.0	

Based on U.S. Bureau of the Census Summary Population Statistics

* Johnson, Miami, Sedgwick, Leavenworth, Wyandotte, Douglas, Shawnee, Butler, and Harvey counties

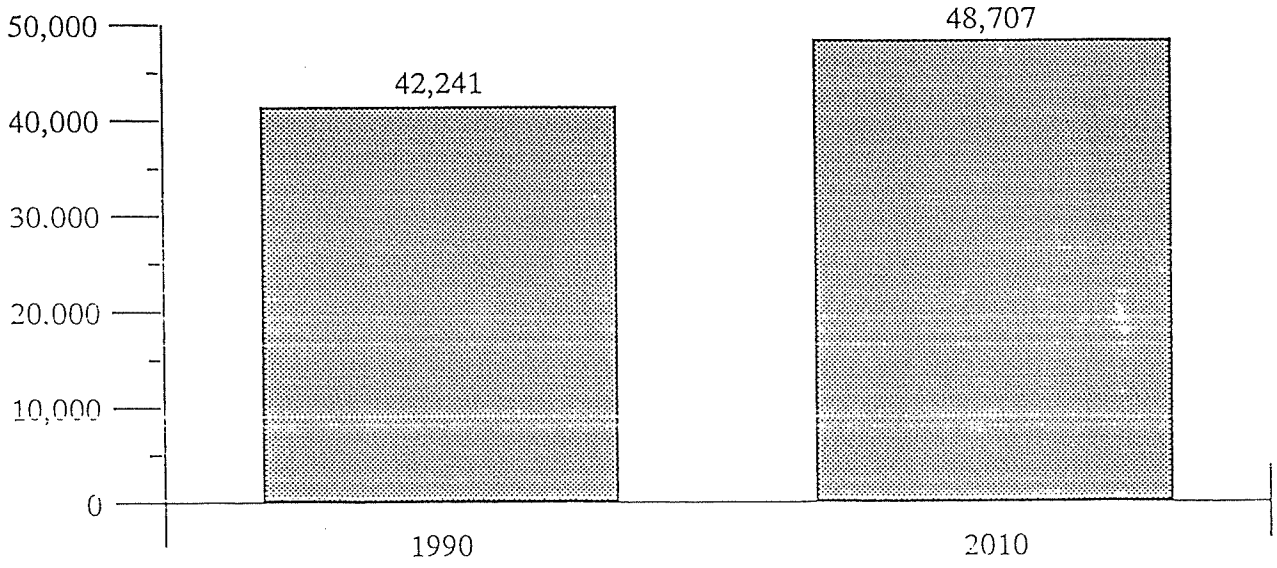
** All other counties

Kansas Population
Age 65 Years and Older[1]



[1] 1990 figure is actual from 1990 census data. Projections for 2010 are from 1980 census data

Kansas Population
Age 85 Years and Older[1]



[1] 1990 figure is actual from 1990 census data. Projections for 2010 are from 1980 census data

Long Term Care Costs

- Nationally, $53 billion was spent in 1988 in the US for long-term care with $43 billion of that being spent for nursing homes. Public programs paid almost 50% of the nation's total nursing home costs (Committee on Ways and Means, 1991).

- Nationally, 94% of all private spending for nursing home care was paid directly by consumers out-of-pocket. Private insurance coverage for long-term nursing home care is very limited and accounts for only 1% of total spending (Committee on Ways and Means, 1991).

- Kansas Medicaid program expenditures for long term care nursing facilities (ICFs/MR excluded) have increased from approximately $90 million in 1986 to over $155 million in FY 1991. This means we spent approximately $3,000,000 per week on nursing facility care in FY 1991.

- In contrast, $3.5 million was spent for the entire fiscal year 1991 for Medicaid elderly home and community-based waiver services.

- The projection for annual Medicaid expenditures for nursing facilities in FY 1992 is $176 million. Factors that have contributed to this increase include new federal regulations and increases in the consumer price index. The number of nursing facility Medicaid recipients participants also increased by 7% from FY 1986 to FY 1991.

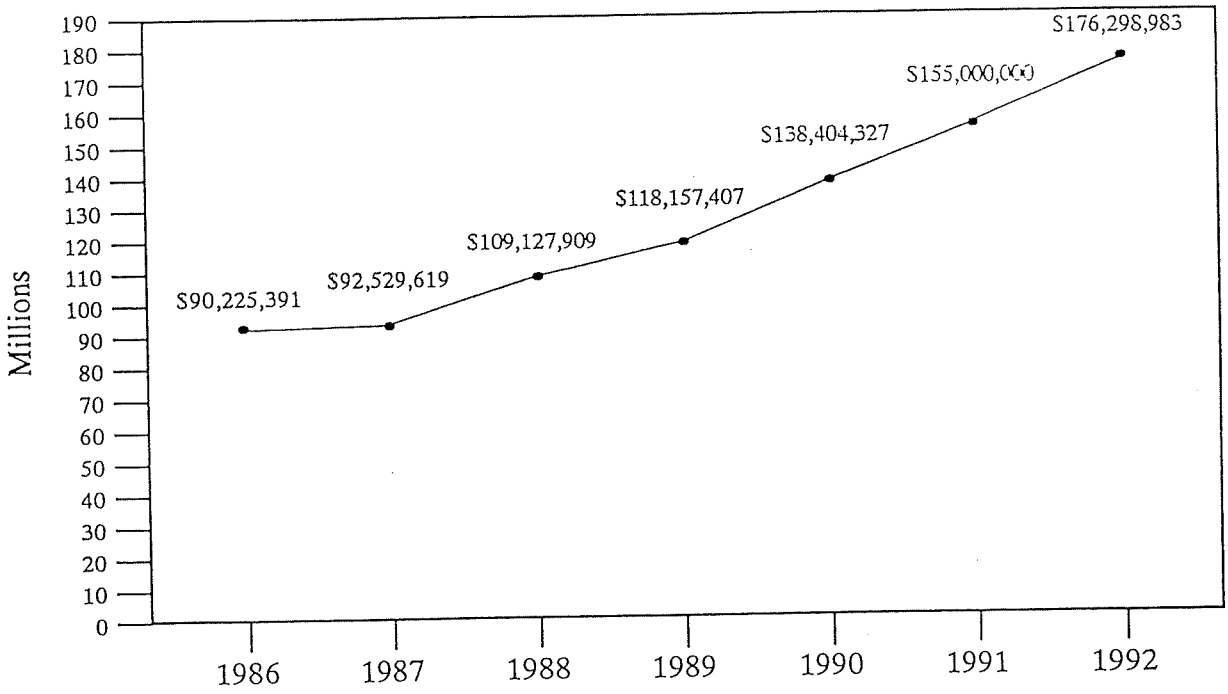
- Medicaid expenditures in Kansas have more than doubled in the last 10 years.

- Over 38% of total Kansas Medicaid expenditures of $485,701,000 was spent on adult care homes in FY 1991. (For definition of adult care home, see Appendix).

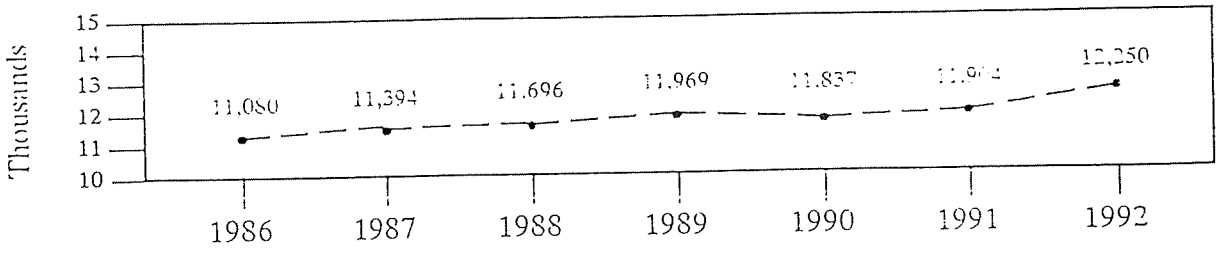
- Although adult care home costs have increased, the proportion of the Medicaid budget expended for adult care homes has remained fairly constant over the last ten years because Medicaid costs generally have also undergone significant increases. However, the regular Medicaid program has also undergone large increases in number of recipients during this period. In contrast, nursing facility Medicaid expenditures have increased over 70% since FY 1986, while number of recipients has increased 7%, from 11,080 in 1986 to 11,904 in FY 1991.

- In fiscal year 1991 over 90% of Kansas public long term care expenditures for the elderly and physically disabled were for nursing facility care.

Nursing Facility Medicaid Expenditures: FY 1986-1992*

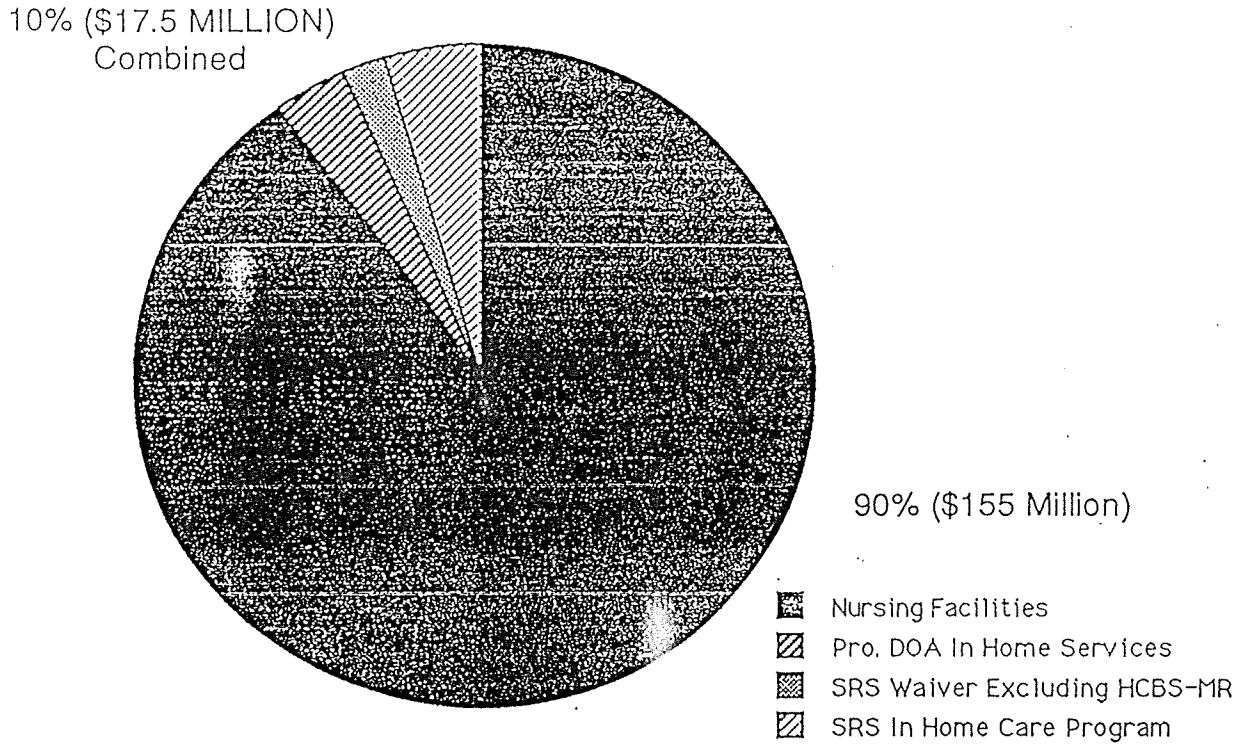


Nursing Facility Medicaid Recipients: FY 1986-1992*



*Excluding ICFs/MR

KANSAS PUBLIC LONG TERM CARE EXPENDITURES FOR ELDERLY AND PHYSICALLY DISABLED, FY1991*



Nursing Facilities	
State and Federal Title XIX Expenditures for Nursing Facilities for Elderly*	$155,000,000
Home and Community Based Services**	
SRS Waiver Excluding HCBS-MR	3,533,000
SRS In Home Care Program	8,158,000
Projected Department on Aging In Home Services	5,828,000
TOTAL	$172,519,000

*(Excluding ICF/MR)

*Note: Home and community based services here refers to services provided both DOA and SRS. This is not to be confused with Medicaid home and community based services commonly called HCBS in Kansas. As indicated above, the SRS HCBS waivers are a subset of the total home and community based services in Kansas.

Home and Community-based Long Term Care Services

Description of Services

- National studies indicate that informal caregivers (spouses, relatives, friends, and volunteers) provide most of the home and community-based care to the disabled elderly (Committee on Ways and Means, 1991). When these informal supports are no longer enough to provide all the care a disabled elderly person needs, publicly provided home and community-based services may supplement informal care so that the disabled elderly person does not have to go to a nursing home to get basic needs met.

- Many times the services needed are not medical services but rather help with activities of daily living (ADLs). ADLs include bathing, dressing, mobility, and eating. Help is also needed with housekeeping, home repair, shopping, and meal preparation. These are termed instrumental activities of daily living (IADLs).

- Examples of community-based services that help meet these needs are: Meals on Wheels, congregate dining, transportation, home maker, skilled nursing, and home health aide.

- Although Kansas has not yet developed a comprehensive statewide array of community-based services, some components are in place.

- SRS administers the home and community-based Medicaid waiver. This waiver program which began in 1982, allows states to develop innovative ways of providing home and community-based services to eligible persons who would otherwise require nursing home care using federal matching funds. An average of 969 recipients per month were receiving services under the Waiver at an average cost of $1,061.23 per month for the period of July '91 through November '91 (Med. Stat. Report HMNR #25).

- The Home Care program, formerly known as the Homemaker Program, is also a SRS community-based program. This program, established in 1975, is not funded through Medicaid, but rather with state funds and with federal Social Services Block Grant money. The Income Eligible Home Care Program targets elderly people who are not eligible for the Medicaid waiver program because they are not completely impoverished. It serves people with incomes up to 150% of poverty. Although the program is clearly needed, both the number of clients receiving in-home care services and the numbers of hours of service provided have actually declined by over 25% between September 1986 and September 1991.

- The Kansas Department on Aging (DOA) estimates they spent approximately $5,828,000 in FY91 for community-based long term care services including homemaker, attendant care, chore, housekeeping, meal provision, and related services. DOA administers Title III of the Older Americans Act which provides federal funds for a number of the programs and requires a 15% state match. These services are not limited to low income elderly people, and some are not targeted to persons considered to be at risk of nursing home care. DOA also has responsibility for the pilot projects funded under the Senior Care Act (SCA). Homemakers and attendant care provided with state and local dollars under the Senior Care Act are charged for on a sliding fee scale and everyone pays at least 20% of the cost. Three pilot projects have been funded in the state. In-home programs funded through SCA served 617 elderly persons with homemaker services and 95 persons with attendant care during FY 91.

- The Kansas Department of Health and Environment regulates home health agencies as well as nursing facilities, and personal care homes. They also provide grants to local health departments to carry out some of the functions discussed below.

- Local health departments, directly responsible to county officials, provide a variety of long term care services including health maintenance screening, health education, and, in some counties, case management.

