Approved: 3-31-93
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 March 17, 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:

Donna L. Whiteman, Secretary, Kansas Department of Social and Rehabilitation Services
Stephen A. Menke, President, Mobile Care, Inc., Great Bend
Melvyn Weissman, Executive Director, Shalom Geriatric Center, Kansas City, Missouri
Mark A. Buhler, Member, Board of County Commissioners, Douglas County
Richard Reding, Life Care Services Corporation, Des Moines, Iowa

Others attending: See attached list

Action on **SB 402** - Ambulatory surgical center defined.

Staff explained balloon of **SB 402** showing a proposed amendment pertaining to language that would be in compliance with medicare regulations on page 2, line 1, after the period, insert: "Before discharge from an ambulatory surgical center, each patient shall be evaluated by a physician for proper anesthesia recovery." (Attachment 1) Senator Walker made a motion to adopt the balloon amendment, seconded by Senator Papay. The motion carried. Senator Walker made a conceptual motion that a 24-hour stay for a patient who stays over into the next day would only be charged for one day. Committee discussion related to the patient that would need to be retained overnight if surgery is performed in late afternoon at a surgical center, and the bill as written refers to a 24-hour maximum stay. If the patient needs to be retained longer than the 24 hours, then the patient would be transferred to a hospital. Senator Walker withdrew his conceptual motion. Senator Langworthy made a motion **SB 402 as amended** be recommended favorably for passage, seconded by Senator Papay. The motion carried.

Hearing on **SB 405** - Restrictions on medical nursing facilities.

Donna Whiteman, SRS, expressed support for **SB 405** with suggested amendments as outlined in her testimony and a balloon of the bill. Secretary Whiteman provided statistical information on the rising number of nursing home residents since 1987, and she noted that this type of growth and cost cannot be allowed to continue without additional dollars to pay for that population. She emphasized that a moratorium on nursing facility beds is necessary to create a stronger focus on community-based services for long-term care while controlling growth of LTC beds. The moratorium proposed in the bill would include a prohibition on the expansion of nursing facility beds through construction, conversion from another licensure category, or the licensing of existing beds which were previously not licensed as nursing facility beds. One proposed amendment would recommend the moratorium from its current version of five to three years to provide continuity and allow time for the effects of the preadmission assessment and referral program to impact available resources. (Attachment 2) In answer to a member's question regarding closing a county home and building a new facility, and if that county would be allowed to replace those beds, Secretary Whiteman stated the bill would limit their ability to do that. In regard to a question of substandard facilities attracting residents and jeopardizing the quality of care that people would receive, Secretary Whiteman stated that there are stringent regulations of the nursing facility industry by the federal government and all facilities would have to comply with those inspections and regulations and make those beds "quality beds." Secretary Whiteman stated that even with Kansas' aging population, Kansas currently has enough beds to go for five years without another bed and still have access to care for all those that need care. It was noted the issue may be if these beds are in the right locations. The doubling of cost is associated with having 420 nursing facilities and more beds than needed -- the law of supply and demand is not working. It was

requested by a member that a comparison be made of other states that have the approximate older population as Kansas with the number of nursing home beds in existence, and also the number of beds currently vacant in Kansas and where they are.

Stephen Menke, Mobile Care, Inc., appeared in support of **SB 405** and stated the bill would provide a stimulus to develop alternatives to traditional care. (Attachment 3)

Melvyn Weissman, Shalom Geriatric Center, appeared in opposition to **SB 405** because construction would not be allowed of their assisted living housing project on the Jewish Community Campus located in Overland Park which would if the bill goes into effect. (Attachment 4)

Mark A. Buhler, Douglas County Commissioner, appeared in opposition to **SB 405** and expressed concern that the county-run facility scheduled to be closed and that the moratorium on building new nursing homes would endanger Douglas County's initiative to provide better beds at a lower cost. (Attachment 5)

Richard Reding, Life Care Services Corporation of Des Moines, Iowa, also expressed concern that passage of **SB 405** would deny construction and licensure of a 35-bed facility called Claridge Court in Prairie Village. (Attachment 6)

The Chair announced that hearing on **SB 405** would be continued on Friday, March 19th.

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

The next meeting is scheduled for March 18, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 3-17-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Wendell Strom	Topeka	AARP-CCTF
Sandra Strand	Lawrence	KINH
Jim Byrn	Topeka	KHCA
John Kiefhaber	Topeka	Ks Health Care Assn.
George Goebel	Topeka	AARP-SLC-CCTF
MARK BUHLER	LAWRENCE	DOUGLAS COUNTY
MARIOT GENDREAU LENZI	COLUMBIA, MD	Boehringer Ingelheim
DARREN WEICHERT	TOPEKA	AKH
Marija Boyd	Topeka	Sen. Jerry Moran
DOUG FOSTER	WICHITA	
Bob Williams	Topeka	Ks. Pharmacists Assoc.
Lyndon Dunn	Topeka	KDOA
Alan Cobb	Wichita	Wichita Hospitals
John Peterson	Topeka	Ks Assn of Home & Aging
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
KAY LeMOSY	Topeka	JAAA
SUE ARMSTRONG	TOPEKA	QSEP
Andrea Burcham	Caldwell	
James Ford	Topeka	Ks. Hosp. Assn.
Joseph F Kroll	Topeka	KDHE
Robert C Harder	Topeka	KDHE
Stan Teasley	Topeka	KDHE
Steve Mark	Great Bend	Mobil Co

Session of 1993

SENATE BILL No. 402

By Committee on Ways and Means

3-2

AN ACT concerning medical care facilities; relating to ambulatory surgical centers; amending K.S.A. 65-425 and repealing the existing section.

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

Section 1. K.S.A. 65-425 is hereby amended to read as follows: 65-425. As used in this act: (a) "General hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have a variety of medical conditions.

(b) "Special hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have specified medical conditions.

(c) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(d) "Governmental unit" means the state, or any county, municipality, or other political subdivision thereof; or any department, division, board or other agency of any of the foregoing.

(e) "Licensing agency" means the department of health and environment.

(f) "Ambulatory surgical center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physician services ~~and~~ *during surgical procedures and until the patient has recovered from the obvious effects of anesthetic and at all other times with physician services available whenever a patient is in the facility; with continuous* registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accom-

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modations for patient to stay ~~overnight~~ *more than 24 hours.*

(g) "Recuperation center" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide treatment for patients who require inpatient care but are not in an acute phase of illness, who currently require primary convalescent or restorative services, and who have a variety of medical conditions.

(h) "Medical care facility" means a hospital, ambulatory surgical center or recuperation center.

(i) "Rural primary care hospital" shall have the meaning ascribed to such term under K.S.A. 65-468 and amendments thereto.

(j) "Hospital" means "general hospital," "rural primary care hospital," or "special hospital."

Sec. 2. K.S.A. 65-425 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

Before discharge from an ambulatory surgical center, each patient shall be evaluated by a physician for proper anesthesia recovery.

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

Senate Public Health and Welfare Committee

Testimony on the Moratorium on Nursing Facility Beds (SB 405)

March 17, 1993

****

SRS Mission Statement

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

****

Madam Chairman and members of the committee, I thank you for the opportunity to present you with this testimony in support of Senate Bill 405.

SRS supports a moratorium that would prohibit additional nursing facility beds, KSA 39-923 (a)(2) and intermediate personal care homes, KSA 39-923 (a)(3) (sometimes referred to as assisted living). Kansas has the nation's highest number of licensed skilled nursing and intermediate care facility beds per 1,000 population age 65 and older. We estimate 87% of all licensed/certified nursing facility beds are in use. Institutional-based LTC costs financed by the Medicaid Program have doubled since FY 1987; and, without effective policy changes, these costs will continue to rise at a rate that cannot be supported by the state's current revenue system.

We are proposing to delete the definition of permanent financing in its entirety. We believe that any such provision should be related to the actual commencement of construction and not evidence of permanent financing. Between the passage of this bill and its effective date, it will not be difficult for the more established providers to secure permanent financing as defined in SB 405.

We propose to amend the definition of commenced construction. The language we propose was used in the Kansas Certificate of Need Program and provides a much tighter definition of commencing construction. Essentially the language would reflect that commenced construction means the sponsor has:

(1) Provided the state agency with a copy of the construction contract which specifies the date by which actual construction is scheduled to begin and the date by which it is scheduled to be completed;

(2) Provided evidence to the state agency demonstrating that the sponsor has the funds available to complete the project; and,

(3) Provided documentation to the state agency that physical construction has begun.

