Approved: 2-15-93
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 February 12, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Robert Harder, Secretary, Kansas Department of Health and Environment
John R. Grace, Kansas Association of Homes for the Aging
Donna L. Whiteman, Secretary, Kansas Department of Social and Rehabilitation Services
Don Moses, Kansas Coalition on Aging
Joseph F. Kroll, Director, Bureau of Adult and Child Care, Kansas Department of Health and Environment
Joanne Hurst, Secretary, Department on Aging
Sandra Stand, Legislative Coordinator, Kansans for Improvement of Nursing Homes, Inc.

Others attending: See attached list

Robert Harder, KDHE, appeared before the Committee to clarify certain financial holdings that had been disclosed and filed in an amended statement of financial interest. Dr. Harder stated from a regulatory standpoint the primary regulator of Wolf Creek is NRC, and urged members of the Committee to keep that in mind. After Committee discussion, Senator Salisbury made a motion the Committee reaffirm its previous action and recommend Robert C. Harder for confirmation as Secretary of the Kansas Department of Health and Environment, seconded by Senator Ramirez. The motion carried.

The Chair opened the hearing on **SCR 1607** - Request post audit review for agencies providing services for aging for overlap, duplication, efficiency and other areas.

John Grace, KAHA, appeared before the Committee and stated 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 by a single state body. 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 and both are providing case management, and H & E conducts inspections of nursing homes, as well as SRS. Other examples were given regarding duplication by various agencies. (Attachment 1)

Donna Whiteman, Secretary, SRS, briefed the Committee on the agencies that are responsibility for adult care home regulation in Kansas. 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. 12,500 persons had been served during the first six month of FY 1993, with a budget of $187 million. The Home and Community-Based Nursing Facility Program as well as Income Eligible Home Care Program were discussed. Information was also distributed to the Committee on recommendations of the Long Term Care Action Committee, which is a joint effort of the Department on Aging, the Department of Health and Environment, and the Department of Social and Rehabilitation Services. (Attachment 2) Committee discussion related to the possibility of SRS and H & E conducting nursing home medicaid audits simultaneously, coordinating Fire Marshal safety codes, moratorium of nursing homes, and area directors contracting at the local level.

Don Moses, Kansas Coalition on Aging, submitted written testimony in support of **SCR 1607**. (Attachment 3)

Joe Kroll, KDHE, stated the department does support coordinating services between agencies, and a post audit report would identify areas of duplication and provide both the executive and legislative branch of government information needed to eliminate overlap of services and enhance cost effectiveness. (Attachment 4)

Joanne Hurst, Secretary of the Kansas Department on Aging, appeared in support of the Resolution and stated the Department on Aging has taken steps to eliminate or avoid duplication of services and submitted testimony outlining those facts. Secretary Hurst concluded her testimony by stating the delivery of aging services requires coordination not only between state agencies, but between state and local agencies and between formal and informal resources. (Attachment 5)

Sandra Strand, KINH, appeared before the Committee and stated caution should be used when regulating the care of the elderly as 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. (Attachment 6)

The Chair announced the subcommittee on **SB 120** would be meeting in Room 527-S at 1:00 today.

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

The next meeting is scheduled for February 15, 1993.

# GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-2-93

| NAME | ADDRESS | COMPANY/ORGANIZATION |
|---|---|---|
| Barb Hinton | Topeka | Legis. Post Audit |
| Mary Blacker | " | AARP - CCTF |
| Lyndon Dunn | " | KDOT |
| Joseph Kroll | Topeka | KDHE |
| Joanne Ouest | Topeka/Lawrence | KDOA |
| Sandra Strand | Lawrence | KINH |
| Myron Dunavan | Topeka | St. Long Term Care Ombudsman |
| C. Kammen | " | KDOA. |
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Kansas Association
of Homes for the Aging

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

**Testimony**

Presented to: Senate Public Health and Welfare Committee
The Honorable Sandy Praeger, Chair
By: John R. Grace, President
Date: February 11, 1993
Re: SCR No. 1607

==========

**We support SCR No. 1607.**

Our growing elderly population, especially the persons 85 and older, in Kansas affects 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 three state agencies of SRS, Health & Environment, and the Department on Aging, all of which have programs and services for the elderly population? 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.**

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913-233-7443
Fax: 913-233-9471

Senate P. H & W
Attachment #1
2-12-93

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.**

Actually, there are other state agencies that provide services to the elderly: KDOT, KDHR, Insurance, Commerce. These programs should also be reviewed in this study.

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.

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

**Senate Public Health and Welfare Committee**
**Testimony on Senate Concurrent Resolution No. 1607**
**February 9, 1993**

Madam Chairman and members of the committee, I appreciate the opportunity to present you with testimony regarding Senate Concurrent Resolution 1607 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. $6.3 million was expended in FY 92.

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 below 150% of poverty. The Department of Aging serves persons 150% of poverty or above.