- At present, Kansas does not require preadmission screening for all nursing facility applicants. Such screening helps to identify who can remain in the community at less cost than in a nursing facility. Kansas currently screens some Medicaid eligible applicants for nursing facilities, and legislation has been proposed to also

screen private pay applicants. Federal matching funds are available to pay for both types of screenings. Currently, Medicaid applicants entering from hospitals and those who have six months as a private pay recipient are exempt from prescreening.

- Pre-admission screening needs to be linked to case management so that the elderly person and their family can see clearly how a plan for community-based services might work. However, Kansas does not have a comprehensive case management system to help elderly people put together a community care plan if they would rather stay in the community than go into a nursing home.

- Kansas also presently does not provide comprehensive statewide community-based services. Elderly people who can not afford service may find themselves unable to get services through either SRS or DOA because of conflicting eligibility requirements and long waiting lists. People who can afford service may find that services are not available in their area.

- When community-based services are not available, a disabled person may have to enter a nursing facility to access needed care. Once a person enters a nursing facility, even services many elderly residents are capable of providing for themselves, such as meal preparation, housekeeping, and bathing, will be formally provided and if the resident is Medicaid eligible, the cost will be borne by the taxpayer.

- A survey of state spending on community long term care services completed by George Washington University researchers, found that Kansas ranked 46th among the 50 states and the District of Columbia on per capita spending on community long term care services (Kansas Coalition on Aging, 1990).

Profile of Clients Receiving Home and Community-based Services

- Because community-based long term care services are provided by both SRS and DOA, and because each has a unique data collection system, it is difficult to create a composite profile of elderly and disabled clients being served in the community. The lack of uniformity and integration of data collection between and within agencies also makes it difficult to make comparisons between people receiving long term care in institutions and people being served in the community. However, profiles of the people receiving community-based long term care services through three major programs have been developed.

- A FY 1991 profile of clients receiving in-home services through the Department on Aging under the Senior Care Act (SCA) indicated:

  - The typical client was 82 years old, white (95%), female (about 75%), and widowed (60%). The average monthly income was $975.58, and they lived alone (74%).

  - Many clients had health problems that made it difficult to perform the activities necessary to live independently. Eighty-two percent were unable to perform simple housework, such as vacuuming and washing dishes. Nearly half of them were unable to do their own laundry (45%) or go shopping (44%). About one-fourth (23%) of the consumers required help during bathing (Miller, R., Pennington, R., et al., 1991).

- A profile of clients receiving home care service under the Medicaid Waiver through SRS in November 1991, indicated that of the 1,258 people receiving services:

  - Over 60% of the clients were 70 and over, over 35% were 80 and over, 75% lived alone, and over half lived in communities of 10,000 or less.

  - Forty-four percent of the clients needed moderate to total assistance in at least two critical Instrumental Activities of Daily Living (IADLs) and two Activities of Daily Living (ADLs). (SRS Home Care Services Monthly Report, November 1991).

- A profile of clients receiving home care service under the Medicaid Income Eligible Program through SRS in November 1991, indicated that of the 4,856 clients receiving services:

  - Over 80% of the clients were 70 and over, over 50% were 80 and over, 88% lived alone, and over half lived in communities of 10,000 or less

  - Forty-seven percent needed moderate to total assistance in at least two critical IADL's and two ADL's.
    (SRS Home Care Services Monthly Report, November 1991).

- **Although income level could be expected to vary between these groups of clients profiled above because income eligibility rules are different for the various programs, the typical consumers of home care services from all three programs are very old women living alone with significant functional impairments.**

Nursing Facilities

Profile of Facilities

- Nursing facilities provide a large variety of long term care services to residents. Some nursing facilities also provide home and community-based services. Services for nursing facility residents include room and board, skilled nursing and therapy services, and assistance with activities of daily living such as bathing, dressing and eating, as well as meal preparation and housekeeping.

- Currently, Kansas has 26,435 licensed nursing facility beds; (not including hospital attached beds). There are an additional 770 personal care home beds in Kansas.

- Of the 370 licensed nursing facilities listed in the January 1992 Directory of Kansas Nursing Homes, 65% are for profit, 29% are nonprofit, and 6% are public.

- When states are compared based on the number of nursing facility beds for every 1,000 individuals over the age of 65, Kansas is among the ten states who have the most beds.

- Kansas nursing facility occupancy rate is 87.53%.

- In Kansas, the Federal Medicaid match for nursing facility costs is currently at the rate of 59.3%

- In Kansas, the Medicaid average daily rate paid nursing facilities was $49.15 for November, 1991.

- A recent study found that if present policies do not change, 43% of our citizens age 65 or over will receive long-term care in a nursing facility *at least once* during their lifetime (Kemper and Murtaugh, 1991).

Number of Licensed Facilities in Kansas/January 1992

	Facilities	Beds
Intermediate/Skilled Care Licensed Homes/Beds	349	26,435
Licensed Free-Standing Personal Care Homes/Beds	2	98
Personal Care Homes Connected With Nursing Facilities	19	672

*19 facilities have a mix of nursing beds and personal care beds. These facilities are listed as nursing facilities. (Directory of Nursing Homes, January 1992) This does not include long term care units attached to hospitals. Personal care homes attached to nursing homes may participate in-home and community-based service programs.

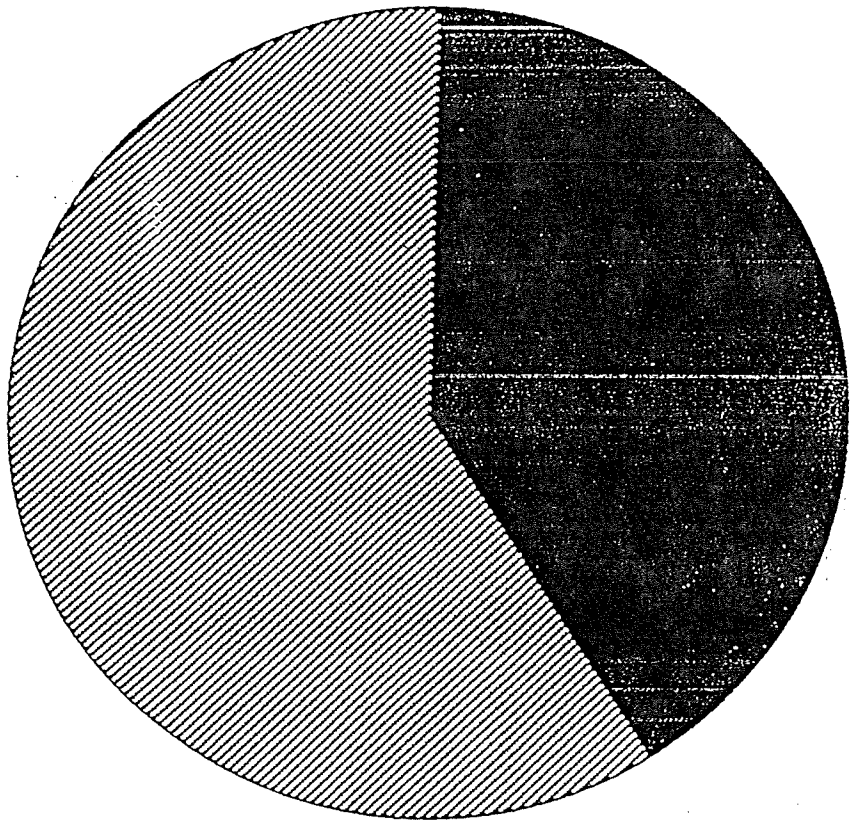
Facility Ownership/January 1992

	Licensed Nursing Facilities
For Profit	238
Non Profit	109
Government	23

Directory of Nursing Homes, 1992.

KANSAS MEDICAL ASSISTANCE NURSING FACILITY EXPENDITURES, FY1991*

(Percent of Contribution to MA)



*(Excluding ICF/MR)

Profile of Nursing Facility Clients

- Approximately 7% of Kansas elderly are currently in a nursing facility. Nationally, the proportion is about 5%.

- In Kansas, approximately 75% of nursing facility residents (includes personal care homes) age 65 and over are female (17,478) and 25% are male (5,843).

- The "younger old" (people 65 to 84) use nursing facilities at much lower rates than the faster growing population of "older-old" (people 85 and over).

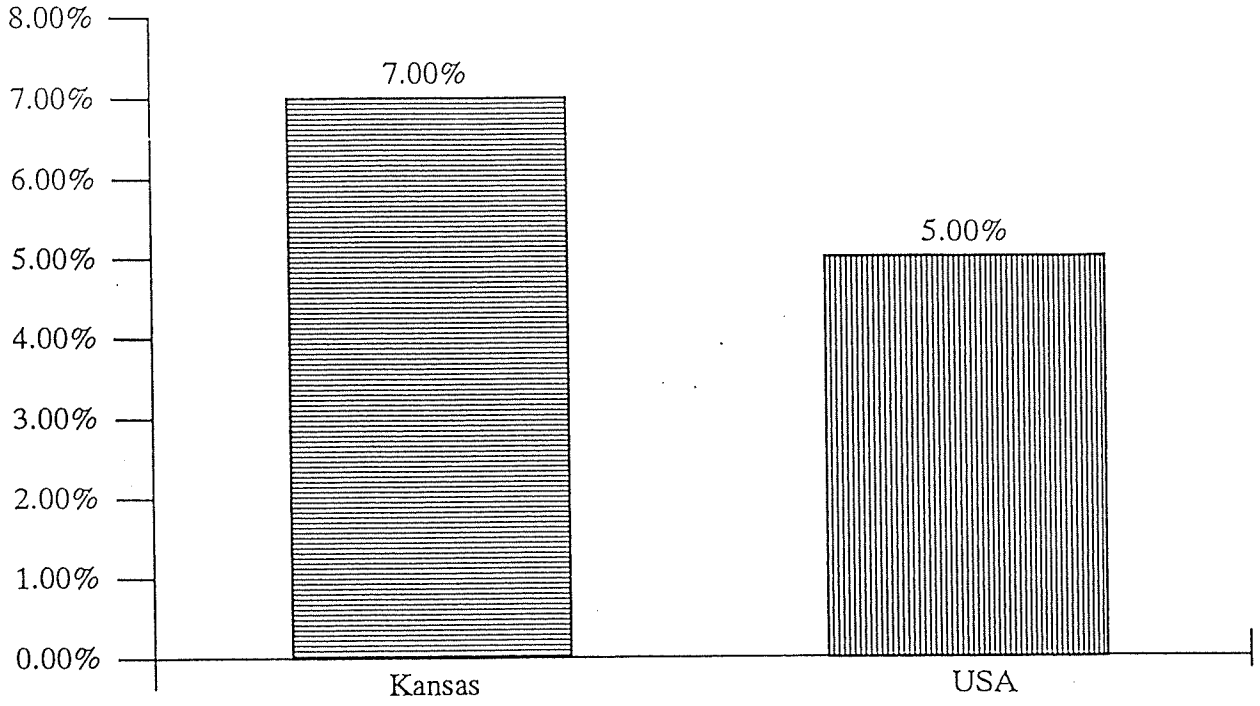
- The population 85+ is at the greatest risk of needing and using long term care services. In Kansas, the 85+ population is expected to increase from 42,241 in 1990 to 48,707 (a 15% increase) in 2010.

- In Kansas, according to a report prepared by The Kansas Coalition on Aging, 3 out of every 10 or approximately 30% of people 85+ live in an institution. Kansas has the 7th highest rate of institutionalization for persons over 85 in the United States (Kansas Coalition on Aging, 1990).

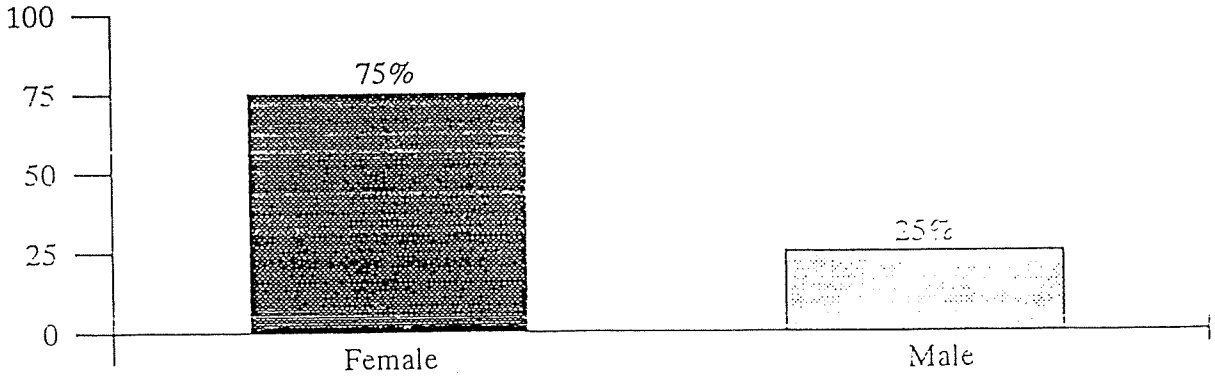
- Analysis of the 1985 National Nursing Home survey indicates that nationally, 78% of nursing home residents were found to need assistance with two or more activities of daily living (ADLs). 55% were severely impaired with four or more ADLs. But 20% of nursing home residents were judged to have no or only one ADL. About 35% of those with no ADLs had a mental disorder as their primary diagnosis. Although comparable statistics are not currently available for Kansas, there is no reason to believe that the Kansas nursing facility population is markedly different from that of the rest of the nation.

- Residents who have no or only one activity of daily living dependency and are not suffering from a mental disorder are the ones most likely to be economically served in the community with necessary supports. Of course, the availability of informal support and service is a crucial factor in determining cost and likelihood of success of community-based services for people at all levels of disability.

Percent of Elders in Institutional Care Age 65+



Kansas Nursing Facility Residents, Age 65 and over, by Sex, May 1, 1991*



Total Residents = 23,321

*Includes personal care homes

Reimbursement Methodology

- The Department of Social and Rehabilitation Services reimburses Nursing Facilities (NF's) for Medicaid residents by using a cost related system. Currently, Medicaid payments to nursing facilities are the same for all Medicaid recipients in a given facility regardless of their care needs. The per diem rates paid for Medicaid residents are facility specific and are based on annual cost reports filed by the providers. The Medicaid average daily nursing facility rate was $49.15 in November 1991.
- The cost reports are used to determine prospective per diem rates and for setting upper payment limits. The rates are determined by dividing the allowable costs by the resident days subject to limitations and then adding factors for inflation, the property component, and other items when applicable.
- The rates are subject to upper cost center limits. The limits are designed to reimburse providers a reasonable and adequate rate for an economically and efficiently operated home as mandated by federal law. Upper payment limits are established annually.
- The cost report is divided into four reimbursable cost centers. Each cost center has an upper per diem payment limit determined from an array of historic cost report data. The limits are based on percentiles for each of the cost centers.