Senate P H & W
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With regard to a provision for a waiver in Section 3, we are recommending that any directive to the Secretary of Health and Environment to develop regulations providing for waivers from the moratorium be stricken from this bill. We believe a moratorium will be most effective if it is iron-clad and has no loopholes. A facility which is destroyed by natural disaster, fire or other casualty, is not prohibited from rebuilding under the language of this bill; and these are the only circumstances in which new construction should be allowed. However, if it is decided to leave the waiver provision and not remove it from the bill, the Secretary of Social and Rehabilitation should be named to develop regulations providing for waivers.

We support the protection from discrimination for Medicaid residents and applicants for medical assistance in the Medicaid Program. We recommend an amendment to the bill that would indicate no nursing facility shall discriminate against recipients of medical assistance who apply for admission to a participating nursing facility on the basis of source of payment. Except as otherwise provided by law, all applicants for admission to such facilities shall be admitted in the order in which such applicants apply for admission. We have labeled this new Section 3 to replace the former section 3 that would have allowed for a waiver.

In 1986/87 there were 27,425 licensed adult care home beds compared to 29,848 total beds licensed in January, 1993. A sample of 304 facilities indicates today that 29% are urban, and 71% are rural. We estimate 64% are for-profit facilities while 36% are not-for-profit. Implementing a moratorium would have no immediate impact on existing nursing facilities and resident care. With an estimated annual growth rate of 2 1/2% in occupancy, it would take over four years to fill the existing vacant beds in Kansas.

A moratorium on nursing facility beds is necessary to create a stronger focus on community-based services for long-term care while controlling growth of LTC beds. There are 39 states with a Certificate of Need (CON) Program. The State of Minnesota, which has strong long-term care community-based programs, has a moratorium program.

The moratorium proposed in Senate Bill 405 would include a prohibition on the expansion of nursing facility beds through construction, conversion from another licensure category, or the licensing of existing beds which were previously not licensed as nursing facility beds. An effective moratorium policy relies heavily on stability. There has been some discussion of establishing a time-limited program here in Kansas. We recommend the moratorium be amended from its current version of five to that of three years to provide continuity and allow time for the effects of the preadmission assessment and referral program to impact available resources.

Session of 1993

SENATE BILL No. 405

By Committee on Ways and Means

3-3

AN ACT concerning medical nursing facilities; limitations on new and converted uses.

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

Section 1. As used in this act:

(a) "Medical ~~nursing~~ facility" means a ~~nursing~~ facility, except it does not include any ~~nursing~~ facility that is operated as an intermediate care facility for the mentally retarded, ~~or a continuing care contract home~~. as defined in K.S.A. 39-923 (a) (2) and (3),

(b) "Bed" means an equipped location at which a patient, client or other individual may receive 24-hour-a-day board and skilled nursing care and treatment.

~~(c) "Nursing facility" means a nursing facility as defined in subsection (a)(2) of K.S.A. 39-923 and amendments thereto.~~

~~(d) "Continuing care contract home" means a home as defined in subsection (c) of K.S.A. 1992 Supp. 40-2231 and amendments thereto where a provider, as defined in subsection (d) of K.S.A. 1992 Supp. 40-2231 and amendments thereto provides continuing care under a continuing care contract, as defined in subsection (a) of K.S.A. 1992 Supp. 40-2231 and amendments thereto.~~

(c) ~~(e)~~ "Commenced construction" means ~~all necessary local, state and federal approvals required to begin construction have been obtained, including all zoning approvals and contracts for construction have been signed.~~ the sponsor has:

(1) Provided the state agency with a copy the construction contract which specifies the date which actual construction is scheduled to begin a the date by which it is scheduled to be completed;

(2) provided evidence to the state age demonstrating that the sponsor has the fu available to complete the project; and

(3) provided documentation to the st agency that physical construction has begun.

~~(f) "Permanent financing" means the owner of the project has a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans or the owner demonstrates sufficient assets, income or financial reserves to complete the project with less than 50% in outside financing.~~

Sec. 2. On and after the effective date of this act:

(a) No license as a ~~nursing home under subsection (a)(2) of K.S.A. 39-923 and amendments thereto and no certificate of registration as a continuing care provider under K.S.A. 1992 Supp. 40-2235 and amendments thereto shall be issued for a~~ medical nursing facility shall be issued for a

which, after the effective date of this act, (1) is constructed, (2) is created by conversion from another licensure category, (3) enlarges the licensed capacity of an existing medical ~~nursing~~ facility, or (4) changes a place which is not a medical ~~nursing~~ facility, ~~including any existing nursing facility that is operated as an intermediate care facility for the mentally retarded~~, into a medical ~~nursing~~ facility, except nothing in this subsection (a) shall apply to facilities which have commenced construction on the effective date of this act ~~or have permanent financing on a project on the effective date of this act~~.

or to an adult care home operated un provisions of K.S.A. 39-941.

or prior to

(b) (1) No medical ~~nursing~~ facility beds that are for all individuals shall be converted to medical ~~nursing~~ facility beds exclusively for individuals receiving mental health care and treatment.

~~(2) No medical nursing facility beds that are exclusively for individuals receiving mental health care and treatment shall be converted to medical nursing facility beds that are for all individuals.~~

~~Sec. 3. The secretary of health and environment may adopt rules and regulations with the concurrence of the secretary of social and rehabilitation services and the secretary on aging which establish procedures and standards under which the secretary of health and environment may grant a waiver of the limitations on the granting of licenses on an individual, regional or state wide basis.~~

Sec. 3. No nursing facility shall discriminate against recipients of medical assistance who apply for admission to such facility on the basis of source of payment. Except as otherwise provided by law, all applicants for admission to such facility shall be admitted in the order in which such applicants apply for admission.

~~Sec. 4.~~ 3 The provisions of this act shall sunset on July 1, ~~1998~~ 1996.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