Donna L. Whiteman
Secretary

Senate PHEW
Attachment #2
2-12-93

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 | 2,347,833 | +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

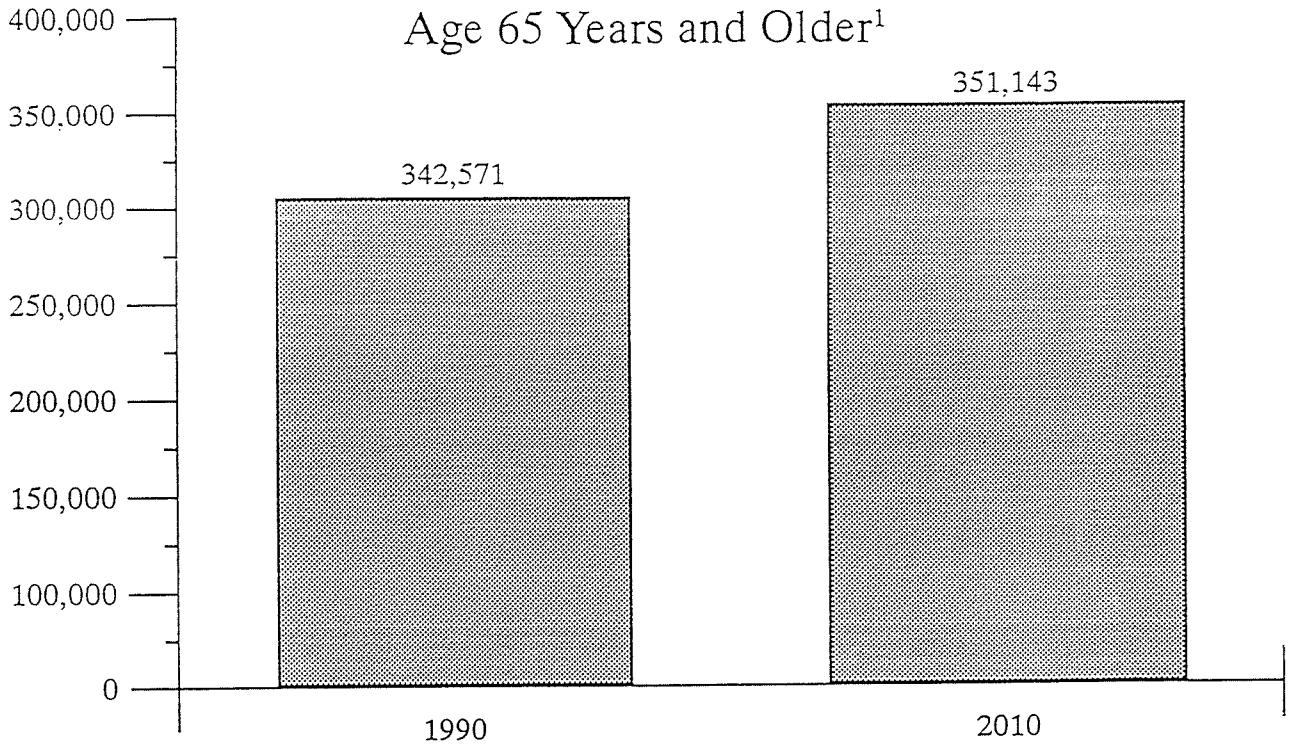
| | Population Over 65 | Percent | Percent of Total Area Population |
|---|---|---|---|
| Metropolitan Counties * | 149,399 | 43.6 | 11.2 |
| Non-Metropolitan Counties ** | 193,172 | 56.4 | 16.9 |
| State Total | 342,571 | 100.0 | |

