Approved: 2-2-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 28, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:
William Wolff, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Others attending: See attached list

Conferees appearing before the committee:

Robert Epps, Commissioner of Income Support and Medical Services,
Kansas Department of Social and Rehabilitation Services

Commissioner Epps, SRS, briefed the Committee on the background and implementation of the preadmission and referral program that is administered by the Kansas Department of Social and Rehabilitation Services. Prior to the implementation of this program, only 22% of Kansans were provided an assessment of their needs when faced with decisions regarding long term care. There are 16 training and educational workshops set up throughout the state, and over 1200 individuals trained in the month of December. As of January 15th, 378 assessors are available statewide with additional assessors added daily, bringing coverage to all but three counties of the state. Part of the complexity and confusion related to this program relate to the number of sanctions that were put into the bill last year. (Attachment 1)

Commissioner Epps stated the current status of the preadmission and referral program indicates 562 case reviews have been completed as of January 19, 1993, which is somewhat in line with the estimated number of assessments per month based on prior experience. The five-page document of the assessment is forwarded to the Kansas Foundation for Medical Care who then determines the level of care by applying the criteria established by SRS. The individual is then informed of the nursing facility, and the appropriate SRS staff is informed of the outcome within 24 hours. The individual can then choose to enter the nursing facility or given access to available community based alternative care.

In answer to a member's question, Commissioner Epps stated the number of nursing home diversions should be available in March. It regard to case reviews, an assessor can do five cases per day, approximately 35 minutes to an hour each. The results of the review are then sent to KFMC. Approximately 12,240 people a year will be seeking nursing home assessments, and the average assessment fee is $80 per person - 75% is reimbursed by the federal government. The amount of funding from the state comes out of the appropriations for the division of medical services. Available alternatives to nursing home care and private pay clients were also discussed. There are approximately 400 individuals on Medicaid that have been inappropriately placed. It was pointed out problems do exist where clients have to wait in a hospital several days prior to their release due to lack of screeners. The total amount appropriated for the first year is $1.5 million state general funds - the total administrative cost to date is $260,000.00, which is split between state and federal. These funds are used for training, contract work with KFMC, and one staff person within SRS. Money is also appropriated to the Department on Aging for the preparation of information.

A staff person from KFMC stated as of this date, there have been 859 cases where the assessments have been completed. Of that, there have been 17 cases where there has been a determination that the patient did not require nursing facility care. To get at an actual number of how many individuals were diverted from nursing facility care, KFMC cannot tell until after the data is completed. The actual number of diversions will not be available until the reports of management through the fiscal year are completed. Senator Langworthy requested this data be furnished to the Committee when it becomes available.

In response to a question regarding delays in receiving decisions from KFMC, Commissioner Epps stated it was regrettable, but delay is one of the problems experienced with the start-up of this program. Spend-down eligibility requirements and assisted living were also discussed. A staff member from SRS stated the average daily Medicaid reimbursement is approximately $50.00, and if an individual is private pay, he or she can still enter a nursing facility - if they are Medicaid, they may enter, but the program (SRS) will not pay for it. It was agreed that more information needed to be made available to the public in order to keep individuals from entering nursing homes because they are unaware of other alternatives available.

The Chair called for action on the minutes of January 13, January 14, January 19, January 20, and January 21, 1993. Senator Jones made a motion to approve the minutes as written, seconded by Senator Hardenburger. No discussion followed. The motion carried.

The Chair called attention to testimony submitted from Donna Whiteman, Secretary, SRS, that was distributed to the Committee on the moratorium on nursing facility beds. (Attachment 2)