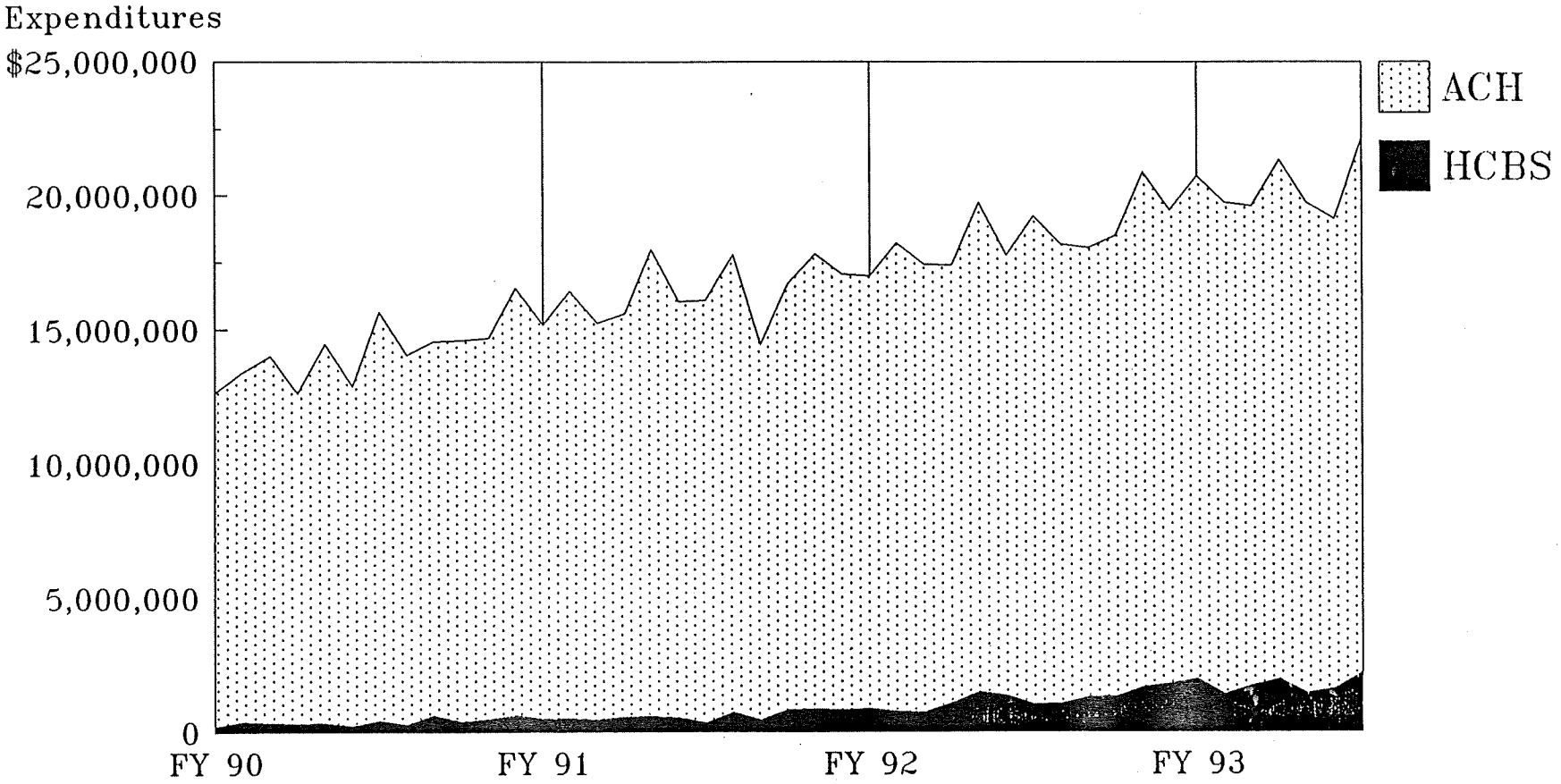
LONG TERM CARE ACTION COMMITTEE
1993 LEGISLATIVE UPDATE
GLOSSARY

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

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

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

TABLE II
LONG TERM CARE EXPENDITURES *
FY 1990 – FY 1993 (thru January, 1993)



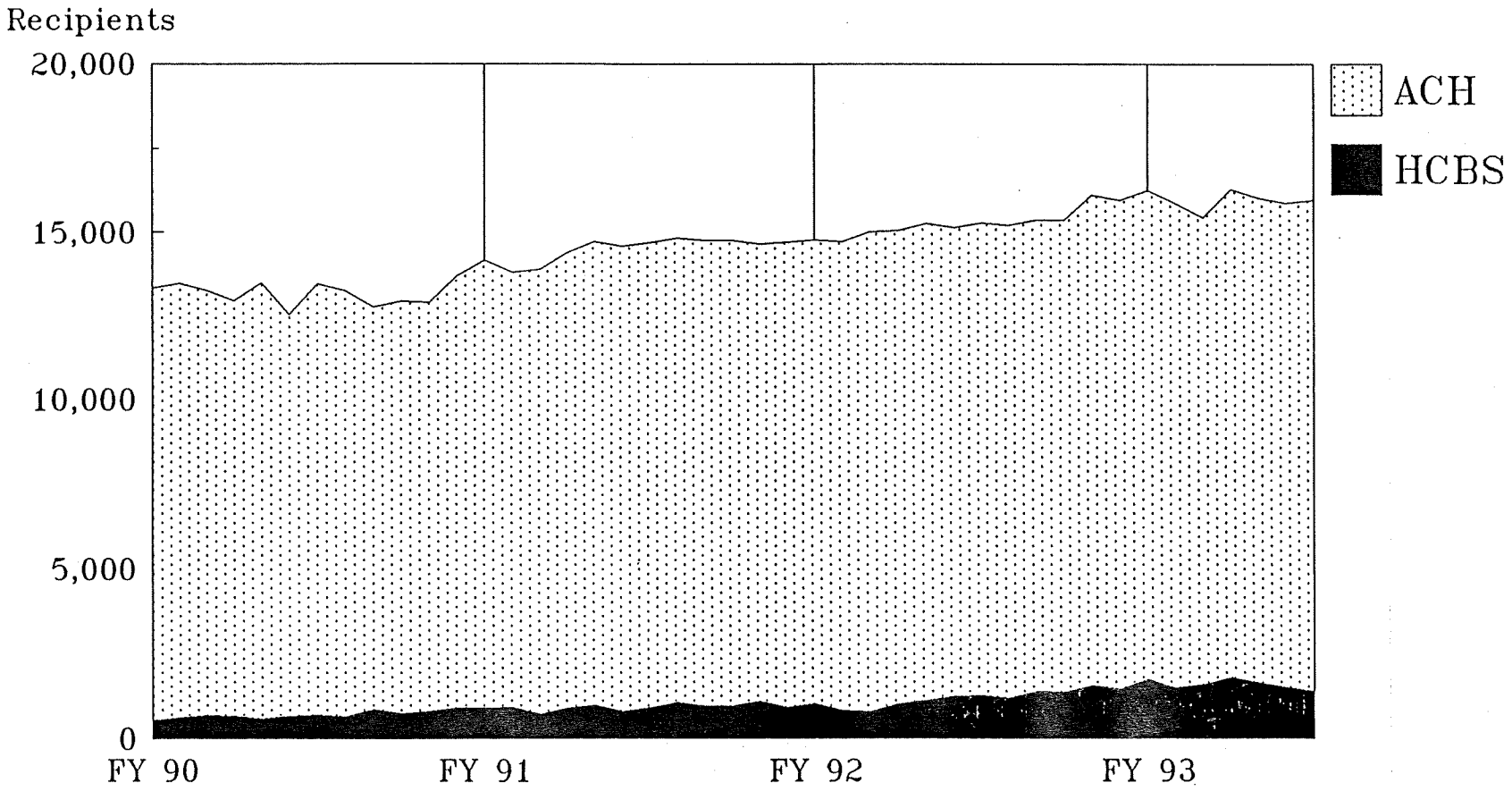
Source: MAR FY 1990 – FY 1993
Prepared by: SRS Mgmt Srvcs 2/93

ACH = Adult Care Home
HCBS = Home and Community Based Services
* Based on Payment Processing Timetable

TABLE I

LONG TERM CARE RECIPIENTS

FY 1990 – FY 1993 (thru January, 1993)

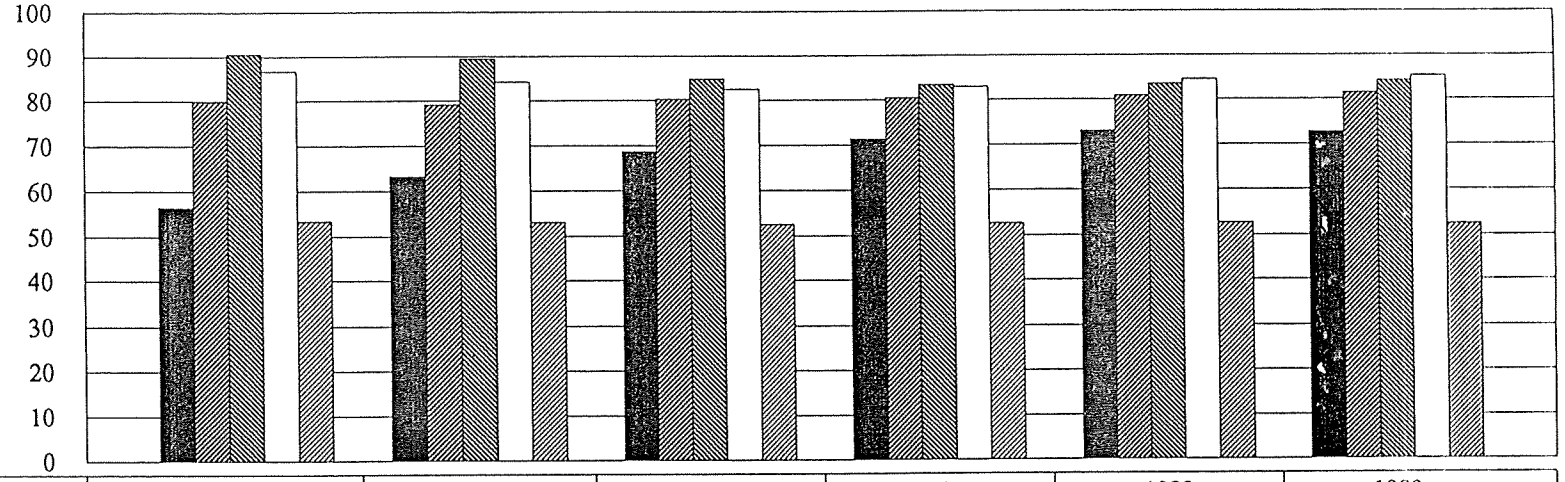


Source: MAR FY 1990 – FY 1993
Prepared by: SRS Mgmt Srvcs 2/93

ACH = Adult Care Home
HCBS = Home and Community Based Services

Number of Licensed Nursing Facility Beds Per 1,000 Population

Age 65 and Older, 1978-1989



STATE	1978	1981	1984	1987	1988	1989
Missouri	56.52	63.2	68.67	71.35	73.07	72.79
Iowa	79.92	79.09	80.29	80.5	80.91	81.44
Nebraska	90.51	89.35	84.71	83.37	83.38	84.19
Kansas	86.66	84.25	82.42	82.95	84.49	85.25
US Average	53.42	53.12	52.57	52.75	52.72	52.48

Using 1989 DATA:

Kansas is highest in the nation with 85.25 beds per thousand.