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

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

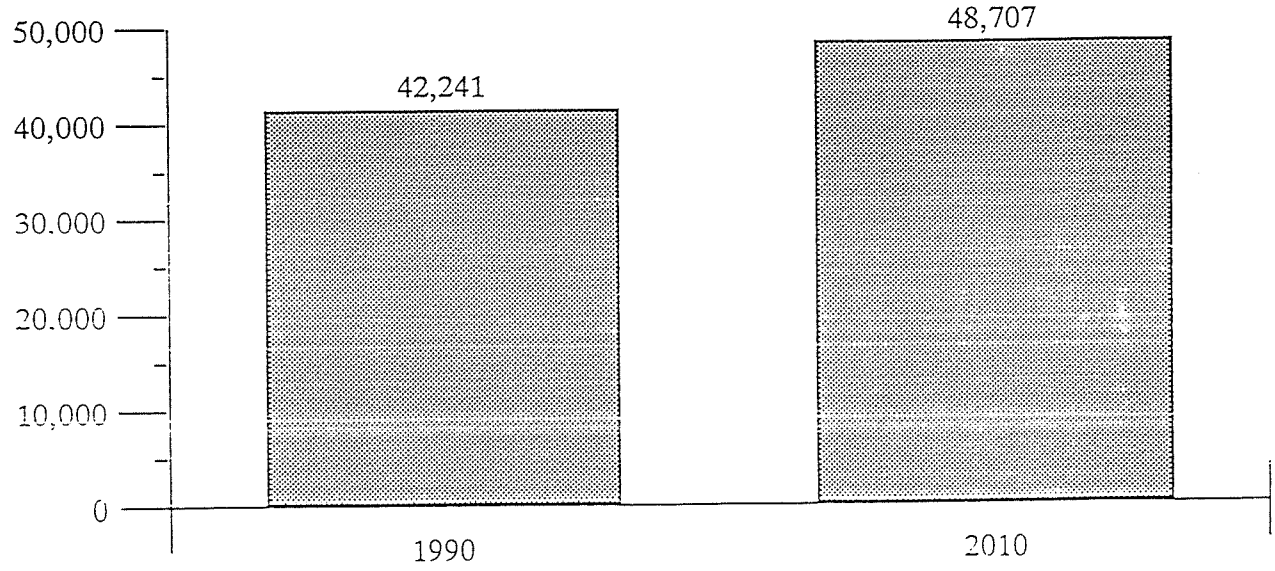
** All other counties

## 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.

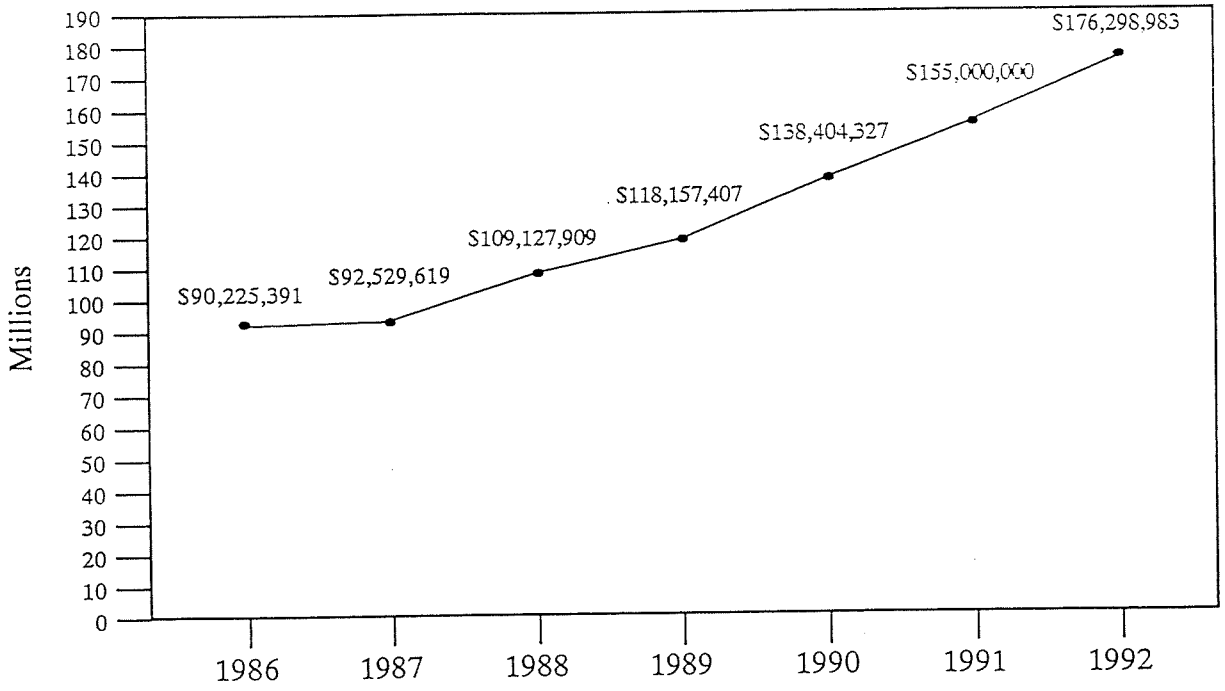
- Medicaid expenditures in Kansas have more than doubled in the last 10 years.

- 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).

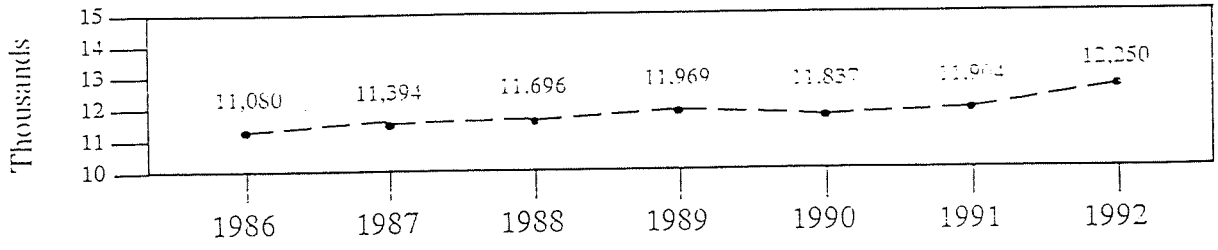
- Although adult care home costs have increased, the proportion of the Medicaid budget expended for adult care homes has remained fairly constant over the last ten years because Medicaid costs generally have also undergone significant increases. However, the regular Medicaid program has also undergone 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*