  The cost centers, percentiles, and per diem limits, effective October 1, 1991, are as follows:

Cost Center	Percentile	Cost Center Limit
Administration	75th	$ 6.69
*Plant Operating/Property Fee	85th	$ 9.35
Room and Board	90th	$15.92
Health Care	90th	$32.82
Sum of four centers		$64.78

*There are two components to the property cost center limit. One is the real and personal property fee which was implemented January 1, 1985. The second is the plant operating cost center which is held to the 85th percentile.

- A provider may be eligible for an incentive factor to be added to their per diem rate. The incentive factor is established to encourage providers to contain administrative and plant operating costs. The lower the administrative and plant operating costs, the higher the incentive factor. The incentive factor is added to the per diem rates after the cost center limits have been applied.

- There are limits established for owner/related party compensation. The Kansas Civil Service salary schedule is used to determine the allowable owner/related party compensation for comparable positions. There is also a per diem limit for administrators, co-administrators, and owners reported in the Administration Cost Center, based on an array of these salaries.

- Resident days are important since they are the denominator in the rate calculation. There is an 85% minimum occupancy requirement. The rates are determined by using the greater of actual days or 85 percent of the maximum occupancy based on the number of licensed beds. The only exception to the 85% minimum occupancy rule is the first year of operation for a new provider in which the actual resident days are used to determine the rate.

- The agency defines cost and resident day requirements through regulations, policies and the Medicaid State Plan.

- Several federal Nursing Home Reform Act (OBRA 87) requirements became effective October 1, 1990. The changes that impact rate setting were combining the skilled and intermediate levels of care, 24 hour licensed nurse coverage, resident assessments, and medical directors and social workers in facilities with more than 120 beds.

- A minimum wage factor was added in the per diem rate for providers who incurred additional costs to bring employees wages up to the new minimum wage standards, effective April 1, 1990 and April 1, 1991.

Case Mix Demonstration Project

- Currently, in Kansas, Medicaid payments to nursing facilities are the same for all Medicaid recipients in a given facility. In order to target reimbursement level more closely to client service needs, a number of states have developed case mix reimbursement methodologies for their nursing facilities.

- Case mix reimbursement is a system of paying nursing facilities according to the mix of residents in each facility, measured by resident characteristics, and service needs. Typically, a case mix reimbursement methodology is used only for reimbursement of direct care costs.

- A case mix system also allows limits to be set equitably because the resident need level or "case mix" of the facility can be considered when limits are put in place.

- In 1989, Kansas Social and Rehabilitation Services was approved for a federal demonstration project to evaluate a case mix reimbursement system for nursing facilities. The title of the project is "Kansas Nursing Facility Case Mix Demonstration".

- The assessment instrument Kansas is using to determine the client's need level or classification is the Minimum Data Set + (MDS+). A federal mandate requiring use of the MDS (or a compatible alternative) in nursing facilities across the country creates an opportunity to develop a statewide as well as a national standardized data base for nursing facility residents. Kansas received federal approval to use the MDS+ instead of the MDS. The MDS+ contains all the questions in the MDS plus additional questions developed as part of the case mix demonstration project.

- The Kansas Nursing Facility Case Mix Demonstration is an integral part of an effort to develop and implement a payment system for nursing facilities that is linked to a quality of care monitoring system. Under a case mix system, it is believed that there would be a better matching of resources to resident care requirements. The primary goal of the demonstration project is to evaluate the impact of various components of a case mix payment system on the quality of care of nursing facility residents.

Conclusion: Future Options

- This fact book details the expected growth in the elderly population, particularly in the 85+ group for which Kansas must prepare. Further development of community-based long term care is necessary to serve the needs of our increasing elderly population.

- Although nursing facilities are an important component of long term care, over reliance on care in nursing facilities will become increasingly expensive. The figure on page 27 illustrates the components needed for a comprehensive long term care system that includes a full array of home and community-based services.

- Policy makers who have developed and researched state efforts to restructure their long term care systems to increase community options, have identified certain elements that they believe are basic to successful restructuring (Pendleton, Capitman, Leutz, Omata, 1990; Long Term Care, 1987; Ladd, 1991). Identified elements include the following options for Kansas policy makers to consider.

- First, a strong gatekeeping function is needed at the point people are considering admission to a nursing facility, or ideally at an earlier point before financial, and informal care resources are depleted. Many states have combined pre-admission screening with statewide case management to help elderly people develop viable community alternatives for their care. This is crucial if a less costly community system for long term care is to ultimately result. Of course, community-based long term services must be developed before they can be accessed.

- Second, a reimbursement system for nursing facilities such as a case mix system, can help target scarce state dollars to those people most in need of such care. Kansas is currently examining the case mix option.

- Third, when long term care services are provided by two or more state agencies (as is the case in Kansas) state level coordination via a policy board is crucial. Coordination of service delivery at the local level is also necessary.

- Fourth, moratoriums or certificates of need to limit nursing facility growth may be needed. It seems that if a nursing facility bed is added, someone will be found to occupy it. If not, occupancy rates will be low. Either way, the state loses because low occupancy rates mean that fixed costs must be allocated to fewer residents, thus causing daily rates to rise.

- Fifth, an integrated data system on community-based long term care makes it possible to determine how many state dollars are being spent, what is being provided, and who is being served. Services can't be properly targeted, overlapping services eliminated, gaps identified, and state spending redirected unless we have basic information. Improvement of the data system in Kansas should be considered.

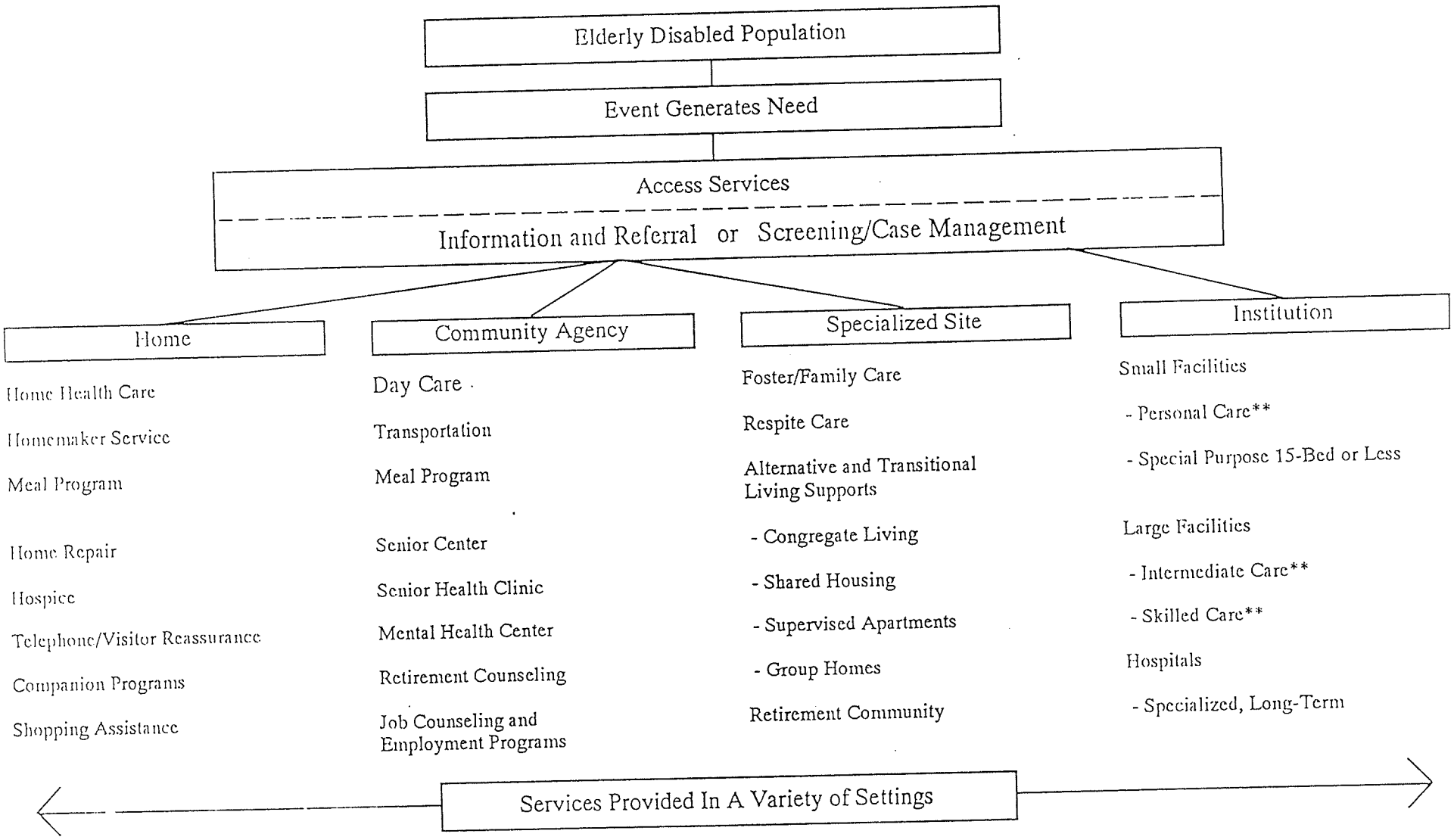
- Sixth, more options need to be developed for people who can't remain at home but really don't need the medical care available in a nursing facility. Other states have reported successful implementation of sizeable programs that fill this gap and are less costly than nursing facility care. Kansas SRS is currently examining these options.

It is time for us to rethink and redirect the state's long term care strategy. The long term care needs of many of our citizens can and should be met in the community.

State agencies are currently working together on an interagency committee to develop and improve long term care programs. The Long Term Care Action Committee was organized in November 1991 and is comprised of staff from SRS, KDHE, and DOA. The committee has made the following recommendations:

1. Expand the Senior Care Act to a statewide program;
2. Fund the SRS Income Eligible Home Care Program at a level to ensure waiting lists are eliminated;
3. Expand utilization of adult family homes, personal care facilities and other housing options;
4. Expand utilization of adult day care and respite care;
5. Develop a database of needs of persons entering adult care facilities. Identify available resources that meet those needs and gaps, and target development of unavailable resources;
6. Mandate adult care homes, medical care facilities and physicians to provide information on community resources prior to admission to institutions;
7. Fund Department on Aging (DOA) to develop and make available Long Term Care (LTC) resource manuals through their information and referral system, SRS area offices, and local health departments;
8. Fund DOA to develop statewide information on long term care;
9. Review the impact of the decision to implement the 300% SSI cap;
10. Enhance interagency collaboration on strategic planning, program development, budgeting, rule making, and legislative issues;
11. Continue to exchange data between state agencies on long term care services;
12. Establish a statewide health insurance counseling program focused on older persons and Medicare, Medicaid, Medicare supplemental insurance, and LTC insurance issues. Study the addition of optional group LTC insurance for state employees.

Comprehensive Long-Term Care Model*



Access Services/Information and Referral/Assessment/Case Management
Advocacy/Ombudsmen/Legal Aid/Protective Services
Income Maintenance/Financial Management

Adult/Health Education
Support Groups

**Many institutional facilities are frequently referred to as nursing homes or, by Kansas statutes, as adult care homes. All terms will be used interchangeably in this report. This model is based on the Long Term Care Continuum Model from the 1984 State Health Plan.

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Appendix: Definitions

Activities of Daily Living (ADLs) Chronic conditions may result in dependence in functions basic and essential for self-care, such as bathing, dressing, eating, toileting, and/or moving from one place to another. These are referred to as activities of daily living.

Adult Care Home Any skilled nursing home (facility), intermediate nursing care home, intermediate personal care home, one-bed adult care home and two-bed adult care home and any boarding care home, all of which classifications of adult care homes are required to be licensed by the Secretary of Health and Environment. Adult care home does not mean adult family home. (Kansas Licensure Law 39-923).

Adult Day Care This is designed to develop and maintain optimal physical and social functioning of the elderly and the physically disabled by providing medical and nursing care (if necessary), one meal a day, and daily supervision. Day care offers only socially oriented services; day treatment provides socially and medically oriented services.

Adult Family Homes These are essentially adult foster homes. No nursing care is provided. Home visits may be provided by a home health nurse. These are licensed by SRS and are 1-2 bed or 3-4 bed homes. They are funded through Social Service Block Grants and private payment.

Board and Care Homes These facilities provide some supervision. Congregate meals, housekeeping and laundry are also provided. No nursing care is provided. They are licensed by the Department of Health and Environment. Some funding through Social Service Block Grants may be available to pay for these homes.

Case Management Case management is comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in conjunction with the provisions of any home and community-based services. Although definitions vary, most experts agree that case management is comprised of seven basic components. These include: identifying and attracting the target population, screening intake and eligibility determination (gatekeeping), assessment, care planning, service arrangement, monitoring or follow-up, and reassessment (InterStudy, 1989).

Metropolitan Statistical Area (MSA) An area qualifies for recognition as an MSA in one of two ways. It contains a city of at least 50,000 population or an urbanized area of at least 50,000 with a total metropolitan population of 100,000.

Night Support This is overnight assistance to recipients in their homes for a period not to exceed 12 hours.

Non-Medical Attendant Care These are personal care services which do not have to be delivered "under the direction of a licensed health care professional".

Non-Metropolitan Counties Those counties not included within the boundaries of metropolitan statistical areas.

Nursing Facility (NF) A facility which has met state licensure standards and which provides health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury. (K.A.R. 30-10-1a)

Personal Care Home Intermediate personal care home means any place or facility operating for not less than 24 hours, in any week and caring for three or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board, personal care, and treatment or simple nursing care is provided and which place or facility is staffed, maintained, and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care, skilled nursing home care or moderate nursing care, but who require domiciliary care or simple nursing care. (KSA 39-923#4)

Residential Care and Training This is supervised, non-medical care in a residence which has been licensed by SRS. Services include basic provision of care and training services according to an established individual program plan (IPP). Care and training services are provided by facilities licensed to provide group living and semi-independent living programs.

Residential Care Facilities These are "group homes" for the mentally retarded and mentally handicapped. They provide supervision and instruction in independent living skills. They are not utilized by the elderly.

RECOMMENDATIONS TO THE 1992 KANSAS LEGISLATURE

RELATED TO LONG-TERM CARE ISSUES

Developed Jointly by

Kansas Department on Aging

Kansas Department of Health & Environment

Kansas Department of Social & Rehabilitation Services

11-20

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BACKGROUND

For more than a decade the Secretaries of the Department on Aging (KDOA), the Department of Health and Environment (KDHE), and the Department of Social and Rehabilitation Services (SRS), have encouraged their staff to work cooperatively on long-term care (LTC) issues. These efforts resulted in the development of the 1978 Home Care Study; the 1984 Joint Position Statement; and the 1986 LTC Plan, resulting from House Concurrent Resolution (HCR) 5052.

In the late fall of 1991 the Secretaries of the three agencies agreed key members of their staff should develop a systematic, comprehensive statewide action plan for the cost-effective delivery of long-term care (LTC) programs and services to the elderly and disabled in Kansas.

The committee met for the first time on November 7, 1991 and subsequently met six additional times including a public forum on December 20, 1991. Advocacy groups and other groups with interests in LTC were invited to comment on the committee's recommendations. Overwhelming public approval was received for the committee's efforts with only a few issues of concern voiced.