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for February 2, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 1-28-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Jane Ford	1263 Topeka Blvd	Ks. Hosp. Assoc.
Larry W. Pitman	2947 SW Wanamaker	Ks Found for Med. Care
Dona Booe	DSOB - 628 So.	SRS / DMS
Joyce Sugrue	DSOB 628 S	SRS / DMS
Robert Epps	DSOB 628 S	SRS
Kathryn LeMosy	JAAA 1195 Buchanan	JAAA
Ellen Elliston	St. Francis Reg. Med. Cntr.	
Jan Anderson	929 N. St Francis	St. Francis
[illegible]	[illegible]	[illegible]
Kevin G. Yowell	DSOB Topeka	Dep't on Aging
Lynda Dunn	Topeka	KDOA
Joanne Hurst	Lawrence	KDOA
Katie Ryle	Topeka	CCTF-AARP
Patricia Maben	Topeka	KDHE
Annette Siebert	Topeka	KAHA
Marilyn Pflaum	✓	KANHAA
BJ Simpson	✓	KHCA
Michelle Lister	✓	Ks. Gov. Consult. Hosp.
Evy Templeton	✓	St. Francis Hospital Topeka
Myron Dunavan	Topeka	St. Long Term Care Ombudsman
Betty Dutton	Lawrence	Older Women's League, Lawrence
Ed Dutton	Lawrence	Do. Co. Advocacy Council on Aging
Freddy Oron	Topeka	American Institute of Architects

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 1-28-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Amy Hoch	Manhattan	Intern
Sandra Strand	Lawrence	KINH
Marilyn Bradt	Lawrence	KCOA
Harold Petty	Topeka	AARP-CCTF
Marvella Markley	Chanute	SEK-AAA
Rachella McBride	Chanute	SEK-AAA
Danielle Noe	Wichita	Wichita Hosp Assoc.
Kerry Townsend	Topeka	KS Hosp Assoc
Barbara Belcher	O.P.	Merck Home Health

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

Senate Public Health and Welfare Committee

Testimony on Kansas Preadmission Assessment and Referral Program

January 28, 1993

Madam Chairman and members of the committee, I thank you for the opportunity to present you with this testimony.

Program Background

Prior to the implementation of Preadmission Assessment and Referral program, only 22% of Kansans were provided an assessment of their needs when faced with decisions regarding long term care. In many of these cases, individuals were not aware of available alternatives to institutional care which met their needs. Medicaid reimbursement was provided to many of these individuals choosing institutional care when private resources were depleted. The cost of institutional care to Kansans during FY '91 was approximately $3,000,000 per week.

Preadmission Assessment and Referral services will provide Kansas with an opportunity to alter the trend of institutionalization to a community based system by providing data and information regarding individuals needs, alternatives for care and underdeveloped service areas. Individuals receiving this service are provided, free of charge, with a professionally administered assessment of need and assistance with referrals to sources which will help them maintain maximum independence.

South Dakota has operated a very successful Preadmission Assessment program reflecting a diversion rate from institutional care of 11.6% during FY '92. Applying this diversion factor to Kansas annual nursing facility admissions an estimated $3.5 million dollars ($1.5 million SGF) will be saved. Oregon, Minnesota and Arizona also operate successful Preadmission Assessment programs.

Implementation Plan

Amending the existing Kansas Foundation for Medical Care (KFMC) PASARR contract, an implementation plan was established, which included a recruitment and training program. In December, 1992, 16 training and educational workshops were presented in various locations across the state. These included educational workshops for nursing facility representatives; training workshops for individuals interested in subcontracting as private providers of preadmission assessment, and training workshops for SRS field staff who will serve as back-up assessors in the instance when privately contracted assessors are not available. Over 1200 individuals were trained during the month of December. Further training workshops are scheduled for the last week of January and the first week of February for individuals who were unable to attend previous workshops. These additional training sessions will provide opportunities for further community based assessors to enroll as providers.

Senate PHW
Attachment #1
1-28-93

S62 Case

Implementation Issues

The problems encountered with initial implementation included too few assessors in some parts of the state; extremely heavy telephone and fax traffic, causing some brief delays in the processing of completed assessment forms; and initial uncertainty by some hospitals and nursing facilities as to their responsibilities in relation to preadmission assessment.

As of January 15, 1993, there were 378 assessors available statewide. Additional assessors are being added daily, bringing coverage to all but three counties of the state. Nursing Facilities, SRS and community based providers will receive updated lists monthly or more often as warranted.