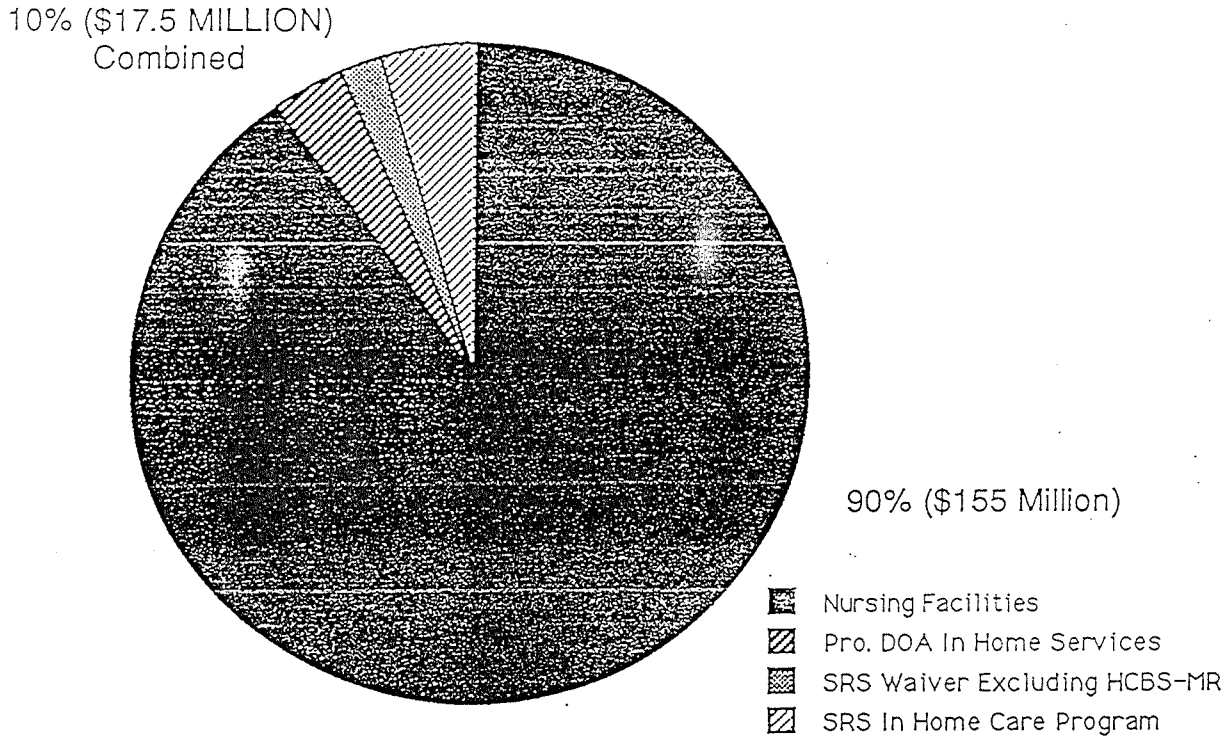



# Nursing Facility Medicaid Recipients: FY 1986-1992*




*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 by 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.

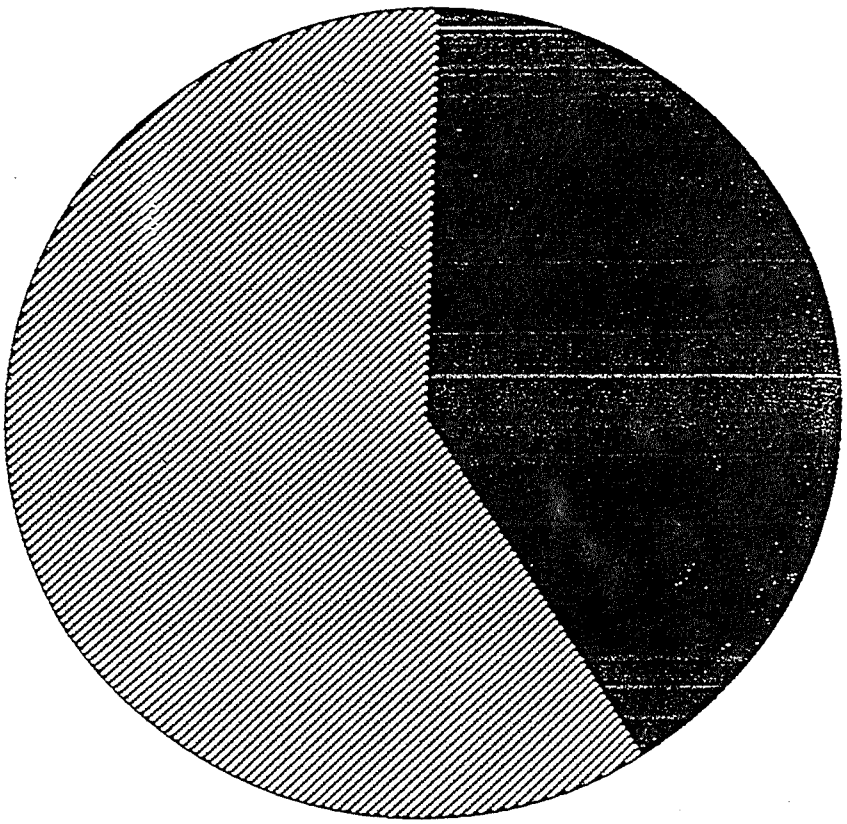
# Facility Ownership/January 1992

| | 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).