Nevada is lowest in the nation with 26.24 beds per thousand.

Nebraska is ranked 2nd, Iowa is ranked 5th and Missouri is ranked 11th.

Currently (1993) Kansas has 80.72 beds per 1,000 population aged 65 or older.

DMS Fiscal unit, 123w\data\NF Beds.wk3 03/15/93

DRAFT

Exhibit 1

Occupancy Rates for Adult Care Homes

Year	Quarter	# of Facilities	# of Beds	Occupancy Rate
1985	1	373	26,808	90.1
1985	2			90.02
1985	3			90.33
1985	4			90.59
Average				90.17
1986	1	373	26,837	90.60
1986	2			90.48
1986	3			89.92
1986	4			89.08
Average				90.22
1987	1	377	27,471	89.41
1987	2			90.06
1987	3			89.91
1987	4			89.2
Average				89.64
1988	1	385	28,485	87.80
1988	2			87.11
1988	3			87.64
1988	4			87.32
Average				87.46
1989	1	399	28,947	87.34
1989	2			88.14
1989	3			88.45
1989	4			88.25
Average				88.04
1990	1	415	29,603	86.68
1990	2			86.09
1990	3			87.3
1990	4			88.09
Average				87.04
1991	1	419	29,817	87.7
1991	2			87.58
1991	3			88.67
1991	4			89.95
Average				88.45
1992	1	420	29,850	88.75
1992	2			88.7
1992	3			89.3

1985 to 1992 = 11.3% bed increase
Occupancy down .8%

KD

Source: Adult Care Home Quarterly Repo

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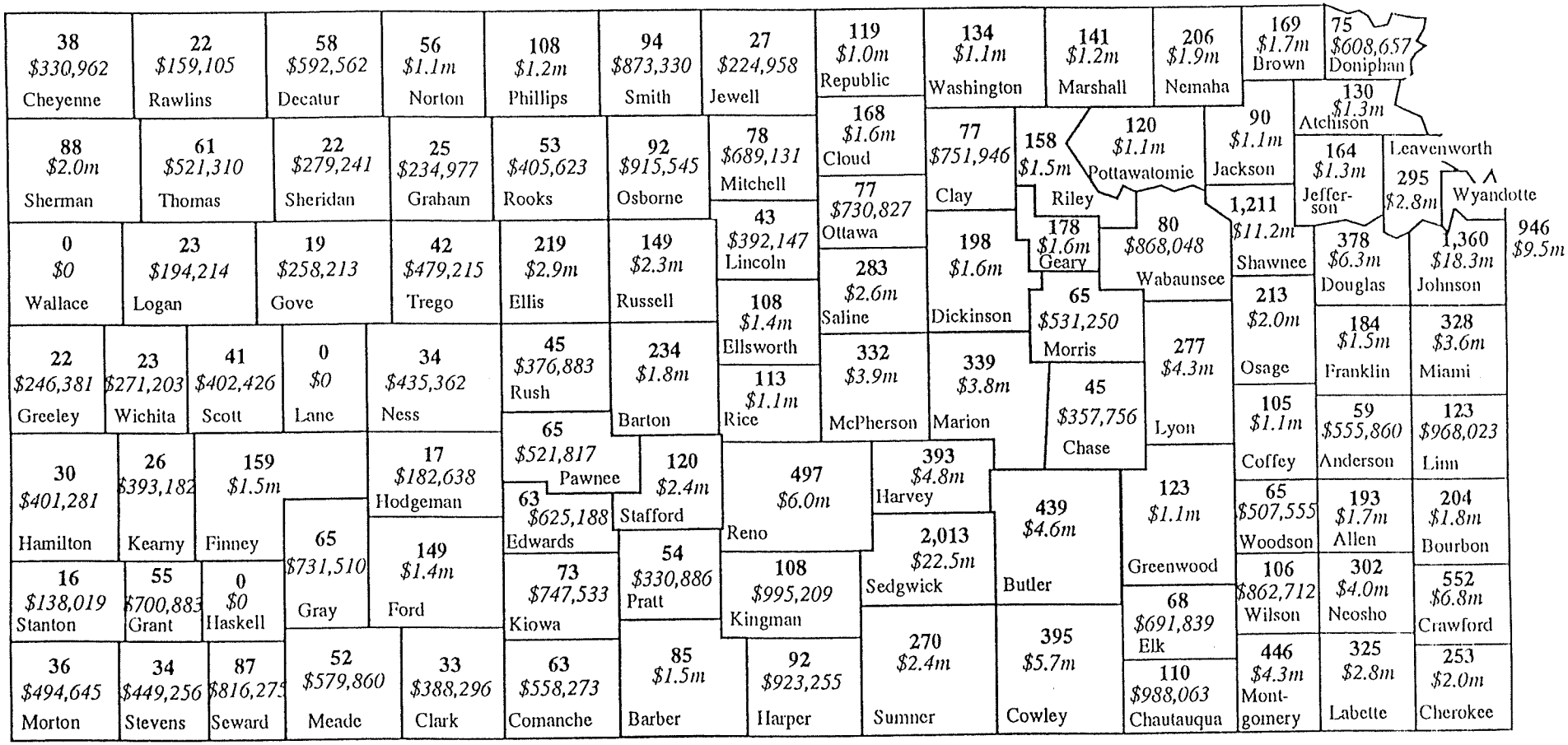
Adult Care Home Unduplicated Recipients by County and Total Expenditures for State FY 1992