SRS field staff have been notified of their ongoing responsibilities in relation to preadmission assessment, and are assisting in recruitment efforts for community based assessors in their respective areas as well as providing assessments throughout the state.

The following individuals are exempt from receiving assessment and referral services entirely:
* Individuals admitted to an acute care facility from an adult care home and subsequently return to the adult care home.
* Individuals transferred from one adult care home to another.
* Individuals entering adult care homes conducted by and for the adherents of a recognized church or religious denomination which provides care for those dependent upon spiritual means, through prayer alone, for healing.

Other individuals being admitted to a nursing facility must receive Preadmission Assessment and Referral services prior to admission with the following exceptions:
* Individuals whose length of stay is expected to be less than 30 days based on a physicians certification.
* Individuals who are admitted to a nursing facility on an emergency basis pursuant to a physicians certification.
* Individuals who have made written request for Preadmission Assessment and Referral services and do not receive such services within ten days.

In each of these three situations, Assessment and Referral services must be provided "post-admission" to meet the requirements of the program and to determine if medicaid reimbursement will be available. Until the outcome of the assessment is known these groups of individuals should be treated as private pay residents by the nursing facility.

Hospital staff planning discharge to nursing facilities must recognize the importance of arranging and/or providing preadmission assessment and referral early in the discharge planning process to avoid unnecessary delays in discharge. Additionally, admission to a nursing facility by an individual may take up to ten days allowing time for the assessment and information/referral process regarding alternative community based services.

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

Senate Public Health and Welfare Committee

Testimony on the Moratorium on Nursing Facility Beds

January 28, 1993

Madam Chairman and members of the committee, I thank you for the opportunity to present you with this testimony.

Reasons for a Moratorium

SRS supports a moratorium that would prohibit additional nursing facility beds for at least five years. Kansas has the nations' highest number of licensed skilled nursing and intermediate care facility beds per 1,000 population age 65 and older. We estimate 87% of all licensed/certified nursing facility beds are in use. There is an overabundance of available beds in the state for new admissions which serves to increase long term care (LTC) costs. Institutional based LTC costs financed by the Medicaid program have doubled since FY 1987 and without effective policy changes these costs will continue to rise at a rate that cannot be supported by the state's current revenue system.

In 1986/87 the Kansas Department of Health and Environment Directory of Adult Care Homes listed 27,425 licensed adult care home beds versus 29,848 total beds licensed in the January, 1993 directory. A sample of 304 facilities from a data base we have maintained for casemix demonstration purposes indicates today that 29% are urban (metropolitan statistical area - Topeka, Lawrence, and Kansas City) and the 71% adult care homes are rural. Lastly, we estimate 64% are for-profit facilities while 36% are not-for-profit. This is generated from KDH&E's second quarter data as reported on KDH&E's Form 200.

Need to Control Costs

Control of growth in LTC beds is essential. A moratorium will help to control overall costs as the cost of care at new facilities is traditionally higher than at older, established facilities. The moratorium would include a prohibition on the expansion of nursing facility beds through construction, conversion from another licensure category, or the licensing of existing beds which were previously not licensed as nursing facility beds. The conversion of adult care home beds to hospital beds should also be restricted. While there has been no actual conversion of adult care home beds, we had seen some down sizing in the number of NF/MH beds to serve strictly the geriatric population and one large ICF/MR expressing a desire to convert to a nursing facility. To ensure successful implementation of a moratorium, the four agencies represented by the Long-Term Care Action Committee have made the following three housing proposals in their 1993 report to the legislature:

* Conduct a feasibility study on the supply and utilization of personal care beds (i.e., for individuals requiring domiciliary care and simple nursing care).

Senate PHEW
Attachment # 2
1-28-93

* Include the Kansas Department of Commerce and Housing in the development of creating alternative housing options; create a training and technical assistance program to stimulate interest in developing cost-effective and efficient alternatives to nursing facility care; develop a guidebook for the training and technical assistance program; and create and maintain a comprehensive chart of all types of available housing for elderly and disabled Kansans.

* Consider appropriations for adapting existing dwellings to function as "alternative housing".