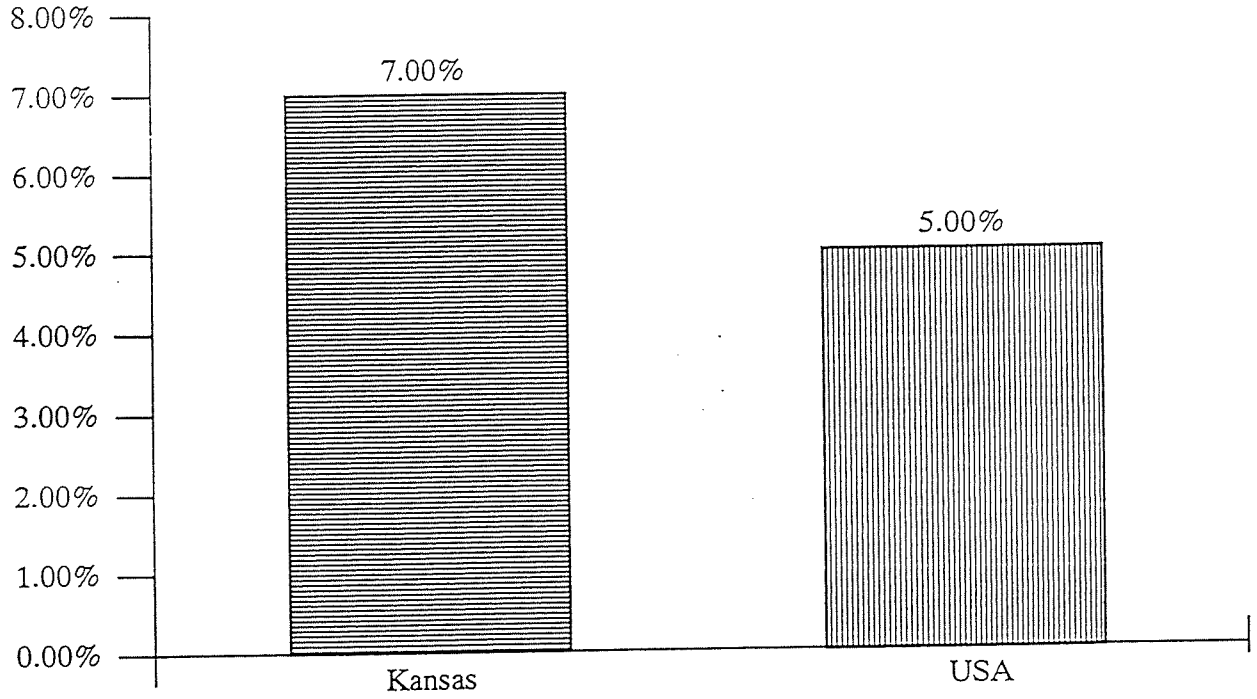
- The population 85+ is at the greatest risk of needing and using long term care services. In Kansas, the 85+ population is expected to increase from 42,241 in 1990 to 48,707 (a 15% increase) in 2010.

- 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).

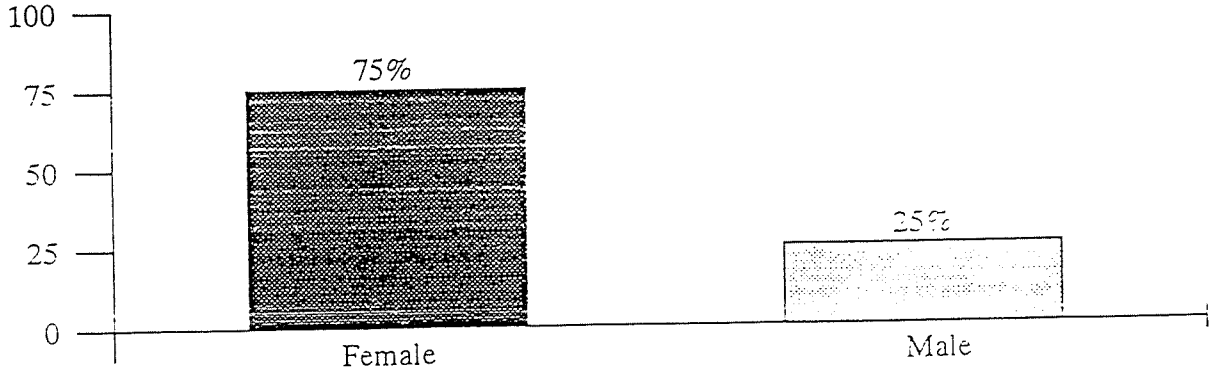
- Analysis of the 1985 National Nursing Home survey indicates that nationally, 78% of nursing home residents were found to need assistance with two or more activities of daily living (ADLs). 55% were severely impaired with four or more ADLs. But 20% of nursing home residents were judged to have no or 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.