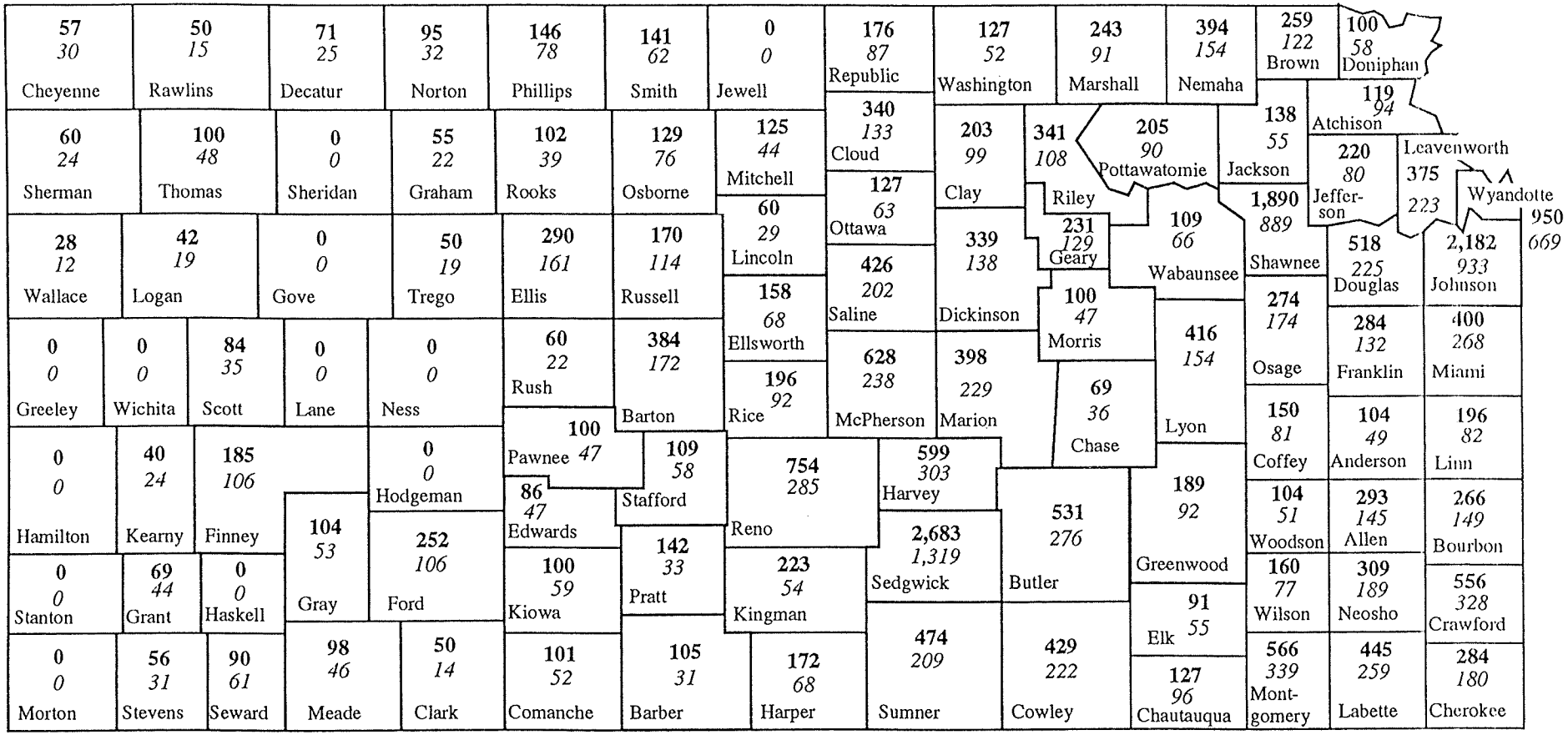
Prepared by: SRS Management Services 2/93

Source: HMMR970 Series

Statewide Recipients = 19,000
Statewide Expenditures = $206,365,313

Note: Does not include Long Term Care Units attached to a hospital

State of Kansas
Number of Medicaid Certified Nursing Facility Beds and Medicaid Recipients in Nursing Facilities as of December 31, 1991



Prepared by: SRS Management Services 3/93

Statewide Medicaid Certirfied Nursing Facility: 26,626

Statewide Medicaid Residents: 12,996

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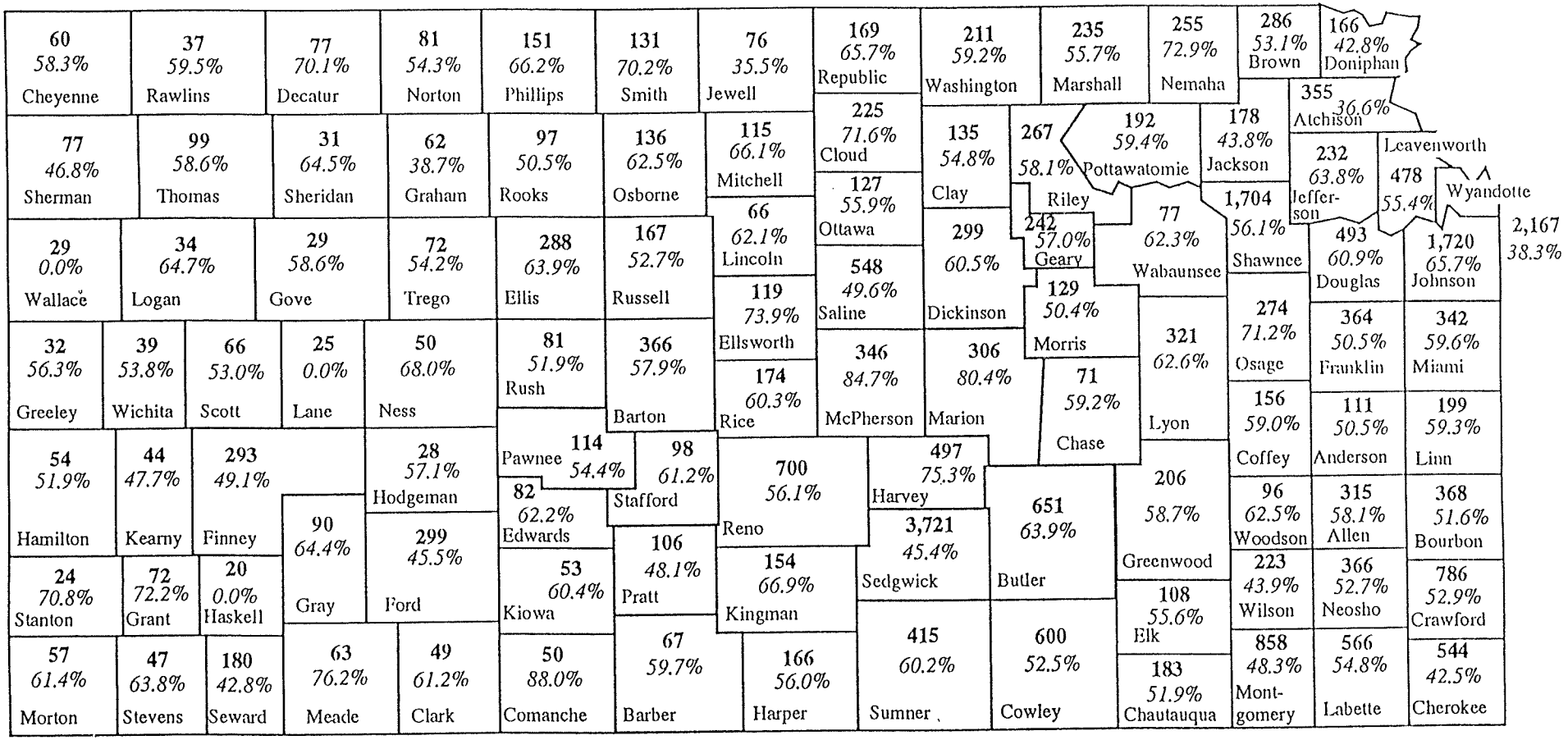
Unduplicated Medical Eligibles by County 65 and Over and Percent of Eligibles 65 and Over in Adult Care Homes for State FY 1992



Prepared by: SRS Management Services 2/93

Source: HMMR970 Series

Statewide Eligibles 65 and Over = 29,660
Percent 65 and Over in ACH = 54.7%

Note: Does not include Long Term Care Units attached to a hospital

LONG TERM CARE FOR THE ELDERLY

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

AND

KANSAS DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

FOR INFORMATION REGARDING THIS PUBLICATION, WRITE:

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

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

March, 1992

TABLE OF CONTENTS

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

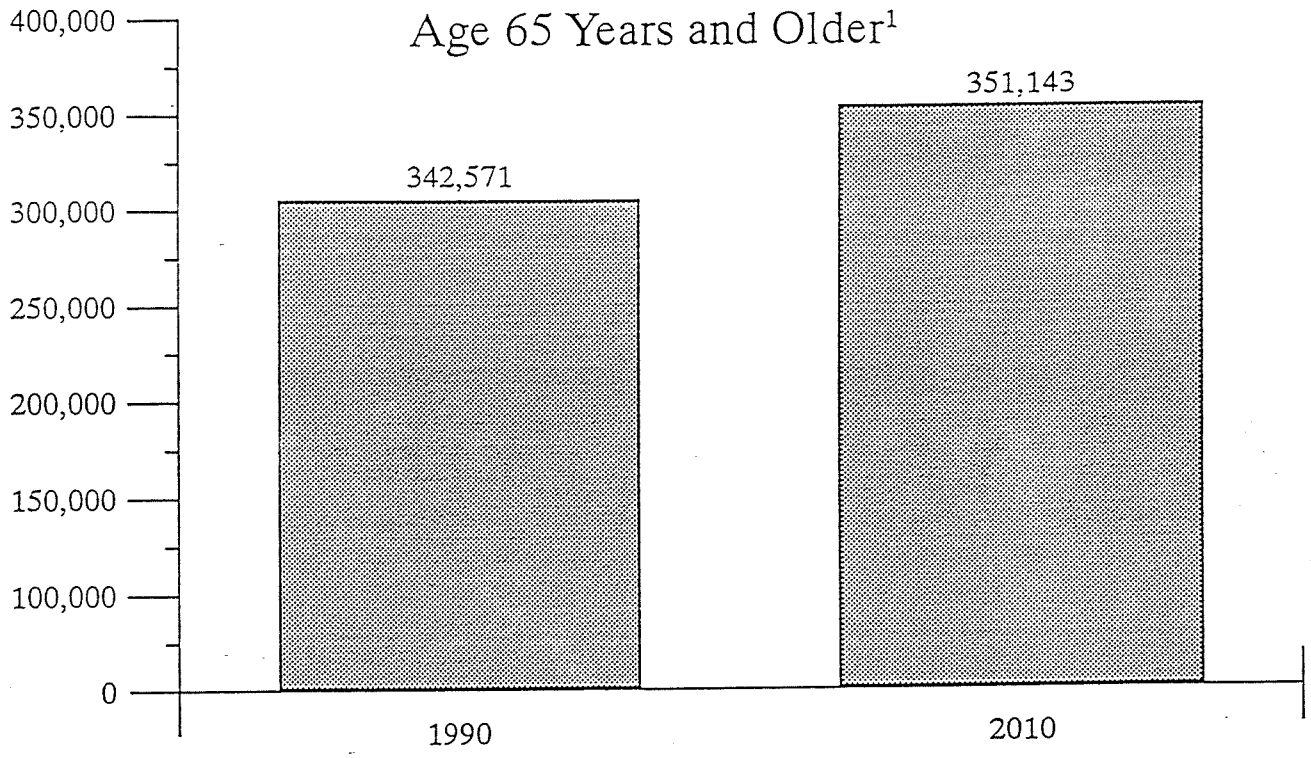
	Population Over 65	Percent	Percent of Total Area Population
Metropolitan Counties *	149,399	43.6	11.2
Non-Metropolitan Counties **	193,172	56.4	16.9
State Total	342,571	100.0	

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

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

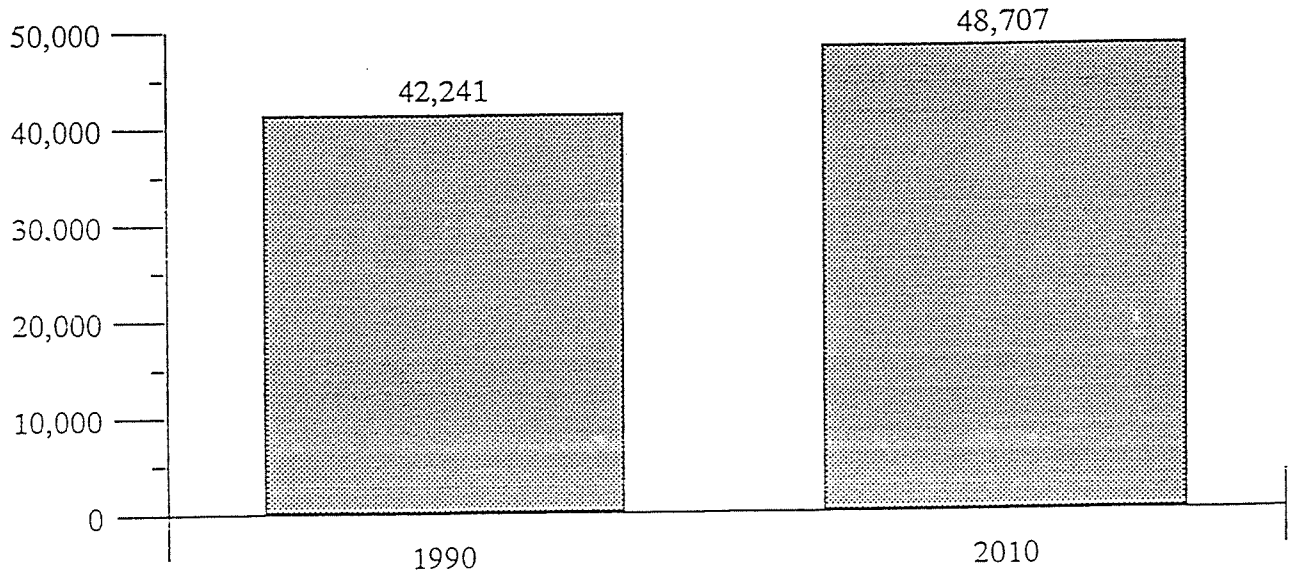
** All other counties

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.

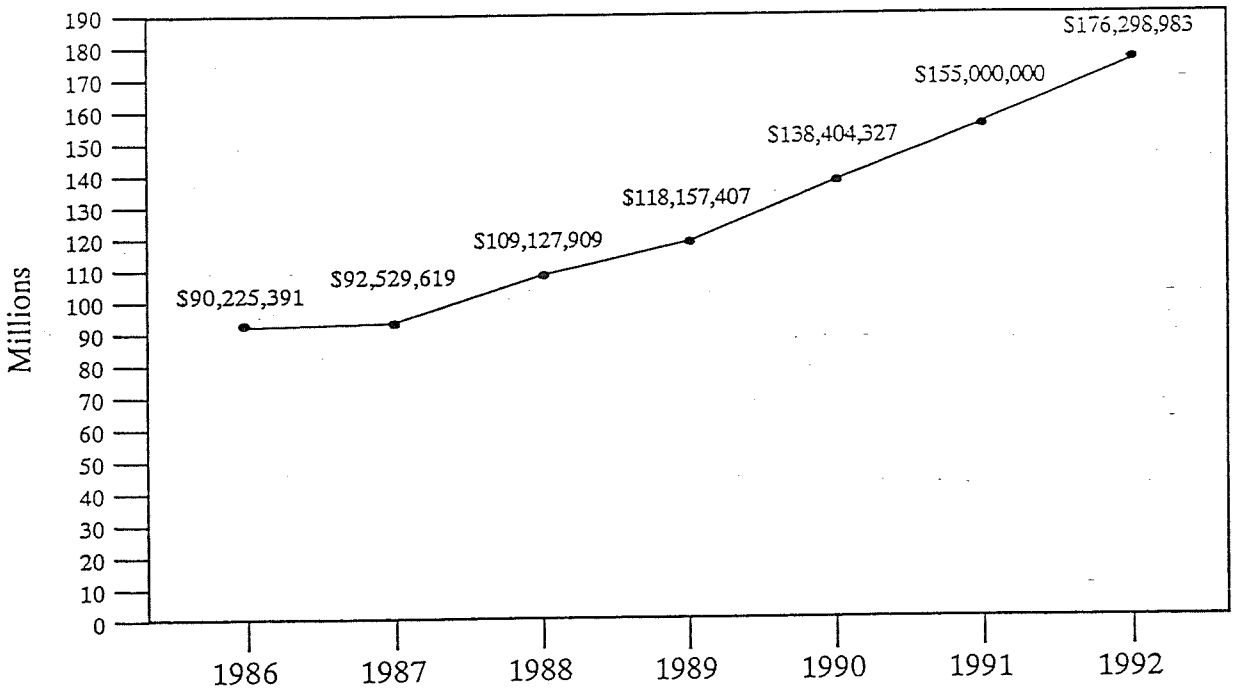
- Medicaid expenditures in Kansas have more than doubled in the last 10 years.

- 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).