There are 39 states with certificate of need (CON) program. The state of Minnesota, which has strong long term care community based programs, has a moratorium program.

Factors to Consider

1. If large Intermediate Care Facilities for the Mentally Retarded are to be phased out, a moratorium will prevent the conversion of these beds to nursing facility beds. Without the moratorium there is the potential for up to 655 beds to become licensed certified nursing facility beds.

2. The moratorium will eliminate building any new facilities, or expanding existing facilities.

3. In the past, nursing facilities have delicensed beds to ensure that the 85% minimum occupancy rule used to establish reimbursement rates would not have adverse effects on reimbursement. The intent of the 85% occupancy rule is an incentive for providers to maintain high occupancy levels. After the first year of operation 85% of the capacity of the facility or actual inpatient days (whichever is greater) is divided into the operational costs to determine the cost per day. Nursing facilities fluctuate the number of licensed beds according to their occupancy to maximize reimbursement. With a moratorium, the statewide occupancy figure will be stabilized and not distorted.

4. With a moratorium, occupancy rates increase from the current 87% statewide to a more efficient level. However, with implementation of "preadmission screening," it is anticipated that the rate of admissions will decrease. If the case mix reimbursement system is implemented, this too may have an impact on occupancy.

5. The immediate result of implementing a moratorium on beds would have no impact on existing nursing facilities and resident care. With an estimated growth rate of 2 1/2% in occupancy it would take over four years to fill the existing vacant beds in Kansas.

Summary

An effective moratorium policy relies heavily on stability. There has been some discussion of establishing a time-limited program here in Kansas. We recommend the moratorium be for five years to provide continuity and allow time for the effects of the preadmission assessment and referral program to impact available resources.

We are currently working with the revisor of statutes on a moratorium bill incorporating these recommendations. Should you have any questions, I will be happy to respond.

Donna L. Whiteman
Secretary

CASE MIX REIMBURSEMENT SYSTEM

The Kansas Nursing Facility Case Mix Demonstration Project is an integral part of a multistate project to develop and implement a payment system for nursing facilities that is linked to a quality of care monitoring system. The Case Mix system provides matching of resources to resident needs. (Attached to this document is a summary of current nursing facility reimbursement methodology.) The three major components of this project are Reimbursement, Quality Assurance, and Resident Assessment.

The nursing facility industry and associations have expressed concerns in the following three areas:

1. Statewide implementation of a case mix reimbursement system would jeopardize the health and welfare of nursing facility residents.

2. Although the original grant indicated the project would be "pilot", HCFA later changed the grant to indicate the project would be statewide.

3. Development of a quality assurance program for reimbursement and quality of care is not yet fully developed.

The concerns related to jeopardizing the health and welfare of residents and lack of a quality assurance program may be related to the perceived lack of development of a quality assurance program tailored to a case mix reimbursement system. The quality assurance portion of the project will be implemented simultaneously with the case mix reimbursement system.

The nursing home industry prefers the case mix reimbursement system be implemented as a pilot. HCFA will not approve a pilot program but will allow a statewide phase-in over a one-year period ending June 30, 1994. Using this phase-in process would provide more control in implementing reimbursement rate changes.

A Case Mix Reimbursement System will provide the following:

- Improved access to services for the acutely ill and Medicare eligibles.
- Improved program quality assurance system.
- Improved quality of care and, therefore, quality of life for residents.
- Improved equity of reimbursement rates among facilities.
- Improved data base for research and information on LTC issues.

The effect of Case Mix Reimbursement System on other programs will include:

- PASARR requirements of an annual resident review will be accomplished through the quality assurance system.
- Facilitate the tracking of individuals admitted to nursing facilities following Preadmission Assessment and Referral Services.
- Provides recipient information on care needs of residents to enhance the development of community-based resources.
- Decrease Medicaid expenditures to hospitals for extended stays for acutely ill patients.

Utilization of a reimbursement system based on resident service needs ensures equitable reimbursement to facilities and provides improved access for acutely ill patients while linking this reimbursement directly to quality of care.