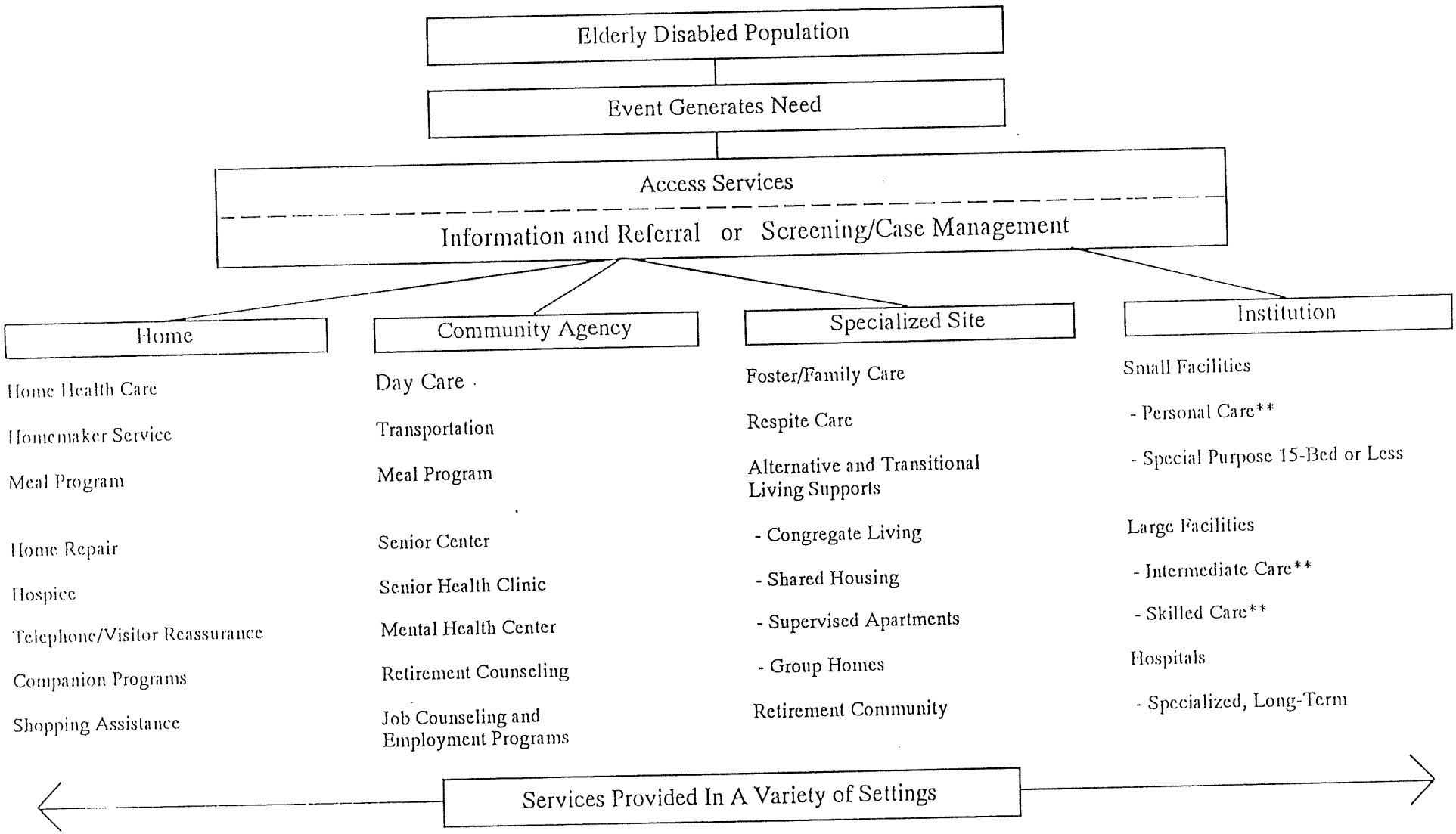
- Sixth, more options need to be developed for people who can't remain at home but really don't need the medical care available in a nursing facility. Other states have reported successful implementation of sizeable programs that fill this gap and are less costly than nursing facility care. Kansas SRS 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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U.S. Bureau of the Census Summary of Population Statistics, (1980).

# 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.

## LONG-TERM CARE ACTION COMMITTEE

**KDOA:**

Lyndon Drew
George Dugger
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**KDHE:**

Joseph Kroll
Patricia Maben
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Rita L. Wolf - Chair
Dona Booe
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# INDEX

## 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.

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# 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.

c. Increase the training of mental health workers and training of all health professionals to better understand current state of knowledge about mental health problems of the elderly and their treatment.