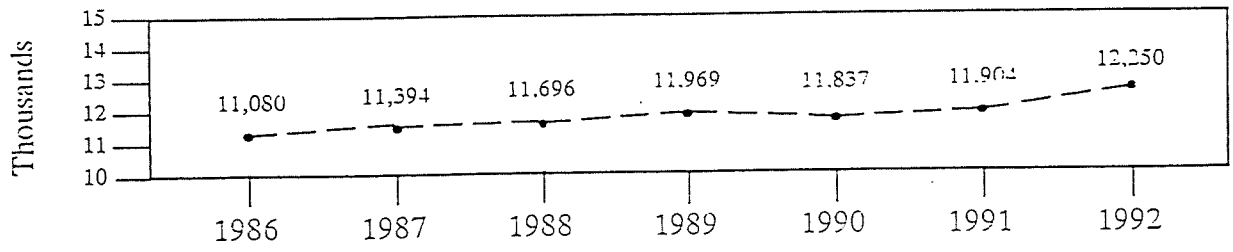
- Although adult care home costs have increased, the proportion of the Medicaid budget expended for adult care homes has remained fairly constant over the last ten years because Medicaid costs generally have also undergone significant increases. However, the regular Medicaid program has also undergone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



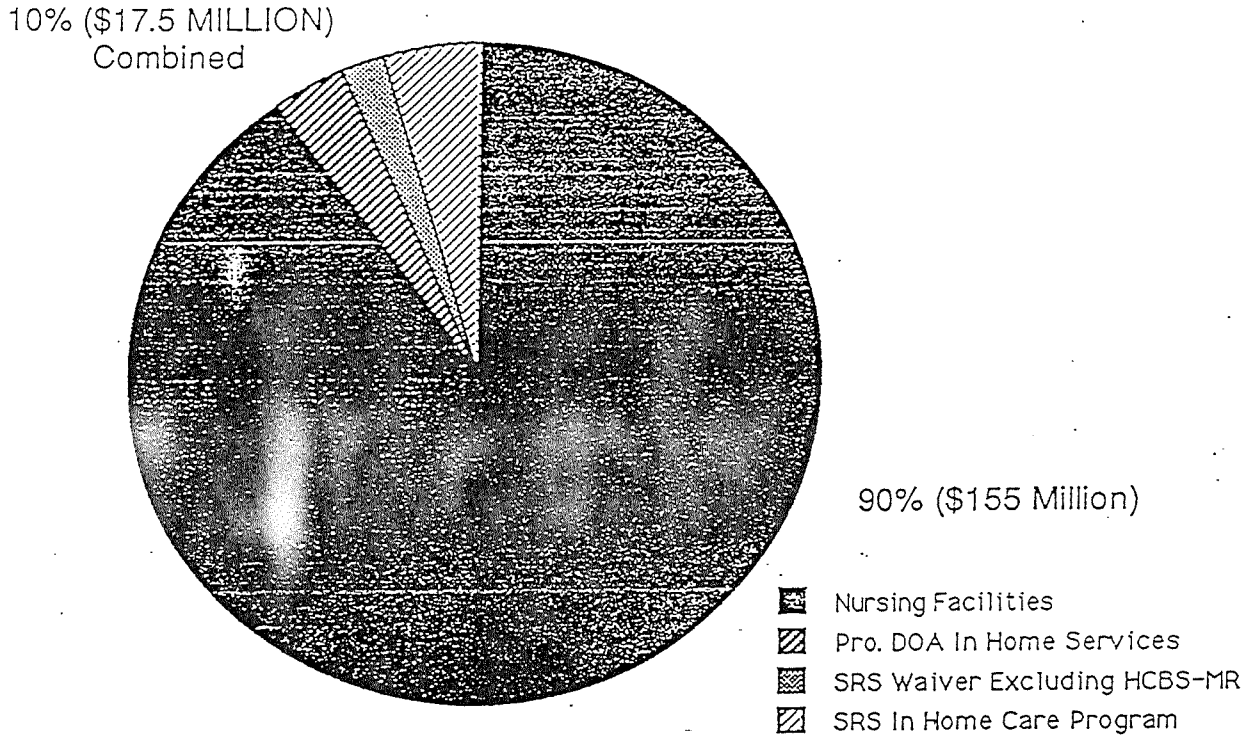
Nursing Facility Medicaid Recipients: FY 1986-1992*



*Excluding ICFs/MR

PAC

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.

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.

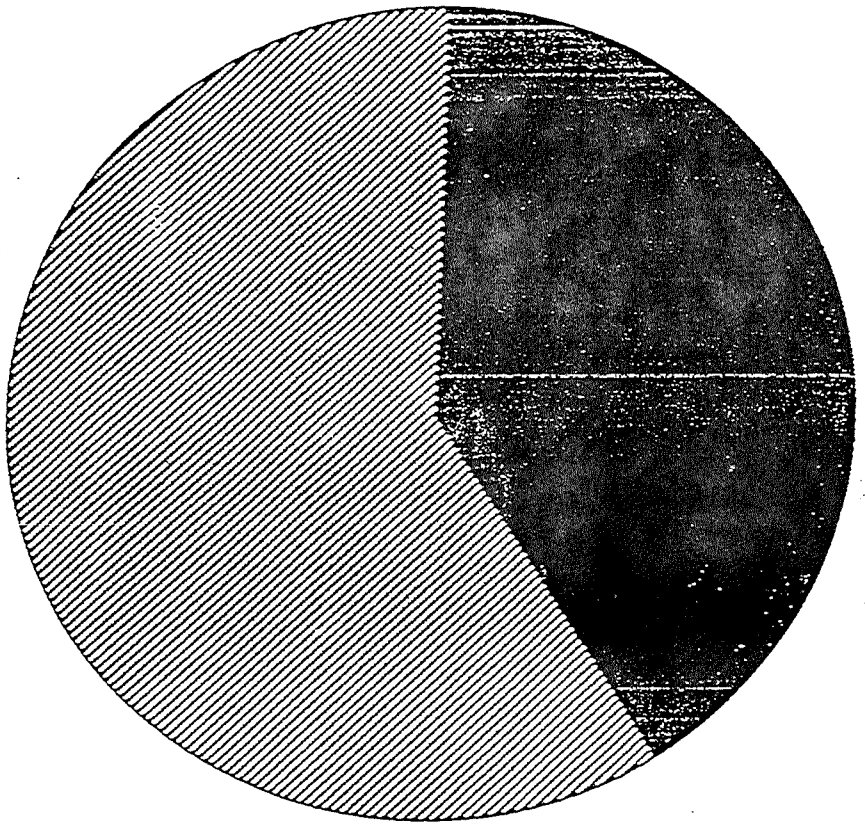
Facility Ownership/January 1992

	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).

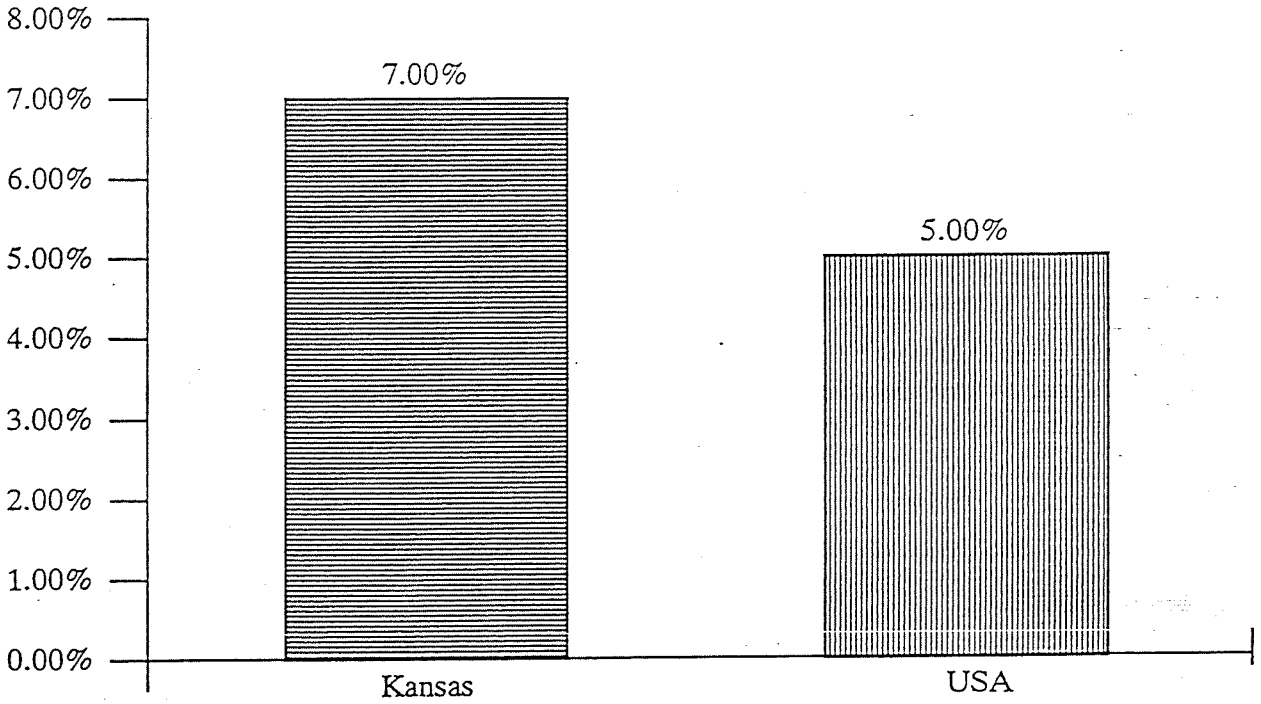
- The population 85+ is at the greatest risk of needing and using long term care services. In Kansas, the 85+ population is expected to increase from 42,241 in 1990 to 48,707 (a 15% increase) in 2010.