The committee decided early on that the best method of response to the legislature early in 1992 was to develop a short, simple and direct report that outlines what has and has not been accomplished in reaching LTC goals since 1986; identifies gaps and/or impediments to the delivery of LTC programs and services; recognizes areas of consensus and divergence among the three agencies regarding LTC issues; coordinates administrative initiatives and legislative tasks of three agencies; and considers the fiscal implications of their recommendations.

STATISTICAL DATA

The statistics reflected below indicate the immediate need for a comprehensive LTC action plan in Kansas and the difficult decisions that face our state:

- The Kansas population 85+ has increased by 26% since 1980.
- Kansas has the 7th highest rate of institutionalization for people over age 85 in the U.S.
- Kansans are spending $3 million per week on nursing home care for Medicaid clients.
- Kansas ranks 46th among the 50 states and the District of Columbia on per capita state spending for community-based LTC services.

*NOTE: (Source: 1988 State Financing of Long-Term Care Services for the Elderly, George Washington University; 1990 U.S. Census; and SRS Medical Services Fiscal Unit)

These statistics indicate our current policy may be limiting options for elderly and/or disabled individuals to remain in their own homes. While the cost-effectiveness of developing and expanding alternatives to institutionalization may not always be immediate, the positive social rewards of assisting this population in maintaining their independence will be.

RECOMMENDATIONS

With these concerns in mind, the LTC Action Committee proposes changes in service development; system reform; and interagency coordination for long-term care. The following recommendations will implement these changes:

SENIOR CARE ACT - Appropriate adequate funds to the Secretary of Aging to ensure expansion to a statewide program. Currently this program covers 13 counties and provides community-based services on a sliding fee scale to individuals with incomes above 150% of poverty in a cost-effective manner with a dollar-for-dollar match required.

* **Basis for Recommendation:** 1991 Evaluation of the Senior Care Act - Final Report.

INCOME ELIGIBLE HOME CARE PROGRAM - Appropriate adequate funds to the Secretary of SRS to ensure that all eligible persons can be served. Currently this program is available in all counties of Kansas and provides community-based services free of charge to individuals with incomes below 150% of poverty. This program is funded through social service block grants and State General Funds.

* **Basis for Recommendation:** Since 1987 utilization of this program has diminished. Funding levels to this point created waiting lists and not all eligible individuals could be served.

HOUSING OPTIONS - Remove barriers and create incentives which will encourage the expansion of adult family homes and personal care facilities. Currently these housing options are available but underutilized as a part of residential personal care. The services consist of room, board and supervision of or assistance with activities of daily living (simple nursing) and are supplied by a state regulated provider. Medical care is not provided. There are 21 facilities for a total of 743 licensed personal care beds in Kansas. Only two of those facilities are freestanding personal care homes. Additionally, there are 60 active adult family homes registered.

* **Basis for Recommendation:** Agency staff recognize that reimbursement rates and financing are identified by potential providers of this service as stumbling blocks to expansion and development of adult family homes and personal care facilities.

ADULT DAYCARE & RESPITE CARE - Appropriate adequate funds to the Secretary of Aging and to the Secretary of SRS to provide daycare and respite care to the elderly and/or disabled population. Currently these programs are available on a limited basis for Medicaid recipients in the HCBS Program and on a very limited basis under the Older Americans Act.

* **Basis for Recommendation:** Research indicates that a large portion of LTC services is provided by relatives and friends. By offering these services we present families with options and assistance for caring for loved ones in their homes.

DATA BASE - Develop a common data base of needs of all persons entering adult care homes by coordinating the collection of data from a combination of services including the existing data base of HCBS, Home Care, and Senior Care Act recipients; the accumulated Minimum Data Set + (MDS+) information; and the proposed preadmission assessment and referral service information that would result from substitute for HB 2566.

* **Basis for Recommendation:** A single source of data on LTC issues is not currently available, and a common data base can be used as a tool in evaluating progress in achieving LTC goals.

INTERAGENCY COLLABORATION - Enhance strategic planning, program development, budgeting, rule-making and legislative activities between KDOA, KDHE, and SRS. Currently these three agencies have major roles in effective development of LTC programs. They must work together to identify available resources that meet our service needs and to close the gaps in existing community-based services, including case management, as well as to direct the development of resources.

* **Basis for Recommendation:** Problem resolution in the early planning stages of any program and policy development will improve the delivery of services from all three agencies.

COMPREHENSIVE RESOURCE INFORMATION - Appropriate adequate funds to the Secretary of Aging to develop, maintain and make available comprehensive LTC resource information (including information about case management) through the KDOA information & referral system, SRS area and local offices and county health departments. This information shall be provided to all physicians, medical care facilities and adult care homes. In conjunction with this effort, funding shall be provided to the Secretary of Aging to develop and maintain a statewide public awareness program.

* **Basis for Recommendation:** A need exists to educate the public of available community-based alternatives for LTC before a personal crisis strikes and little planning time for families is available.

MANDATED INFORMATION - Mandate adult care homes, medical care facilities and physicians will be mandated to provide information on community-based resources available within an area prior to admission to a long-term care facility in accordance with proposed substitute for 1991 HB 2566.

* **Basis for Recommendation:** Based on MDS+ (minimum data set) data approximately 56% of admissions to nursing facilities were from hospitals. Individuals and families most often seek information from medical providers, especially physicians, when a health crisis occurs.

PREADMISSION ASSESSMENT & REFERRAL - Require that all applicants seeking adult care home placement receive an assessment of need and be given referrals to any appropriate and available services. This assessment and referral process shall be performed in accordance with the substitute for 1991 HB 2566. Currently Medicaid applicants seeking adult care home placement from general hospitals or applicants institutionalized longer than six months do not receive an assessment of need for adult care home placement.

* **Basis for Recommendation:** Individuals must be informed of alternatives to institutionalization before their financial and personal resources are depleted or are no longer available.

300% SUPPLEMENTAL SECURITY INCOME CAP - Have the Secretary of SRS review the impact of the decision to implement the 300% SSI cap rule for persons seeking Medicaid coverage for nursing home care.

* **Basis for Recommendation:** The public and advocacy groups have raised concerns over the implementation of this policy which they perceive to reduce access to LTC.
* **Divergence:** The Secretary of Aging recommends the legislative review of the 300% rule.

HEALTH INSURANCE COUNSELING - Establish a statewide health insurance counseling program focused on older persons, Medicare, Medicare supplemental insurance, Medicaid and LTC insurance issues. Since a current counseling program does not exist, the committee recommends utilization of existing social services organizations in conjunction with the Insurance Commissioner and the Secretary on Aging to organize, plan and develop a counseling program.

* **Basis for Recommendation:** Elderly and disabled populations are vulnerable to overstating or understating their insurance needs. With such a high volume of complicated insurance options existing, this population requires a counseling service to ensure the value of private and public monies expended towards insurance premiums is maximized.

TAX INCENTIVES - Review Kansas' tax structure to evaluate potential incentives that could be created to encourage in-home care for the elderly and/or disabled.

* **Basis for Recommendation:** Real and timely financial incentives enhance a family's ability to care for elderly and disabled in the home and reflect an attitude of support towards this type of care from the state level.

FISCAL IMPACT

The committee recognizes the need for a detailed fiscal analysis of these 12 recommendations and this analysis shall be provided by the specific agency assigned to each of the recommendations and will be available January 17, 1992.

LEGISLATIVE ISSUES

In addition to the recommendations, the legislative issues identified below were reviewed and the following comments made:

- HB 2566: The committee recommends adopting the substitute for HB 2566 as attached. The development of this substitute does not restrict choice or access to nursing facility placement but will provide the elderly and disabled with information on community-based service options.

- SB 54: The committee does not support this bill. It is a higher priority to work on internal administrative issues and funding for the Home Care Program. KDOA does not take a stand on this issue.

- SB 377: The committee does not support this bill. The three state agencies responsible for the delivery of long-term care services are working together and making progress.

- HB 2567: The committee does not support this bill for the following reasons: 1) It compromises the availability of quality care; 2) limits choice; 3) does not realistically control nursing home costs in that it does not address the bed utilization issue; 4) does not promote community-based services; 5) does not take into account variations throughout the state on the availability of beds based on geographic issues or demographics; and 6) indirectly sanctions inadequate care.

- HB 2033: The committee does not support this bill. We support a tax credit for families caring for the elderly and/or disabled in their own home. HB 2033 is too limited because: 1) serves only eligible HCBS clients; 2) benefits provided are untimely and inadequate; 3) no realistic measurement of fiscal impact at this time.

CONCLUSIONS

Through our action group's efforts, we have defined a vision of providing a continuum of care for the elderly and/or disabled and this effort will be further enhanced by our three agencies' continued collaborations. We must emphasize the importance that the concept of an assessment and referral service system can only succeed if community based services are available as alternatives. Development of community-based services and the implementation of the assessment process must occur simultaneously to be truly effective and to limit the potential of adverse impact on a vulnerable population.

ATTACHMENTS: A - Substitute HB 2566
B - Status Report
C - Secretaries' Endorsement

LTC Action Committee
Substitute
House Bill No. 2566

An act concerning social welfare; relating to providing Kansans information and assistance in obtaining appropriate long-term care services.

Be it enacted by the legislature of the State of Kansas:

(a) The secretary of the department on aging shall assure that each area agency on aging shall compile comprehensive resource information for use by individuals and agencies related to long-term care resources including all SRS area offices and local health departments. This information shall include, but not be limited to, resources available to assist persons to choose alternatives to institutional care.

(b) Adult care homes as defined in K.S.A. 39-923 and medical care facilities as defined under K.S.A. 65-425 shall make available information referenced in section (a) to each person seeking admission or upon discharge as appropriate. Any licensed practitioner of the healing arts as defined in K.S.A. 65-2802 shall make these same resources available to any person identified as seeking and/or needing long-term care.

(c) (i) The secretary of the department of social and rehabilitation services shall develop a uniform needs assessment instrument to be used by all providers of assessment and referral services.

(ii) On and after the effective date of this act, no person shall be admitted to an adult care home providing care under Title XIX (Medicaid) unless the person has received assessment and referral services as defined in c(i). These services shall be provided under the Senior Care Act, under the Older Americans Act, by the secretary of the department of social and rehabilitation services, or by other providers as identified by the secretary.

(d) This act shall not be construed to prohibit the selection of any long-term care resource by any person. An individual's right to choose does not supersede the authority of the secretary of social and rehabilitation services to determine whether the placement is appropriate and to deny eligibility for long-term care payment if inappropriate placement is chosen.

DB:csl
01/02/92

STATUS REPORT
1987-1991

Based on the recommendations identified by the interagency committee of 1986, pursuant to HCR 5052, the following is a brief summary of the status of each recommendation:

Short-Term Implementation Plan 1987-1989

1. Develop a continuum of long-term care service programs in each county.

   a. Mandate a prioritized continuum of care services in every county. Care services will include: meals, homemaker, personal care, respite care, medical transportation, chore and counseling.

      STATUS: Aging network in-home meal availability has expanded although waiting lists and unmet demand for additional meal sites still exist. SRS income eligible home care service hours are 30% fewer than in 1986. State funds for elderly transportation ($390,000 annually) are now available. Some oil overcharge funds have been used to purchase vehicles for elderly transportation programs although unmet demand still exists. The state and local funded Senior Care Act program now provide homemaker and attendant care services in thirteen counties. Waiting lists exist in these counties. Older Americans Act funding has not kept pace with inflation during the 1980's.

   b. Fund homemaker services at a level that will ensure that waiting lists are eliminated.

      STATUS: Waiting list data is no longer maintained at the state level. Service hours provided currently are about 30% below 1986 levels.

   c. Use the Department on Aging, Department of Health and Environment, and Department of Social & Rehabilitation Services as options for channeling money to service providers for service development.

      STATUS: Continues to occur.

   d. Set a maximum on the value of support services provided to each person.

      STATUS: SCA, HCBS and Income Eligible Home Care programs have established maximums.

   e. Offer services on a sliding fee scale.

      STATUS: SCA utilizes a sliding fee scale. Older Americans Act continues to preclude use of a means test. Income eligible home care does not have a co-pay.

   f. Opportunities should be available for families to participate in the financial as well as social support function for long-term care.

STATUS: SRS allows families to pay the difference between what nursing facilities charge for a private room and semi-private room.

g. Establish a service credit bank as a small part of the comprehensive plan.

STATUS: Department on Aging has recently received a small grant that will be used to recruit volunteers. Establishing a service credit bank is one option.

2. Increase the use of local agencies, including local health departments, as providers of long-term care, especially in rural areas.

a. Provide funding to non-profit long-term care service providers for use in developing services such as in-home personal care.

STATUS: Local health departments have been used as providers of attendant care services in the SCA program. KDHE funds a cardiac risk reduction program.

b. Establish a health promotion prevention and wellness pilot project (e.g. Project Lively) in each planning and service area to establish programs on injury control, proper drug use, better nutrition, and improved fitness and provide dental, vision, hearing and foot care screenings (education).

STATUS: KDOA has designated 15% of one person's time to do health promotion activities. KDOA and KDHE have been jointly implementing a Healthy Aging seminar service. Project Lively is no longer a program of KDHE.

c. Start a grant-in-aid program of in-home support services for Older Kansans on a sliding fee scale. Match local funding.

STATUS: Senior Care Act program established in 1989 and now operating in thirteen counties.

d. Provide for an individual Kansas income tax credit for any person providing in-home care for a disabled person, whom the taxpayer claims as a dependent.

STATUS: HB 2033 (1991 session) passed by Public Health and Welfare and currently pending in House Taxation Committee.

3. Expand alternative sources of funding for long-term care, including private long-term care insurance programs.

a. Enact state standards for long-term care insurance.

STATUS: SB 132 (1987 session) passed in 1987 becoming effective January 1, 1988. Implementing regulations were adopted by Insurance Department in 1988. The Department is currently updating regulations.

b. Require that insurance policies that supplement Medicare coverage include coverage for home health aide services, for a minimum of $500 per year when the services are provided by a certified home health agency nurse and when the policy holder's physician certifies in writing that the services are medically necessary.

STATUS: OBRA 90 standardized Medigap coverage into 10 discrete packages. The National Association of Insurance Commissioners has developed new Medigap policy standards to guide state development of new standards which must be in place by the summer of 1992. Four of the ten packages cover at home care after a hospital stay.

4. Reduce the possibility that private pay nursing home clients spending jointly held resources to pay for nursing home care will leave a healthy spouse without resources to remain independent.

a. Fund Medicaid and HCBS services to cover increased caseload.

STATUS: SRS is currently providing adequate funds for these programs.

b. Enact a division of assets law.

STATUS: SB 264 (1987 session) passed in 1988. This was superseded by federal regulations in 1989. In 1991, SRS implemented the 300% SSI Cap which affects a portion of the population served by the spousal impoverishment provisions of 1989.

5. Address issues related to the training/education, continuing education, availability/distribution, and reimbursement of health and social service professionals and providers.

a. Create for a four-year period, a state level Health Personnel Task Group composed of representatives from the educational institutions, health and social services professions and provider organizations to assess the adequacy of current and projected health and social services, adequacy of current training/education programs, and related issues to ensure future requirements for adequate and appropriately trained personnel to staff the proposed long-term care system.