STATUS: The Kansas Plan for a Client Centered Community Based Mental Health System, September, 1989 contains the following action step: "Develop and facilitate statewide training for mental health professionals" (57). This action step would partially fulfill the goal to "increase interagency collaboration to better meet the mental health needs of the elderly." The report on implementation of the state plan (September 30, 1991) said, "Statewide training is still seen by the Special Populations Committee as an important part of developing appropriate mental health services for the elderly. The committee will continue to plan how to offer or facilitate training, with the support of Mental Health and Retardation Services and Department on Aging."

The annual conference of the Mental Health Association of Kansas on November 8, 1991 was devoted to training on mental health and aging.

The conference report on the U.S. Department of Health and Human Services FY 1992 budget encourages "the Department of Health and Human Services to provide funds for rural outreach programs which provide geriatric training by geriatric mental health specialists to individuals working with elderly persons, for the purposes of detecting mental health conditions common among the aged." Kansas State University Cooperative Extension Service plans to submit a proposal to fund a training program for rural geriatric mental health providers.

d. Review and establish a mechanism by which standards for continuing education programs containing gerontology-geriatric content are required as a condition for relicensure, re-registration, re-certification or continued employment for professional and other health and social service personnel who serve the aging population. A credentialling system for personnel not currently credentialled should be considered.

STATUS: The National Board for Certified Counselors, Inc., of Alexandria, Virginia, has initiated a certification process for professional counselors who specialize in assisting older persons. The National Board for Certified Counselors began accepting applications in January 1991.

Psychiatrists interested in specializing in geriatric psychiatry can be certified by the American Board of Psychiatry and Neurology. The Board administered the first geriatric psychiatry certifying examination in April 1991.

e. Review and recommend necessary changes in reimbursement policies to encourage health care and social service personnel to serve geographically underserved areas and to encourage students to enter training programs where shortages exist.

STATUS: The 1989 Kansas Legislature created the nursing student scholarship program (K.S.A. 74-3291 et seq.). Of the 250 scholarships

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.

The North Central/Flint Hills Area Agency on Aging conducted a long-term care needs assessment during the summer of 1990. A survey sought to assess functional need as well as formal service demand. The Kansas Commission on Veterans Affairs prepared a study of older veterans in FY 1990.

d. Develop and implement procedures for obtaining data on the health, functional, and social characteristics of Older Kansans.

STATUS: These procedures have not yet been developed.

e. Develop and implement a statewide data collection computerized data management system.

STATUS: The KDHE 1991 grant application to the Robert Wood Johnson Foundation to plan an integrated health information system was not approved. The establishment of a Kansas health care data system is the top priority of the AARP State Legislative Committee.

2. Provide a comprehensive, coordinated community-based long-term care system in Kansas.

a. Expand core services to encompass housing services (including home repair), emergency alert services including telephone reassurance), non-medical transportation, seven day congregate and in-home meals, legal services, and adult day care.

STATUS: The Department of Commerce is preparing a Comprehensive Housing Affordability Strategy. Gov. Finney is reorganizing the Department of Commerce to create a division on housing.

Senior Care Act regulations (K.A.R. 26-8-3) list residential repair and transportation for care services as priority services.

The Department of Transportation distributes $390,000 annually pursuant to the Elderly and Handicapped Coordinated Public Transportation Assistance Act (K.S.A. 75-5032 et seq.)

Pursuant to the Older Americans Act of 1965, Section 307(a)(22) as amended by P.L. 100-175 in 1977, the Kansas Department on Aging established minimum percentages for area agencies on aging to budget for legal services from the Older Americans Act III-B funds. The minimum percentage increased from 6% in FY 1989 to 7% in FY 1990 and 1991 to 8% in FY 1992 (KDOA PI-88-2, PI-90-2).

The Department of Education School Food Service Section now provides federal reimbursement monies from the Child Care Food Program to adult day care centers. The funds must be used to provide nutritious meals and snacks for enrolled participants in care.

b. Develop a comprehensive continuum of services. The list of services in the state Health Plan and the Harvey County long-term care plan, when combined, describe such a continuum.

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.

1/10/92
DATE

Joanne E. Hurst
Joanne E. Hurst, Secretary of KDOA

1/10/92
DATE

Azzie Young
Azzie Young, PhD., Secretary of KDHE

1-10-92
DATE

Donna L. Whiteman
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.<br><br>**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.<br><br>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.

## SECRETARIES' ENDORSEMENT

We, the Secretaries of the Kansas Department on Aging (KDOA), the Kansas Department of Health and Environment (KDHE), and the Kansas Department of Social and Rehabilitation Services (SRS), do hereby accept and endorse the recommendations of the Long Term Care Action Committee, with divergencies as noted, included in this Update of Activities and Recommendations to the 1993 Kansas Legislature Related to Long Term Care Issues.

December 17, 1992
Date

Joanne E. Hurst, Secretary of KDOA

12-17-92
Date

Robert C. Harder, Secretary of KDHE

12-17-92
Date

Donna L. Whiteman, Secretary of SRS

To represent the Kansas Department of Commerce and Housing (KDOCH) as an adjunct to the Long Term Care Action Committee, I have reviewed this document.