STATUS: IN 1986 AND 1987, the Administration on Aging and the Fund for the Improvement of Postsecondary Education funded the expansion of the gerontological curriculum development begun in Western Kansas to Iowa, Missouri, Nebraska, and Southeastern Kansas. No state level task group has been established.

b. Education for relevant health and social service professionals should contain mandated, structured content on gerontology and geriatrics.

STATUS: The Center on Aging became operational at the University of Kansas Medical Center on December 1, 1986. Since July 1, 1988, all senior medical students have taken a required four-week clerkship in Geriatric Medicine. KDHE implemented competency testing for nurse aides in 1990 pursuant to OBRA 1987.

to be be awarded each year, 100 scholarships are to be awarded to nursing students whose sponsors are located in rural areas. A sponsor can be any adult care home, any medical care facility, any psychiatric hospital, or any state agency which employs licensed practical nurses or licensed professional nurses.

f. Fund gerontological health care education for local health service agency staffs.

STATUS: The University of Kansas has received a $2.8 million grant from the National Institute on Aging to establish an Alzheimer's Disease Center.

Long-Range Implementation Plan 1990

1. Identify the types, prevalence, and severity of health and social characteristics of Older Kansans.

a. Identify and compile existing data on the health and social characteristics of Older Kansans.

STATUS: The Heartland Center on Aging prepared in 1991 a technical assistance document on the National Medical Expenditure Survey. The document presents national, regional, and census-division level estimates of characteristics of the non-institutionalized population for persons aged 60 or more and for persons aged 45 to 59. A method to produce State and local estimates is also presented.

b. Review existing data to identify deficiencies and gaps in relation to health and social characteristics of Older Kansans.

STATUS: To expand the In-Home Nutrition program, KDOA has requested in its FY 1993 budget submittal funding of $217,455 for 96,264 additional in-home meals. This request is based on the number of people on waiting lists for in-home meals as of September, 1991.

c. Review existing data to ascertain the prevalence and severity of health and social problems among Older Kansans.

STATUS: Blue Cross and Blue Shield of Kansas conducted a survey in 1987 of 1,00 Kansans, 67% age 64 and over, 33% in the 55 to 64 age group. Responses were broken out in four areas: marital status, health, finances and insurance.

The Kansas Coalition on Aging prepared "A Report on the Status of the Very Old in Kansas: A comparison with Selected States:" in January, 1990.

The Kansas Hospital Association prepared "Profiles of Kansas Hospitals" in 1990. Older patients accounted for 37.5 percent of hospital discharges in 1988. This was higher than any other age group under the age of 65.

STATUS: SRS continues to develop its Community-Based Long-Term Care program as a comprehensive package of services for adults who are functionally impaired due to disability or age.
Each Area Agency on Aging continues to provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers.

c. Require local long-term care plans by Area Agencies on Aging in collaboration with local elected officials, community service providers, and consumers.

STATUS: The Senior Care Act of 1989 requires that area plans "be developed with support of a local or regional coordinating committee comprised of representatives of senior organizations, home health agencies and health departments, department of social and rehabilitation services offices and other interested groups (K.S.A. 75-5928(b). The Administration on Aging funded three Project Care coalition building projects in Kansas in FY1992. These coalitions will develop an active plan to addres some priority unmet need for home and community-based service.

Short Term Coordination Plan 1987-1989

1. Extend case management services for the elderly to maintain them in their own homes.

a. Use the Kansas Department on Aging as the central or umbrella agency for channeling money to Area Agencies on Aging in order that they may provide or contract for case management services. The Kansas Department on Aging would be responsible for the development of case management . Area Agencies on Aging would designate a case management agency in each county in consultation with county commissioners, community service providers, and consumers.

STATUS: There is currently limited case management available in the state and many counties are uncovered. This is primarily due to lack of funding and services. An independent Kansas Case Management Association consisting of private and public funded case managers has been started.

It is the feeling of this group that there was little coordination between the 3 SRS pilot case management projects started in 1990 and local exisiting case management projects funded either through KDOA or with local funding.

b. Continue to involve family members in the case management process.

STATUS: KDOA submitted a proposal to the Administration on Aging to develop a "self-administered case management program" that would train individuals and families how to do case management for themselves, spouses and family members. The proposal was not funded.

c. Develop standardized assessment and standardized format for care plans and provide for on-going monitoring and follow-up.

STATUS: Assessment instruments and care plan formats remain unstandardized. Attempts to develop a standard assessment for the Senior Care Act and the SRS Homecare program were unsuccessful.

Long-Range Coordination Plan

1. Assure authority, funding, and staff for interdepartmental coordination through an Interdepartmental Council on Long-term Care (Option c).

a. The Kansas Department on Aging should have adequate funding and staff to develop, implement and provide a comprehensive, coordinated, community-based long-term care system for the State.

STATUS: Budgetary constraints have resulted in staff cutbacks in the agency. KDOA testimony on SB377 indicated that to adequately participate in the effort described above that staff and resources would need to be added to the agency.

b. Establish a Policy Board on Long-Term Care made up of experts in the areas of health services, social services and health planning for the elderly. This Board will report directly to the Governor and State Legislature.

STATUS: Not developed.

c. An Interdepartmental Council on Long-Term Care shall be established.

STATUS: KDOA is establishing a state eldercare coalition to plan for development of services for older persons at risk. This activity is a part of the Administration on Aging Project Care eldercare coalition demonstration program. Otherwise, this goal remainst undeveloped, other than the current activities of the Long-Term Care Action Committee.

Objective No. 1 "A continuum of long-term care services should exist in Kansas communities so that there are alternatives to institutional care."

STATUS: The development of a continuum of LTC services has been uneven at best. While an in-home service program based on a sliding fee scale was established, it receives very limited funding, operates in only 13 counties, provides only two services, and has waiting lists. Older Americans Act funding has not kept pace with inflation during the 1980's. Although the OAA was amended in 1987 to include Title III-D in-home services for frail older adults, only a token amount of funding has been provided. Income eligible home care services are about 30% fewer than they were in 1986. KDOA has required that a minimum of 20% Title III-B funds be used for in-home services.

SECRETARIES' ENDORSEMENT

We, the Secretaries of Kansas Department on Aging (KDOA), Kansas Department of Health and Environment (KDHE), and Kansas Department of Social and Rehabilitation Services, do hereby accept and endorse the recommendations and the substitute for HB 2566 as referred to in the LTC Action Committee's 1992 Report to the Kansas Legislature.

DATE 1/10/92

Joanne E. Hurst, Secretary of KDOA

DATE 1/10/92

Azzie Young, PhD., Secretary of KDHE

DATE 1-10-92

Donna L. Whiteman, Secretary of SRS

UPDATE OF ACTIVITIES AND RECOMMENDATIONS TO THE 1993 KANSAS LEGISLATURE RELATED TO LONG TERM CARE ISSUES

Developed Jointly by

Kansas Department on Aging

Kansas Department of Commerce and Housing

Kansas Department of Health and Environment

Kansas Department of Social and Rehabilitation Services

December 16, 1992

LONG TERM CARE ACTION COMMITTEE

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NOTE: The first time a word or phrase defined in the glossary is used in the document text, it is in bold type.

BACKGROUND

The Long Term Care Action Committee (LTCAC) was established in November, 1991, to bring key members of the Departments of Social and Rehabilitation Services (SRS), Health and Environment (KDHE), and the Department on Aging (KDOA) together to coordinate these agencies' activities on long term care issues. Due to concerns about the availability of non-institutional housing, an adjunct was added in October, 1992, from the Department of Commerce and Housing (KDOCH). Made up of senior staff members, the committee meets on behalf of the agency Secretaries to discuss shared long term care issues and to make recommendations to improve services to elderly and disabled Kansans. The departments presented to the Kansas Legislature a report with recommendations in January, 1992. Departmental staff continued to meet during 1992.

STATISTICAL DATA

The statistics reflected below indicate the continuing need for a comprehensive LTC action plan in Kansas and the difficult decisions that face our state:

* While Kansas families have the highest level of out-of-pocket health care expense in the nation ($2,530), Kansas spends the 44th lowest amount of all state and local monies on health.

* Kansas has the highest number of **long term care beds** (excluding ICF-MR beds) per 1,000 persons age 65+.

* Nationally, families headed by someone 65+ now spend over twice as much on out-of-pocket health care expenses as they did before Medicare was established.

* In 1989 Kansas ranked seventh highest in the length of average stay for Medicaid ICF (including ICF-MR) residents.

Sources: Reforming the Health Care System: State Profiles 1991, Revised Trends In States' Nursing Home Capacity, the Wall Street Journal, and State Elderly and Long Term Care Databook

These statistics indicate our current policy may be limiting options for elderly and/or disabled individuals to remain in their own homes. While the cost-effectiveness of developing and expanding alternatives to institutionalization may not always be immediate, the positive social rewards of assisting this population in maintaining their independence will be.

LEGISLATIVE ACTION

PREADMISSION ASSESSMENT AND REFERRAL

In reviewing state legislation still pending from the 1991 session, the LTCAC considered House Bill 2566, which included provisions for the prescreening of individuals seeking nursing facility (NF) care. In general, the bill required that most people entering a nursing facility be screened to determine if this was an appropriate level of care for their needs. Changes were made in the language of the bill to assure that the preadmission screening appropriately assessed the needs of the individual seeking care, included referrals to community based care when needed, and that a data base be established to track the needs of persons seeking adult care situations. Also the bill stipulated that no person was to be refused admission to an adult care home on the basis of this assessment and a resource guide to assist the elderly and disabled and their families select the correct level of care was to be published. Medicaid reimbursement for NF care is dependent on financial eligibility and medical need.

In late January, 1992, SRS Secretary Donna Whiteman presented the LTCAC's revised language in her testimony before the House Public Health and Welfare Committee which enacted "Substitute for HB 2566." After being amended in both the House and the Senate, Substitute for HB 2566 was further amended into Senate Bill 182 and subsequently approved by the legislature and governor.

SB 182 called for the adoption of a uniform needs assessment instrument by January 1, 1993. This instrument is to be used by providers of assessment and referral services to assist the elderly and disabled and their families in determining the right level of services and care needed when seeking admission to an adult care home. This same assessment will also serve as a means to collect data to determine the need for additional community based services. The "Kansas Preadmission Assessment and Referral Instrument" has been developed to meet both of these very important needs.

The instrument consists of questions concerning the elderly or disabled person's current living situation, health status, and ability to function. SRS has recently revised its Medicaid Preadmission Screening and Annual Resident Review (PASARR) contract with the Kansas Foundation for Medical Care (KFMC) to cover the administration of all preadmission assessments, including enrolling and training providers of assessment and referral, collecting and paying related fees, determining the assessment outcome, maintaining the data base, and providing management reports.

The provider of assessment and referral will be responsible for providing information to the elderly or disabled person concerning appropriate services. These services include those available in the community. It is believed that this information and the referrals for services will prevent unnecessary admission of individuals to nursing

facilities and also help identify alternative resources needed. Unfortunately, in many areas of the state, community services will not be available, resulting in premature admission to an adult care home.

Additionally SB 182 mandated adult care homes, medical care facilities, and physicians to provide information on community based resources available within the area prior to admission to a long term care facility. A "Long Term Care Resource Guide" is currently being developed by KDOA and will be made available to SRS Area Offices, medical offices, local health departments, senior centers, Area Agencies on Aging (AAA) and is to be given to anyone seeking or needing long term care. Funding for this guide was provided jointly by KDOA and SRS.

The guide is being broken down into two parts, one which provides general information about the types of community based long term care services available within the state and who might benefit from them, and one which gives specific organizations to contact about these services. In addition to services for the elderly, information about the state's independent living centers will be included to assist the disabled population in finding services. Eleven separate documents are being created so that each AAA planning and service area will have a guide addressed specifically to its constituents. KDOA anticipates that, with the assistance of SRS, KDHE, and the AAA's, the guides will be distributed by January 1, 1993.

A status report on the implementation of SB 182 will be provided to the legislature in March, 1993.

SENIOR CARE ACT

The 1992 Kansas Legislature appropriated in HB 2720 funding for a statewide **Senior Care Act** (SCA) program. Another bill, SB 674, lowered the local match requirement during the first year for new projects from one-to-one to one-to-two. AAA's have implemented the program in cooperation with a local or regional coordinating committee in 59 counties where local match was available.

Kansas State University completed the third annual evaluation of the SCA in September. The evaluation concluded: ". . . for every dollar spent by the state on SCA programs, the state saves $2.09 in the state's portion of potential Medicaid costs." In general, the Kansas State University reports that the SCA is "making in-home services affordable for many elderly Kansans who would otherwise be unable to afford them."

300% SUPPLEMENTAL SECURITY INCOME (SSI) CAP

The 1992 Kansas Legislature amended via SB 182 the 300% Supplemental Security Income cap on Medicaid eligibility for nursing facility care. Medicaid recipients who were residents of a nursing facility on September 1, 1991, and who subsequently lost eligibility in the period

September 1, 1991, through June 30, 1992, due to an increase in income, are to be considered to meet the 300% income eligibility test.

Bills proposing the removal of the cap, HB 2844 and SB 548, died in the Senate.

TRANSFER OF HOME CARE

The LTCAC did not support SB 54, transferring the SRS Home Care Program to KDOA. It was a higher priority to work on internal administrative issues and funding for the Home Care Program. KDHE did not take a stand on this issue.

SB 54 was killed by the Senate Public Health and Welfare Committee.

LONG TERM CARE COMMISSION

The LTCAC did not support SB 377, creating a Long Term Care Commission. The three state agencies responsible for the delivery of long term care services were working together and making progress.

MORATORIUM ON BEDS

The LTCAC did not support SB 2567, prohibiting medical assistance for new or converted NF beds because it: 1) compromised the availability of quality care, 2) limited choice, 3) did not realistically control NF costs in that it does not address the bed utilization issue, 4) did not promote community based services, 5) did not take into account variations throughout the state on the availability of beds based on geographic issues or demographics, and 6) indirectly sanctioned inadequate care.

HB 2567 died in the House Public Health and Welfare Committee.

DEPENDENT CARE TAX CREDITS

The LTCAC did not support HB 2033, authorizing tax credits for dependent care. The committee supported a tax credit for families caring for the elderly and/or disabled in their own homes. However, HB 2033 was considered too limited because: 1) it served only eligible HCBS clients, 2) benefits provided were untimely and inadequate, and 3) no realistic measurement of fiscal impact was available at that time.

HB 2033 died in the House Taxation Committee.

DATA BASE

KDOA and SRS are in the process of developing a data base on unmet need for community services as required by SB 182. Data collection begins January 1, 1993.

INTERAGENCY COLLABORATION

The LTCAC continues to meet on a regular basis and has expanded its membership to include the Department of Commerce and Housing. KDOA and KDHE staff have been represented on several committees established by SRS to assist with the implementation of SB 182. SRS provided matching funds for KDOA to develop the Resources Guides for SB 182. SRS will be meeting with KDOA to discuss a proposal for joint training for LTC Case Managers. Communication will continue regarding policy changes by one agency which can substantially impact another agency.

HEALTH INSURANCE COUNSELING

KDOA had its grant application for federal funds to establish a health insurance counseling program for Medicare beneficiaries approved. KDOA expects to begin to offer the counseling service in one area in the spring of 1993.

UPDATES AND RECOMMENDATIONS

The LTCAC continues to propose changes in service development, system reform, and interagency coordination for long term care. Below is an update and our recommendations on several important LTC topics:

SENIOR CARE ACT - Although additional state funds were provided in 1992 to expand Senior Care Act services from three planning and service areas to all eleven areas, only 59 counties currently have such services. Many other counties could not match the state funds. The state/local matching requirement increases from two-to-one to one-to-one next year.

> ***Recommendation:** Consideration should be given to funds being available to ensure provision of Senior Care Act services in all 105 counties. Exempt aging mill levies from the aggregate tax limit. Examine the impact of the matching requirement.
>
> ***Basis for Recommendation:** There continues to be an unmet need for these services which independent evaluations have shown to be cost effective.

INCOME ELIGIBLE HOME CARE PROGRAM - No additional funding for the **Income Eligible Home Care Program** has been received. SRS currently has or projects it will have waiting lists for services in several management areas. Implementation of SB 182 may increase waiting lists in other areas as well.

> ***Recommendation:** Consideration should be given to funds being available to ensure that all eligible persons can be served.
>
> ***Basis for Recommendation:** Current services levels for this program continue to be considerably below those of 1986 because funding has been reduced. It became necessary to establish a

priority system for services based on need and the availability of funding. A medical model based on functional levels was adopted to serve as a priority system.

Waiting lists and short-fall funding also adversely impact the Senior Care Act, which allows service to Income Eligible clients when there is a waiting list. This reduces services for those just over the Income Eligible guidelines, the original target for the SCA.

HOUSING OPTIONS - Although some growth has occurred, there continues to be significant gaps in the continuum of housing options that is necessary to complement the developing continuum of community based long term care services. This committee recognizes the need for quality nursing facilities when this is an appropriate level of care. However, we feel strongly that much work needs to be done to increase the availability of **alternative housing** solutions for the elderly and/or disabled. Within the last year, the number of facilities offering **intermediate personal care** (IPC) has increased from 21 to 27 facilities, and the number of licensed IPC beds has increased from 743 to 940 beds. There are now five facilities providing this level of care which are not affiliated with a nursing facility. This is an increase of three facilities.

The LTCAC has devoted considerable time during 1992 to housing issues. As previously mentioned, the committee has added the Department of Commerce and Housing (KDOCH) as an adjunct to facilitate the discussion of housing issues. KDOCH has recently published a Comprehensive Housing Affordability Strategy (CHAS) which incorporates a housing needs assessment done by KDOCH. Also, a directory of housing and supportive services is currently being developed by KDOCH. KDOA has submitted comments on the CHAS recommending that a portion of federal HOME funds be earmarked for alternative housing for the elderly. HOME funding cannot be utilized for alternative housing for the elderly unless such housing is indicated within the CHAS, and the identified population served falls within the guidelines outlined within the CHAS. **See DOCH/Housing Data Sheet, Attachment A.**

The four state agencies will cooperate in the development of a training program, including a "How To" guide, for interested communities and potential providers of residential care services. In addition, the regulations for **adult family homes** (Community Based Adult Family Foster Care) will be reviewed and possibly updated by the LTCAC. **See Alternative Housing Proposal #2, Attachment B.**

***Recommendation:** Subject to the results of a feasibility study, SRS will research and write a Medicaid waiver proposal to reimburse intermediate personal care home use in cases where the net cost is less than that of placement in an adult care home. See Alternative Housing Proposal #1, Attachment C.

Legislative approval should be granted to establish an elderly subsidized housing ombudsman program in KDOA subject to the availability of federal funds. Consideraation should be given to funds being available to start two **shared housing** projects in unserved areas and a deferred payment loan program for elderly home repairs and accessibility modifications. **See Alternative Housing Proposal #3, Attachment D.**

***Basis for Recommendation:** Medicaid reimbursement for intermediate personal care home services is available only in very limited circumstances. It appears that there will be instances where it will be cost effective to provide more comprehensive Medicaid coverage for IPC residents.

A lack of available information on starting and maintaining alternative housing solutions may be a deterrent to the development these cost effective services. Limits in the regulations for adult family homes may also be restrictive.

The availability of an elderly subsidized housing ombudsman can facilitate the "aging in place" of residents and delay or prevent movement to more institutional housing. Shared housing is available in only five counties. Expansion into other counties provides additional alternative housing options for the elderly. Home repair and accessibility modification programs help turn existing elderly housing into alternative housing and reduces the need for more costly housing arrangements. There is a very large unmet need in this area, particularly regarding accessibility modifications. Money provided under this program will eventually be repaid with interest.

***Divergence:** KDHE supports a moratorium on personal care beds and does not support the use of state funds to reimburse IPC homes.

ADULT DAYCARE & RESPITE CARE - **Adult day care** and **respite care** reimbursement rates under the Home and Community Based Services (HCBS) Medicaid waiver program have not been adjusted since 1985. KDOA, in cooperation with SRS and KDHE, prepared and submitted a grant proposal to the U.S. Health Resources and Services Administration to fund a respite program for people with Alzheimer's Disease. Congress appropriated funding for FY 1993. Further opportunities for funding may be available in the future.

KDHE's licensure regulations for nursing facilities contain provisions for adult day care services in nursing facilities. Twenty-nine NF's currently offer day care services. No state agency regulates adult day care services offered in sites other than NF's. Nursing facilities may provide respite care. Current regulations do not contain specific regulations for this service. Proposed licensure regulations contain a section devoted to respite care services. The

proposed regulations were written to encourage nursing facilities to offer this service.

*Recommendation: Consideration should be given for funds being available for these services to provide alternatives to NF placement.

Provide KDHE statutory authority to develop regulations to provide a framework for the development of adult day care services outside NF's and provide the public a mechanism for assuring quality in the services provided.

*Basis for Recommendation: Existing reimbursement rates result in limited provider participation in these programs. The lack of regulations may be a deterrent to the development of adult day care services.

COMPREHENSIVE RESOURCE INFORMATION - As funds were not appropriated in 1992, KDOA had to use Senior Care Act funds (matched by Medicaid funds) to pay for the resource directories.

*Recommendation: Consideration should be given for funds being available to update and reprint the resource directories without having to use Senior Care Act funds.

*Basis for Recommendation: The use of service funds to print and distribute directories reduces the amount of in home services provided under the Senior Care Act.

300% SUPPLEMENTAL SECURITY INCOME CAP - The 300% SSI cap remains in effect with certain persons with VA pensions and cost of living adjustments being made exempt from the cap.

*Recommendation: The 300% cap should remain in place.

*Basis for Recommendation: When the cost of care surpasses the ability of the state to pay for it, limits must be set. The cap provides cost savings to the state while still providing care for many needy Kansans.

*Divergence: KDOA recommends that the cap be repealed as the estate recovery law has removed much of the rationale for the cap. With the exception of limited examples where HCBS services have been provided, there exists no plan for providing care for people above the cap and in need of nursing home care.

TAX INCENTIVES - No review of Kansas' tax structure has taken place to evaluate potential incentives that could be created to encourage in-home care for the elderly and/or disabled.

*Recommendation: The 1993 legislature should review Kansas's tax structure as indicated.

*Basis for Recommendation: Appropriate tax incentives can encourage in home care for the elderly, which can delay nursing home admission and conversion to Medicaid.

MORATORIUM ON BEDS - After much consideration during the past year, the LTCAC reversed its stand on a moratorium on beds.

*Recommendation: A moratorium should be placed on the expansion of NF beds through construction, conversion from another licensure category, or the licensing of existing beds which were previously not licensed as NF beds. The conversion of adult care home beds to hospital beds should also be restricted. Protection from discrimination for Medicaid residents and applicants should be included in any cap. Housing options should be expanded as the moratorium is implemented.

*Basis for Recommendation: The cost of care at new facilities is traditionally higher than in older, established facilities. This results in higher Medicaid expenditures. Also, with fewer available NF beds, the expansion of lower cost alternative services will be encouraged. Hospital occupancy rates have decreased significantly over the past decade and conversion of adult care home beds to hospital beds is not necessary to meet need.

*Divergence: In addition to the moratorium on NF beds and adult care home beds being converted to hospital beds, KDHE supports a moratorium on IPC beds.

NEW RECOMMENDATIONS

CASE MANAGEMENT - The Senior Care Act (SCA) serves individuals in need of in home services such as homemaker and non-medical attendant care with monthly income above 150% of poverty (currently $827 for a one person household). SCA services are administered by the AAA's and are available in 59 counties in Kansas. Recipients of SCA services are charged a fee for services on a sliding scale.

During the 1992 legislative session KDOA received funding through state general funds and Title III-B of the Older American's Act to implement a statewide case management network through their 11 AAA's. Each AAA contracts for case management services in the best manner available in their area (such as through the local health department or through private case management services).

The Income Eligible (IE) homecare program serves individuals in need of homemaker, non-medical attendant, and case management services with monthly income at or below 150% of poverty. These services are available in all counties through local SRS offices at no charge. Funding for the IE program is state general fund and federal Social Services Block Grant funds. Should funding levels not meet the needs

for this program, the SCA program will serve this population. However, they will be charged for the services.

***Recommendation:** Consideration should be given to funds being available to maintain the case management program established in KDOA in 1992 and to provide adequate funding to SRS to provide continuing case management services for the IE program.

Funding should also include provisions for KDOA, KDHE, and SRS to coordinate a statewide case manager training program to ensure equity throughout the various programs and providers of these services. Additionally, a long term plan should be developed to coordinate case management services between KDOA and SRS, including the coordination of preadmission assessment and referral services with case management services.

***Basis for Recommendation:** Last year's KDOA appropriation included some non-recurring federal funds. Without additional state funds, current case management services provided by KDOA cannot be maintained. Case management will assist individuals seeking nursing facility admission but able to be served in the community to find needed services.

Cost savings will be realized through joint training efforts. Also, through training and cooperation, all case managers will be better aware of the wide range of programs available and who qualifies for each program, eliminating duplication and confusion.

FISCAL IMPACT

The committee recognizes the need for fiscal analysis of its recommendations. Analysis of any recommendation herein will be provided upon request by the legislature.

CONCLUSIONS

Through our action group's efforts, we have defined a vision of providing a continuum of care for the elderly and/or disabled and this effort will be further enhanced by our agencies' continued collaborations. We must emphasize the importance that the concept of an assessment and referral service system can only succeed if community based services are available as alternatives. Development of community-based services and the implementation of the assessment process must occur simultaneously to be truly effective and to limit the potential of adverse impact on a vulnerable population.

LONG TERM CARE ACTION COMMITTEE
1993 LEGISLATIVE UPDATE
GLOSSARY

1-2 Bed Adult Family Home (Community Based Adult Family Foster Care)	A private residence in which care is provided for not less than 24 hours in any week to clients who by reason of aging, illness, disease or physical or mental infirmity are unable to live independently but are essentially capable of managing their own care and affairs. No nursing care is provided by the adult family home.
1-5 Bed Adult Care Home	A facility which provides supervision of activities of daily living to residents, and may provide supervision and services by licensed nurses. **NOTE:** Sometimes the term "Adult Care" is used synonymously with "Long Term Care." If used in this manner, it will not include "1-5 Bed," which is a particular licensing definition.
300% Supplemental Security Income Cap	The income limit for qualifying for Medicaid nursing home benefits. If an individual's income is less than or equal to this amount, he may be eligible for Medicaid payment of nursing home expenses. If income exceeds this limit, no nursing home benefits can be provided although the person may still qualify for other medical benefits. The monthly cap as of January 1, 1993, is $1302.
Adult Day Care Center - Freestanding	A facility which provides day supervision, a meal, and social activities. Some medical services may also be provided.
Adult Day Care Center in Nursing Facility	A nursing facility may offer their services to clients needing day only care under their license as a nursing facility.
Alternative Housing	Non-institutional long term care. Includes a continuum of housing options and community based services.

Attendant Care Services	Medical attendant care provides medically-related services under the direction of a licensed health professional to clients in their private homes. Non-medical attendant care provides personal care which does not have to be directed by a licensed health professional (bathing, dressing, etc.).
Home Health Care Services	Home Health Agencies are licensed to provide skilled nursing services to clients in their private homes.
Homemaker/Personal Care Services	A variety of services including skilled health care, personal care, shopping, meal preparation, housekeeping, etc. which are provided to clients in their private homes.
Income Eligible Home Care Program	This SRS program is designed to provide services to individuals who are able to reside in a community based residence if some services are provided. Recipients must be at least 18 years old, have a need for in-home services based on a formal assessment and meet the program's financial criteria. The program currently serves individuals at or below 150% of poverty. Recipients do not have to be Medicaid eligible. Services included are homemaker, nonmedical attendant, residential services, and case management.
Intermediate Personal Care Home	A facility licensed to provide simple nursing care to persons who require supervision of activities of daily living, but do not require the direct supervision by a licensed nurse 24 hours a day.
Long Term Care Bed	A bed in a facility licensed by KDHE as a nursing facility or in a long term care unit of a licensed hospital.

Nursing Facility	A facility licensed to provide services to individuals who by reason of aging, illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves, and require accommodation in a facility staffed to provide 24 hours a day supervision by licensed nursing personnel. Nursing facilities may also choose to participate in the Title XIX Medicaid program.
Respite Care Services	A variety of services to provide temporary relief for a person caring for an elderly or disabled person.
Senior Care Act	A state and locally funded program of in-home services available through Area Agencies on Aging on a sliding fee scale to Kansans age 60 and older.
Shared Housing	A living arrangement in which two or more unrelated persons live together, each with their own private space but sharing common areas such as the kitchen, living room, laundry, etc..
Skilled Nursing Facility	A nursing facility which is certified by the Health Care Finance Administration (HCFA) as a skilled nursing facility and can provide care to residents under the Medicare program.

ATTACHMENTS

Department of Commerce and Housing
Housing Data Sheet

Background

Under Executive Reorganization Order #23, The Kansas Division of Housing was approved by the 1992 Kansas Legislature and formally created July 1, 1992, within the newly renamed Kansas Department of Commerce and Housing. The Division is headed by Undersecretary Dennis M. Shockley.

The Division of Housing combines a wide array of housing programs within a single entity, and provides the administration required in order to receive federal housing funding. Weatherization and Community Services Block Grant funding, formerly housed in SRS, currently form a part of the Housing programs/initiatives in the new Division. A 1-800 Housing Hotline number that may be utilized following December 1, 1992, will provide housing information to interested Kansans. A statewide Housing Services Directory will also be developed by the new Division.

Home Owner Rehabilitation and Rental Rehabilitation

The new $6.5 million Division of Housing HUD HOME program provides an emphasis on housing assistance for first time homebuyers, homeowner rehabilitation, rental rehabilitation, and tenant based assistance. Applications for homeowner rehabilitation must be made by city and/or county governments to HOME program staff during the funding cycle. Rental rehabilitation applications must be filed by Community Housing Development Organizations during the funding cycle.