December 17, 1992
Date

Robert Knight, Secretary of KDOCH

**KANSAS COALITION ON AGING**
**1195 S.W. Buchanan**
**Topeka, KS 66604**

TESTIMONY PRESENTED TO
THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
CONCERNING SCR 1607

February 9, 1993

Madam Chairperson and Members of the Committee:
The Kansas Coalition on Aging appreciates this opportunity to comment on SCR 1607, requesting the Legislative Post Audit committee to direct a review of the programs and services affecting the elderly to determine whether those programs are duplicative, and whether they are serving their intended goals effectively and efficiently.

These programs are of the utmost importance to KCOA. Our positions support development of a complete range of long term care services, nutrition services, transportation services, protection from abuse, and housing alternatives appropriate to the needs of aging Kansans. Clearly it is in our best interest to assure that the programs already in place be operated effectively in every way, and that coordination among services and the agencies that provide them be of the highest order.

There are several programs we suggest might be of particular interest in such a study.

Adult family homes appear to have been used primarily for placement of mentally retarded or mentally ill clients, with little use as an alternative for the elderly. Indeed, the program has been relatively little used at all, due perhaps in part to the reimbursement rates that discourage potential providers. This is not to say that the adult family home should not be used for the mentally ill or mentally retarded, only to suggest that perhaps a segment should be more closely aligned with the elderly with input from the Department on Aging.

Adult abuse may need to be revisited in the light of greater emphasis on in-home care and community placements. Where does this program belong as it relates to the elderly?
We would urge a careful evaluation of the adequacy and allocation of funding for long-term care, noting, for example, that when the income-eligible home care program of SRS is underfunded, it may affect the Senior Care Act as well.

The above suggestions are not meant to imply that the programs are not well designed or efficient, only that in the light of our desire for a comprehensive plan of services for the aging

Senate PH&W
Attachment #3
2-12-93

community these are some in which further development or closer coordination might be of value.

KCOA supports SCR 1607 in the hope that it will provide a base to build a truly comprehensive plan to meet the needs of aging Kansans. We hope that if the review is approved, the organizations and individuals that comprise the aging community will have ample opportunity for further comment on the general outlines of the study.

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, Secretary

Reply to:

Testimony Presented to

The Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Concurrent Resolution 1607

Senate Concurrent Resolution 1607 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.

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 supercede such direction and duplication continues. A post audit report that will identify areas of duplication would provide both the executive and legislative branch of government information needed to eliminate duplication and enhance cost effectiveness.

It is recommended that Senate Concurrent Resolution 1607 be passed as proposed.

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

Date: February 9, 1993

Senate PH&W
Attachment #4
2-12-93

Testimony on SCR 1607
Legislative Post Audit Study of Aging Services

by the
Kansas Department on Aging

before the
Senate Public Health and Welfare Committee
February 9, 1993

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

## History of Coordination

The issue of duplication and overlap of services has arisen before. In these instances, we have taken steps to eliminate or to avoid 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.

- 1986 Kansas Legislature passed a resolution (HCR 5052) requiring the secretaries of Aging, Health and Environment, and SRS to jointly develop a comprehensive plan for providing community alternative long-term care services for the elderly including "methods of coordination of efforts among the appropriate state agencies and between the state agencies and community agencies." The three agencies submitted the plan in December, 1986. The three agencies submitted a status report as an appendix to their 1992 recommendations to the Kansas Legislature on long term care.

- 1989 Kansas Legislature authorized the Senior Care Act with a provision (K.S.A. 75-5928(b)) requiring that 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." In addition, K.S.A. 75-5935(a) requires the Secretary on Aging to establish and appoint an interagency coordinating committee "to advise the secretary on implementation of the program developed under [the senior care] act." Our 1992 House Appropriations Subcommittee emphasized these provisions when it recommended the expansion of the program statewide (Subcommittee Report on HB 2720, 1992, p. 4).

Senate P. H&W
Attachment #5
2-9-93

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

- When the Department on Aging issued policy (KDOA PI-91-3) in 1991 for funds granted under the Older Americans Act, Title III, Part G for elder abuse, the Department emphasized coordination:

  > Prevention activities must be coordinated with SRS Adult Protective Services, KDHE Bureau of Adult and Child Care, and the Long Term Care Ombudsman Program. All publicity must refer reports of institutional abuse to KDHE's toll-free number (1-800-842-0078) and reports of noninstitutional abuse to SRS Adult Protective 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.

KINH Kansans for Improvement of Nursing Homes, Inc.

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

**TESTIMONY PRESENTED TO**
**THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE**
**CONCERNING SCR 1607**

**February 12, 1993**

Madam Chairperson 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 state funding for nursing home care. We also appreciate the concern that the agencies providing services to the agencies 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 on 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 word of caution on the subject of so-called "unnecessary and costly regulations and oversight." 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. Neither cost effectiveness nor efficiency will be achieved by eliminating such protective regulations.

Respectfully submitted,

Sandra Strand

Sandra Strand
Legislative Coordinator

Senate PH&W
Attachment #6
2-12-93