The Community Development Division within the Department of Commerce and Housing has Community Development Block Grant funding that may also be utilized via applications from municipalities for the purposes of housing rehabilitation.

Home Repair Programs

The Weatherization program within the Division of Housing began with a small program to caulk and weatherstrip homes of low income families; it has presently evolved to a multi-funded program which inspects and repairs home for energy efficiency. The goal of the program is to decrease fuel consumption among low income families, with an emphasis on families who are elderly as well as individuals with disabilities. Homeowners as well as tenants are eligible for weatherization assistance through applications filed within Community Action Agencies, and other participating agencies throughout the state. Funding may be used to inspect homes, seal air leaks, repair or replace furnaces, install insulation, and make other repairs as appropriate.

Long Term Care Action Committee
Alternative Housing Proposal #2

To encourage the expanded use of alternative housing facilities, including shared housing and assisted living programs, for the elderly and disabled in Kansas, the LTCAC makes the following recommendations:

(1) The Kansas Department of Commerce and Housing (KDOCH) be invited to become an adjunct of the LTCAC for the purpose of providing guidance and expertise in the matters of housing and economic development.

The creation of a viable economic base for otherwise faltering local economies will help influence communities, corporations, and individuals to invest in the development and continuation of these facilities. Additional incentives, such as reasonable reimbursement rates, favorable financing, etc., should also be considered to promote interest in alternative housing plans.

Special attention will need to be paid to assure adequate medical facilities in the community and surrounding area. The population utilizing alternative housing facilities could possibly need higher levels of medical care than otherwise needed in the community. This should go hand-in-hand with the state's work to improve access to primary medical care in rural Kansas.

(2) The LTCAC create a training and technical assistance program to stimulate interest in developing cost effective and efficient alternatives to nursing facility care. Such alternatives include, but are not limited to, Adult Family Homes (Adult Family Foster Care), adult day care and respite care, and personal care facilities. A significant part of this program will be to provide information to the public which might otherwise not be aware of the benefits of developing housing alternatives for the elderly and disabled.

As part of this process, the regulations concerning Adult Family Homes need to be reviewed and, if necessary, revised to more adequately meet the housing needs of the elderly and disabled in Kansas. There is some concern that this is not an appropriate level of care for the clients it is serving.

(3) The LTCAC develop a guidebook for the above-mentioned training and technical assistance program.

(4) A comprehensive chart of all types of housing for elderly and disabled Kansans be created and maintained by SRS, with the assistance of the other agencies represented on the committee.

Included in the chart will be the continuum of care from private home care to nursing facility care, where facilities are located, what populations they serve, the number of available placements, and which organization(s) license or register them.

Once developed, this chart will be available for use in the training and technical assistance program as well as to others involved in the procurement of long term care for the elderly or disabled.

Long Term Care Action Committee
Alternative Housing Proposal #1

Although Kansas ranks very high nationally for the proportion of nursing facility (NF) beds per 1,000 persons age 65+, it ranks very low for the number of residential care (personal care in Kansas) beds. Personal care beds are less supervised than nursing facility (NF) beds and allow the residents more independence. They are also less costly than nursing facility beds. Current reimbursement for personal care beds through the Home and Community Based Services (HCBS) Waiver is limited to facilities with twenty or fewer beds. This requirement eliminates from Medicaid reimbursement most of the facilities licensed in this state as Intermediate Personal Care (IPC).

To increase the supply and utilization of personal care beds in Kansas, the LTCAC recommends that a feasibility study be conducted. The study will ask the following questions:

1. Is there a difference in the level of mental and physical functioning between residents in an IPC facility and those in an NF?

2. Are there Medicaid recipients in an NF whose level of functioning would allow them to reside in an IPC facility if reimbursement from the State of Kansas were available?

3. Is there a large enough pool of potential recipients to make this a cost effective alternative to NF placement for Medicaid recipients?

Methodology of the study will require the following:

1. A data collecting instrument will be developed using selected items from the Minimum Data Set Plus (MDS+).

2. Residents in a personal care unit of a long term care facility will be asked to participate in the study.

3. Residents who agree to participate will be asked to complete a permission form which will state that the data obtained will not contain resident specific identifiers to maintain confidentiality.

4. The nursing staff of the facility will assess the residents in an IPC facility using the modified MDS+ form and submit the data to SRS.

5. The assessment data will be encoded in a manner which will allow comparative analysis with the data obtained from the assessments performed in the IPC section with regular MDS+ assessments performed in the NF section.

Schowalter Villa, a facility with 111 licensed nursing facility beds and 49 intermediate care beds, has agreed to assist with these assessments at no cost to the state. Myers and Stauffer staff has agreed to encode the data and perform the requested analysis at no additional cost to SRS.

If the study proves successful in determining that a sufficient number of Medicaid NF residents could function in a personal care setting, then SRS would pursue establishing a Medicaid waiver for reimbursement for this level of care. Below is an example of how the program would work and the cost savings anticipated:

An average Medicaid reimbursement rate for an NF bed is $1600.00 per month. A typical private pay monthly rate for IPC care is $1000.00. The personal needs allowance for a personal care resident is set at $50.00 per month ($20.00 higher than that for a regular NF resident to provide an incentive for clients to use this level of care). To provide additional incentive for clients to use this level of care, estate recovery would not be applied for this program.

To provide incentive for providers, the state allowed personal care reimbursement level would be set at a higher percentage of cost than for NF care. For the purposes of this example, the level is set at 90% of the private pay rate. The resident's income is $800 per month.

EXAMPLE

NF Cost $1600		IPC Cost $900	
Resident Share . .	$770	Resident Share . .	$750
State Share . . .	$340	State Share . . .	$ 60
Federal Share . .	$490	Federal Share . . .	$ 90
TOTAL:	$1600		$900

Net state savings: $280 ($340 - $ 60)

In addition to allowing more freedom of choice to HCBS clients, the new reimbursement levels may also provide the opportunity for "relocating" existing Medicaid NF residents to the less expensive IPC level of care. If success is achieved in moving residents to IPC, then the program could be expanded to move residents to other community based LTC settings.

Long Term Care Action Committee
Alternative Housing Proposal #3

BACKGROUND

Although there has been much discussion in Kansas in recent years about the lack of a continuum of community based LTC services and the resultant very high utilization of expensive institutional LTC services, there has been relatively little discussion of a similar lack of a continuum of housing services. Too often older Kansans have faced the dichotomy of living in either totally independent environments (e.g. their own homes) or totally dependent environments (e.g. adult care homes).

Because the overwhelming preference (86% according to a national AARP poll) of older persons is to live in their existing dwelling for the rest of their lives and because those dwellings are the major living and health care environment for those persons even and especially frail older persons, this proposal will encompass developing alternative housing as well as adapting existing elderly dwellings to function as "alternative housing."

RECOMMENDATIONS

1. The state should consider a pool of $50,000 as seed money to start up two shared housing projects in unserved areas.

2. The state should consider a pool of $200,000 to start up a deferred payment loan program for elderly home repairs and accessibility modifications in selected areas.

3. The state should authorize (via enabling legislation) an elderly subsidized housing ombudsman program in the Kansas Department on Aging to be funded by a federal grant.

Kansas Association
of Homes for the Aging

Enhancing the quality of life of those we serve since 1953.

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Testimony

Presented to: House Appropriations Committee
The Honorable Rochelle Chronister, Chair
By: John R. Grace, President
Date: February 17, 1993
Re: HCR No. 5015

==========

We support HCR No. 5015.

Our growing elderly population, especially the persons 85 and older in Kansas, impacts the state budget dramatically since many programs are involved in funding services for the aging.

Kansas elderly citizens are asking: How can we use the dollars that are currently in the system to get better or improved services?

There are three major areas that could be evaluated in this study:

1) What are the costs associated with the duplication or lack of coordination that occurs among the state agencies of SRS, Health & Environment, and the Department on Aging, and the other state agencies that provide services to the elderly: KDOT, KDHR, Insurance, Commerce? There are a wide variety of programs and services that impact our elderly population that are currently offered independently by each state agency that if coordinated could be more effectively delivered and more efficiently delivered by a single state body.

Example: SRS has home care programs for $12 million for certain elderly persons; KDOA has a Senior Care Act program that also provides home care services for $1.2 million. Both are also providing case management.

Example: H&E conducts inspections of nursing homes; SRS spends $250,000 on Inspection of Care.

ATTACHMENT 12

2) What services are now being delivered by our government agencies that could be more efficiently and economically delivered by private organizations? Each state agency has a number of programs that are staffed and provided to elderly citizens. There are several programs that could be contracted to private organizations that would lower the cost of the operation or would provide more units of service delivered based on the existing dollars expended.

Example: SRS spends about $6 million on Home Care for income eligible elderly through SRS employees; perhaps these services could be contracted to private organizations.

3) What are the costs of current state regulations and interpretations of state and federal regulations for nursing facilities and home health agencies that exceed the federally mandated regulatory requirements? There are areas where Kansas exceeds the federal mandates for nursing home requirements which impact the cost of care in Kansas nursing facilities. In addition, there are areas of the regulations that the regional office of the Health Care Financing Administration enforces and emphasizes in the inspection of nursing homes that could be challenged with the help of our congressional representatives to impact and lower the cost of care in nursing facilities.

Example: Federal Government requires 75 hours of nurse aide training; Kansas requires 90 hours.

In conclusion, by reexamining the way we deliver these services, we should achieve some financial savings and make those services more accessible for the clients.

Thank you Madam Chair.

Testimony on HCR 5015
before the
House Appropriations Committee
by the
Kansas Department on Aging

February 17, 1993

The Kansas Department on Aging today offers its full cooperation in the proposed study by the Legislative Division of Post Audit.

I would like to briefly highlight some of our coordination activities and to offer the committee some ideas as it considers a study of aging programs.

Coordination

The resolution limits the scope of the study to three agencies. Other agencies are involved in the coordination of aging services. For instance, the Department of Transportation (which funds transportation services for older Kansans), the Department of Commerce and Housing (which has participated with the three state agencies named in the resolution in planning for housing alternatives for older Kansans), the Kansas Insurance Department (which regulates Medicare supplement and long term care insurance policies), the Commission on Veterans Affairs (which serves older veterans), the Department of Human Resources (which works with KDOA on employment programs), the Human Rights Commission (which enforces the age discrimination in employment act), and the Department of Revenue (which administers the Homestead Tax Refund). Just listing these agencies gives you some idea of the coordination efforts necessary to deliver "aging services" in Kansas.

Here are some examples of how the state has taken steps to eliminate or to avoid coordination problems:

- Legislative Division of Post Audit made a study in 1988 of transportation services for older adults and for people with a disability. The legislature subsequently passed the Kansas elderly and handicapped coordinated public transportation assistance act in 1989 and the Kansas coordinated transit districts act in 1992.

- 1992 Kansas Legislature authorized funds for statewide case management services. When the Department on Aging issued its request for proposals, the Department required that case management providers participate as members of the interagency coordinating committees established under the Senior Care Act. The request for proposal also stated:

  > Plans shall describe methods of coordination. New case management services shall not compete with or duplicate existing case management services. Where

ATTACHMENT 13

necessary, existing case management services shall be expanded with funds from this grant, using contracts for services.

- KDOA and KDHE have been commended for their partnership in promoting the health of older Kansans. The final report from Nancy Kaufman, a consultant funded by the National Resource Center on Health Promotion and Aging concluded (May 29, 1991):

> Kansas has had a long-term beneficial relationship between KDOA and KDHE, including using Prevention Block Grant funds to fund local public health agencies to conduct LIVELY (cardiovascular risk reduction) programs for older Kansans., The two agencies have also collaborated on Walking Kansas, pedestrian and driver safety programs for the elderly, and an innovative Healthy Aging Seminar Series for local health and aging providers. The cooperation and innovative programming is unique and should receive national recognition.

We hope to continue this relationship as we implement Title III, Part F of the Older Americans Act, which has provided new funding for preventive health services.

There have been times when the three state agencies have disagreed on program implementation and policy issues. For example, our 1992 and 1993 reports on long term care note our disagreement on the 300% cap on medicaid eligibility for nursing home care. Despite our disagreements, we have been able to work together on programs and policies. The Long Term Care Action Committee is an example of this cooperation.

Ideas for the Study

The Legislative Post Audit Committee can be assured that we will cooperate with a study of aging services. To be complete that study should recognize that aging services are not just federal and state programs administered by three state agencies.

Many aging services are funded by aging mill levies authorized under K.S.A. 12-1680. In 1992, 79 counties levied an average of .496 mills and generated $7,266,704 for aging services (KDOA IM 92-13). Counties also contribute to aging services from general funds; therefore, the $7 million from aging mill levies is a minimum estimate of the local share in funding aging services.

Local contributions are essential to KDOA services. Older Americans Act programs require a local match of 10 percent. The

Senior Care Act requires a local dollar for dollar match this year in three areas and next year in all areas of the state.

We recommend that the study also recognize the extensive network of volunteers who deliver aging services. Many of the managers at nutrition sites, the drivers of transportation services, the people who deliver meals to homebound people, and the information and referral resources are volunteers. Without them, the aging network would collapse.

Last year, the Department established a volunteer eldercare corps with a one-year federal grant and established a goal of recruiting 3,000 new volunteers. This year, we are establishing with another federal grant a health insurance counseling program using volunteer counselors. These programs are just two examples of how volunteers have been the backbone of the Older Americans Act service system.

Conclusion

We believe such a study should consider local and volunteer contributions because they are evidence of the leverage available to federal and state funds. The delivery of aging services requires coordination not only between state agencies but between state and local agencies and between formal and informal resources.

Caregivers still provide 80% of the care for older adults with disabilities. Most older adults are productively making contributions to their communities. To correctly assess the service delivery systems, we have to consider these contributions to understand the system's efficiency and cost effectiveness.

JEH:rd

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842-3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON APPROPRIATIONS
CONCERNING HCR 5015

February 17, 1993

Madam Chair and Members of the Committee:

Kansans for Improvement of Nursing Homes is a statewide consumer organization of approximately 800 members whose goal is to improve the quality of care and the quality of life in nursing homes and to do so at an affordable cost.

We understand and share the Legislature's concern about the rising costs of caring for the state's older citizens, particularly those who require nursing home care. We also appreciate the concern that the agencies providing these services do so as efficiently as possible.

We were encouraged by the recent recommendations of the Long Term Care Action Committee, which is a joint effort of the Department on Aging, the Department of Health and Environment, the Department of Social and Rehabilitation Services, and the Department of Commerce and Housing. This committee has made a good start at addressing common concerns. We hope they will continue working to explore cost effective alternatives for providing services and to develop a comprehensive Long Term Care Plan. KINH believes the Long Term Care Action Committee could be enhanced by inviting citizens, consumers, and local service providers to be actively involved in the development of local resources.

We would like to insert a word of caution regarding the contention that regulation and oversight are unnecessary and costly. The regulations that govern the care of the elderly and people with disabilities are minimum standards that serve to protect vulnerable people. Regulations provide a way for the state to ensure that it is getting good value for the $3 million per week it spends on nursing home care.

KINH supports HCR 5015 and we hope that it serves as the impetus for a truly comprehensive plan to meet the needs of older Kansans.

Respectfully submitted,

Sandra Strand

Sandra Strand
Legislative Coordinator

ATTACHMENT 14

Jefferson County Health Department and Home Health Agency

1012 Walnut — Hwy. 59, P.O. Box 324
Oskaloosa, Kansas 66066
(913) 863-2447

Our Hearts Are In The Right Place . . .

At Home In Jefferson County

ADMINISTRATOR
Debbie Nickels R.N.C.
County Health Officer

Senior Services in Jefferson County our Agency is involved with through:

KDHE:

Defines Kansas Laws for *Home Health, Nursing Homes, the Hospital (Regulatory)
Adult Abuse (Regulatory)

SRS:

HCBS (Provider)
Homemaker Services (Provider)
Medical Card
*Wellness Monitoring

KDOA and AREA AGENCY on AGING:

Administer Title III B and III D Grants
- Transportation
- Information and Referral
- Legal Aide
- Meals - Oskaloosa/Valley Falls
- *RHHA B & D
- *MSC

Administer Kansas State Funded Grants
- *Senior Care Act
- *Case Management

*Programs provided through Jefferson County Health Department, Home Health and Hospice.

SRS:

HCBS and Homemaker Programs income based

HCBS personnel are allowed to do personal care but do not have to be aides or trained. Question how closely they are supervised. Not following OSHA/Universal Precautions if providing personal care

HCBS is at times slow to get initiated

HCBS services may be coordinated by a Social Worker but they are not always knowledgeable in a client's physical care needs We asked to start a monthly coordination meeting with our local SRS staff on senior services to improve communication and discuss resources to keep Jefferson County residents at home.

ATTACHMENT 15

KDOA and LOCAL AREA AGENCY on AGING:
Administers grants to local agencies to provide services

A lot of client service dollars lost through Administration requirements

Currently through our Agency the clients using Senior Care Act services have income levels in the 20% and 30% range. Those in the 20% and possibly 30% levels may be eligible or are receiving Homemaker or HCBS services through SRS, except for the personal care we do.

The Senior Care Act is a new program for our county, we provide Attendent Care and Respite. For the Senior Care ACt, this fiscal year, the match was to be 2 - 1 (approximately 67% to 33%). Two state dollars for each local dollar. During the first four months, Oct., 1992 through Jan. 1993, the ratio was our **AGENCY - 57% to JAAA 42%.**

This just gives you a small overview of the difficulty in coordinating a few of the services for the elderly in our county.

RECOMMENDATIONS:

1. Agree that a review of agencies providing services to the elderly be conducted.

2. Include the local service providers in the review process to gather their ideas on how to decrease cost.

3. Determine a simplified mechanism for allocation of funding that decreases Administrative cost - i.e. change grant writing practices, quarterly vs monthly reporting, etc. (Specifically through KDOA) Suggest billing for services like we do through EDS. Put our funding into direct client services.

4. Assess possible options to combine services and consider local agencies that are State and Federally regulated, trained and supervised as an option of choice in providing appropriate long term care in the communities.

JEFFERSON COUNTY HEALTH DEPARTMENT AND HOME HEALTH AGENCY PROGRAM

Glossary of Terms

Senior Services

SRS - Social Rehabilitative Services

1. Adult Protective Services (APS) role is to investigate, assess risk and offer services to adults, 18 and over, in the community who are experiencing abuse/neglect, self-abuse/neglect or exploitation.

2. Homemaker Services provides such services as cleaning, laundry, shopping or cooking to persons who meet Social Service Block Grant income guidelines and have a verified need for the service due to physical handicaps. Eligibility and a plan of care are developed through an assessment process. Once approved for service, the client receives case management contacts on at least an annual basis.

3. Case Management Services assist eligible clients in gaining access to needed medical, social, educational and other services, to encourage the use of cost-effective medical care by referrals to appropriate providers, and discourage overuse of costly services for routine procedures. Case management provides the necessary coordination with the service providers.

   Case management may include the following function:

   - Evaluation and/or re-evaluation of level of care;
   - Assessment and/or reassessment of the need for waiver services;
   - Development and/or review of the plan of care;
   - Coordination of multiple services and/or providers;
   - Monitoring of quality of care;
   - Review of medical necessity of waiver services; and
   - Determination of cost-effectiveness of waiver services for an individual.

4. Home and Community Based Services (HCBS) provides a variety of services to persons who are: 1) eligible for Medicaid; 2) have been screened appropriate for nursing home care if HCBS services were not chosen. The screening team of nurse and social worker develops a plan of care to meet the client's needs, the cost of which cannot exceed the cost of nursing home care. Possible options in the plan of care include homemaker tasks as described above as well as non-medical attendant care, respite for caretakers, adult day health, night support, medical alert and wellness monitoring. Case management at least on a monthly basis is provided to HCBS clients.

Jefferson County Health Department, Home Health Agency and Hospice

1. Multiphasic Screening Clinics - Federal senior service program through Jayhawk Area Agency on Aging, funded by Kansas Department on Aging and Jefferson County mil levy. Provides health screening and educational services per protocol for 60 and older at 9 different sites in Jefferson County every month. Any age individual may request services during clinics. Donations welcome.

2. RURAL HOME HEALTH AIDE B - Federal senior service program through JAAA and funded by KDOA and Jefferson County mil levy. Provides in home personal care services 1 times a week to age 60 and older persons who do not need skilled care but need assistance to remain independent. No fee for service, donation only.

3. RURAL HOME HEALTH AIDE D - Same as above.

4. Senior Care Act - State senior service program through JAAA, funded by KDOA and Jefferson County mil levy. 1) Provides the same personal in home care services as RHHA B and D but is based on income. Case manager assesses community service need per protocol. 2) Provides short-term home based respite care to a client in lieu of the clients regular source of support up to 4 hours per week.

5. Case Management - State senior service program through JAAA funded by KDOA and Jefferson County mil levy. Provides personnel to design and implement a coherent service delivery program for an older person with multiple or complex needs who may be served by several discrete service providers. This includes actions which involve the creation of a care plan operation.

6. HCBS/Prescreening - SRS program where the Senior Service RN teams with SRS care worker to assess medicaid eligible persons whether at home or in a nursing home to see if the current living situation is appropriate for ADL abilities and caregiver resources.

7. Wellness Monitoring - SRS program where an RN assesses every 2 months a referred medicaid eligible person for response to their prescribed medical regimen where ongoing skilled nursing visits are not indicated through Home Health.

HH\SRCRACT\TRMGLSRY
10/19

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, Secretary

Reply to:

TESTIMONY PRESENTED TO

THE HOUSE APPROPRIATIONS COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Concurrent Resolution 5015

House Concurrent Resolution 5015 is a request that the Legislative Post Audit Committee direct a review of agencies providing services to the aging for purpose of discovering overlapping or duplication of services and determine the cost effectiveness and efficiency of such services. It is identical to Senate Concurrent Resolution 1607.

The Kansas Department of Health and Environment supports such an audit. Identifying and clarifying respective agency area of responsibility is paramount to good government. Even when action has been taken to reduce duplication, bureaucratic inertia tends to supersede such direction and duplication continues. A post audit report that will identify areas of duplication would provide both the executive and legislative branches of government information needed to eliminate duplication and enhance cost effectiveness.

It is recommended that House Concurrent Resolution 5015 be passed as proposed.

Presented by: Joseph F. Kroll, Director
Bureau of Adult and Child Care
Kansas Department of Health and Environment

Date: February 17, 1993

ATTACHMENT 16

STATE OF KANSAS

DEPARTMENT ON AGING
Docking State Office Building, 122-S
915 S.W. Harrison
Topeka, Kansas 66612-1500
PHONE (913) 296-4986
FAX (913) 296-0256

Joan Finney
Governor

Joanne E. Hurst
Secretary of Aging

February 17, 1993

The Honorable Rochelle Chronister, Chair
Appropriations Committee
Room 514-S, Statehouse
Topeka, KS 66612

Dear Representative Chronister:

Attached you will find testimony on House Concurrent Resolution 5015. I had hoped to be present to testify today but am not able to do so. This is sent to support the resolution.

Sincerely,

Charles Oldfather

Charles Oldfather, Chair
State Advisory Council on Aging

CO:ms

ATTACHMENT 17

Testimony on HCR 5015

by Charles Oldfather, Chair
State Advisory Council on Aging

February 17, 1993

The State Advisory Council on Aging supports HCR 5015 and recommends its passage.

The State Advisory Council on Aging has the statutory responsibility to advise the Secretary of Aging. Our members represent Kansas citizens, including older Kansans. We have always seen our role as broader than one agency. Our annual reports have reviewed programs throughout state government and made recommendations on programs administered by any state agency.

In our review of aging programs, we have sometimes found potential coordination problems. State agencies have been willing and able to coordinate programs to prevent unnecessary gaps in services.

For example, one of our State Advisory Council members served as a member of and information and referral services task force last year. The task force created a five-year plan for improving access to aging services. The Kansas Department on Aging adopted the plan in August as part of the State Plan on Aging.

One outcome of the task force has been a recent memorandum of understanding between the Kansas Department of Health and Environment and the Kansas Department on Aging. A copy is attached. We foresee better coordination between health and aging services because of our planning activities.

This is but one example where state agencies have been able to work with each other and with Kansas citizens to improve aging services.

Agreement Between for Office of Government and Community Relations of the Kansas Department of Health and Environment and the Kansas Department on Aging
January, 1993

WHEREAS, the Office of Government and Community Relations of the Kansas Department of Health and Environment set a goal in 1991 to enhance the working relationships within KDHE, with other public and private agencies, and the community to maximize health care and environmental services for citizens of Kansas.

WHEREAS, the Bureau of Adult and Child Care of the Kansas Department of Health and Environment serves as a member of the Interagency Committee and the Long Term Care Action Committee with representatives from the Kansas Department of Social and Rehabilitation Services and the Kansas Department on Aging.

WHEREAS, the Office of Chronic Disease and Health Promotion of the Department of Health and Environment has collaborated with the Kansas Department on Aging to promote healthy living by Older Kansans pursuant to Objective #8 of the FY 90 to 93 State Plan on Aging.

WHEREAS, the Kansas Department of Health and Environment has convened a Healthy Kansans 2000 Steering Committee, including the Secretary of Aging, to aid in the selection of priority issues for Kansas.

WHEREAS, the 1992 Kansas Legislature enacted legislation (New Section 2 of Senate Bill 182) requiring the Secretary of Aging to assure that each area agency on aging shall compile comprehensive resource information for use by individuals and agencies related to long-term care resources including all area offices of the Department of Social and Rehabilitation Services and local health departments.

WHEREAS, the five year information and referral/assistance plan adopted in August, 1992 by the Kansas Department on Aging as a State Plan on Aging amendment includes Goal IV, Objective 1: "The Kansas Department on Aging will establish interagency memos of agreement and/or understanding with state health agencies."

THEREFORE, the Office of Government and Community Relations and the Kansas Department on Aging, in order to increase coordination and cooperation at the state and local level, and thus to facilitate the development of comprehensive and coordinated service delivery systems enter into the following agreement:

The Office of Government and Community Relations and the Kansas Department on Aging jointly agree to:

(1) Inform each other of proposed changes in policy, program,

or activity that affect their respective constituencies;

(2) Convene a symposium for Area Agency's on Aging Information and Referral/Assistance staff and health care providers by October 1, 1993.

(3) Disseminate information such as the "Legal Guide for Senior Citizens," "A Caregiver's Guide to Alzheimer's and Related Disorders," "How to Select a Special Care Unit," and the comprehensive resource information compiled pursuant to Senate Bill 182 (1992).

(4) Collaborate with the Kansas Department on Aging Business and Aging Leadership Coalition to develop a network of professionals who have an interest in health care and aging from the business and aging community.

(5) Support the various activities of the bureaus and offices of the Department of Health and Environment as they work with the divisions of the Department on Aging.

This agreement shall be effective upon its execution, shall continue until June 30, 1998, and shall be automatically continued for an unlimited number of one-year periods thereafter until terminated by either party by written notice to the other party 30 days in advance of such termination. This agreement may be amended at any time by mutual agreement. Nothing in this agreement shall be construed as limiting cooperative activities to those described above.

Robert C Harder 1/22/93

Robert Harder, Ph.D. Date
Secretary
Kansas Department of Health
and Environment

Joanne E. Hurst 1/11/93

Joanne E. Hurst Date
Secretary
Kansas Department on
Aging

Pamela Johnson Betts 1/22/93

Pamela Johnson Betts Date
Director
Office of Government &
Community Relations
Kansas Department of Health
and Environment

Lyndon S Drew 1/11/93

Lyndon S. Drew Date
Director
Division of Planning, Policy
Analysis & Advocacy
Kansas Department on Aging

Testimony on HCR 5015

February 17, 1993

I urge the Committee to look at aging services from the consumer's perspective. That view of the world can be confusing and frustrating to someone who needs help but doesn't know where to turn.

Aging advocates succeeded in 1977 in creating the Kansas Department on Aging as a separate cabinet-level department of state government. Before 1977, the state unit on aging was a division of SRS. We fought for a separate department because older Kansans did not want to be lost in the largest department of state government.

The statute authorizing the Kansas Department on Aging envisioned a large role for the Department in aging services. The statute (K.S.A. 75-5908) gave the Secretary of Aging the powers and duties:

* To evaluate all programs, services and facilities for the aged within the state and determine the extent to which present public or private programs, services and facilities meet the needs of the aged.

* To evaluate and coordinate all programs, services and facilities for the aging presently furnished by state and federal agencies and make appropriate recommendations regarding such services, programs and facilities to the governor and the legislature.

* To function as the sole state agency to develop a comprehensive plan to meet the needs of the state's senior citizens.

Despite this statute, we find today that services are funded and delivered by many agencies; and, planning and coordinating the delivery of those services is fragmented. The state plan on aging, for example, is a sole function of the Kansas Department on Aging. The State Advisory Council on Aging, by statute (K.S.A. 75-5914(d)) reviews and comments upon this comprehensive plan. However, SRS is now developing a five-year plan for aging services in addition to the state's comprehensive plan and without the advice of the Council.

When planning is fragmented, the service delivery system is potentially inefficient and confusing. Older Kansans would much prefer to be served by a system where the Kansas Department on Aging delivered aging services through the aging network of area agencies on aging. From the point of view of older Kansans, the services, including transportation and in-home services, should be available through the same agency that plans and provides for our legal services and information and referral services.

ATTACHMENT 18

The 1992 Kansas Legislature enacted the Interagency Provision of Services for Children, Adolescents and Families Act. The Act provides for the regional interagency councils which will collaborate in the provision of services for children and adolescents in Kansas who require multiple levels and kinds of specialized services which are beyond the capability of one agency.

The aging network has already area agencies on aging which can coordinate the delivery of aging services. We can fulfill the intent of the advocates in 1977 by allowing these agencies to coordinate all aging services.

Marge Zakoura Vaughan, Vice-Chairperson
State Advisory Council on Aging