- 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).

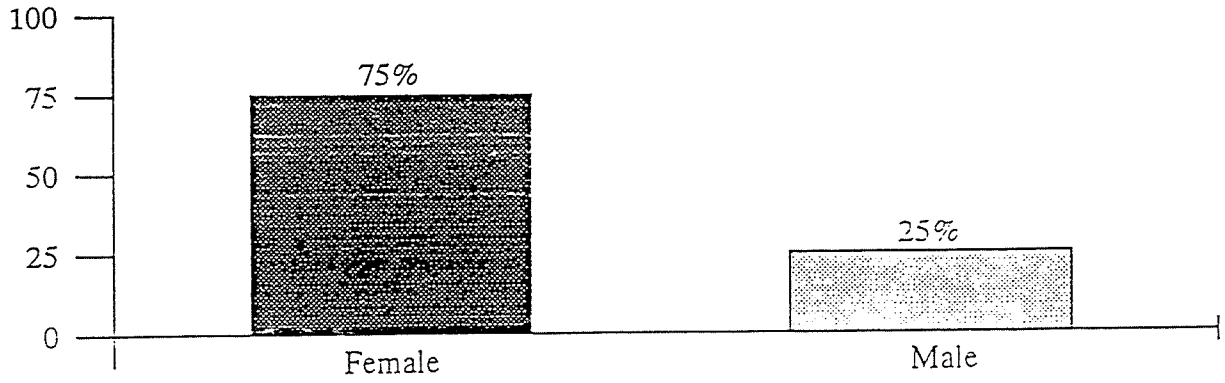
- Analysis of the 1985 National Nursing Home survey indicates that nationally, 78% of nursing home residents were found to need assistance with two or more activities of daily living (ADLs). 55% were severely impaired with four or more ADLs. But 20% of nursing home residents were judged to have no or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

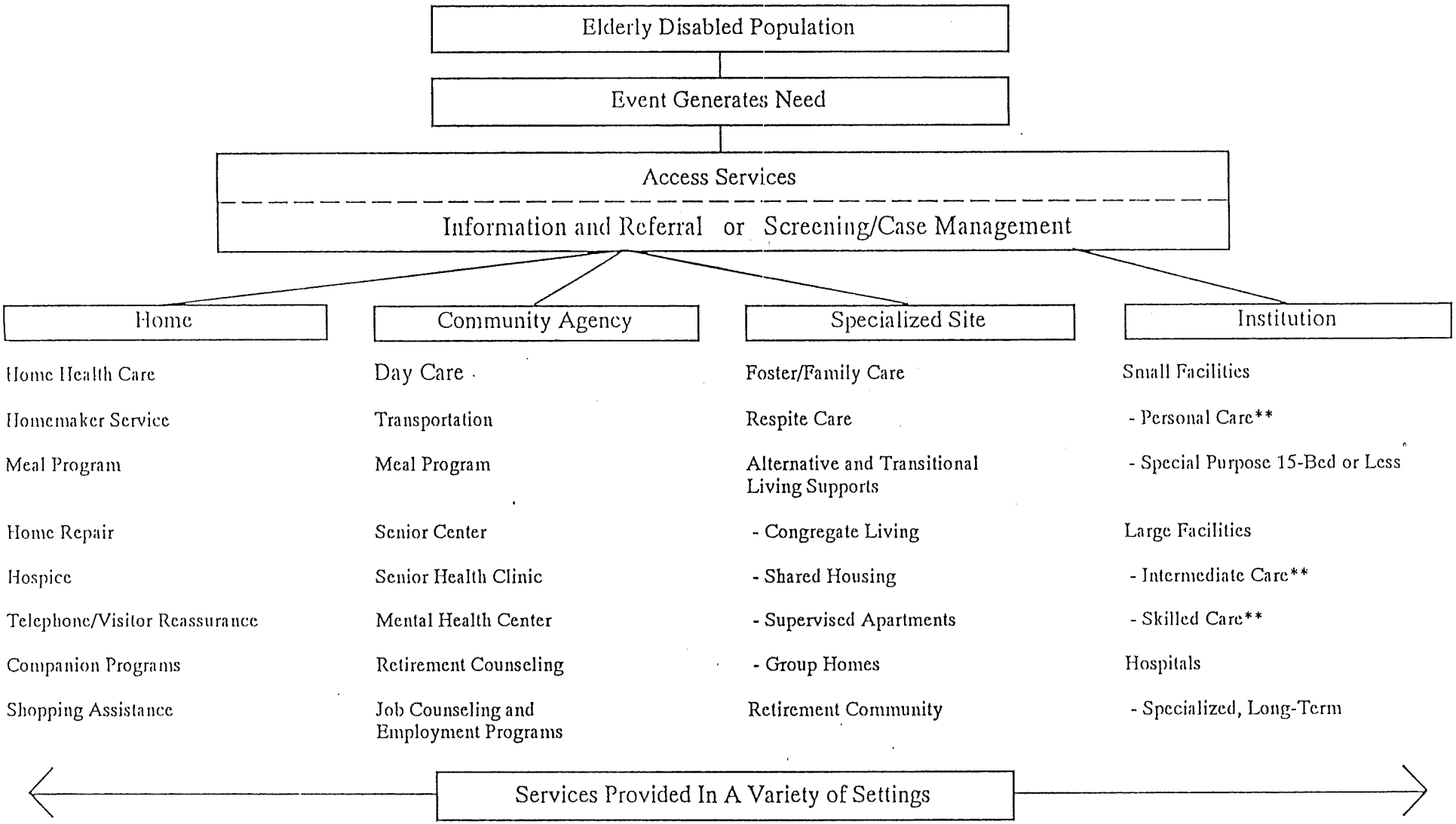
- Sixth, more options need to be developed for people who can't remain at home but really don't need the medical care available in a nursing facility. Other states have reported successful implementation of sizeable programs that fill this gap and are less costly than nursing facility care. Kansas SRS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

Sources

1980 Census Data Projections for the State of Kansas By Age, (IPPBR 1989), University of Kansas.

1990 Census Data for the State of Kansas By County and PSA, File 1990 CPH-1 (Proof Copy).

Case Mix Informer, Vol. 1, No. 1, Kansas Department of SRS, December, 1991.

Center for Health Services Research. (July 1986). Long-term care for the elderly. School of Public Health, University of Minnesota.

Chenoy, Catherine, (1986) Estimate of need and utilization of home health services in Kansas. Institute for Public Policy and Business Research, University of Kansas, Lawrence, Kansas.

Committee on Ways and Means. (1991). Green book (overview of entitlement programs). Washington, DC: U.S. House of Representatives.

Congressional Research Service (1988). Medicaid source book. Background data and analysis. Washington, DC: U.S. House of Representatives.

Directory of Adult Care Homes. (November, January 1991). Kansas Department of Health and Environment, Topeka, Kansas.

Kansas Coalition in Aging, (January, 1990), A report on the status of the very old in Kansas: A comparison with selected states.

Kansas Commission on Veterans Affairs, Kansas State University Research Foundation, (1990). Needs assessment of aging Kansas veterans.

Kansas Department on Aging, Office of Long Term Care Ombudsman (1991) Annual report. 1988, 89, 90.

Robert Wood Johnson Foundation. (1991). Challenges in health care. Princeton, NJ: Author.

Telephone conversations and memos from SRS, DOA, and KDHE staff.

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.

TESTIMONY ON
SENATE BILL NO. 405

Presented to
Committee on Public Health and Welfare
by
Stephen A. Menke
President, Mobile Care, Inc.

Madam Chairman and Distinguished Senators:

I would like to thank you for the opportunity to speak in support of Senate Bill No. 405

I come to you this morning as a health care professional with 20 years experience in health care administration. During the last two years I have been conducting intensive research in an effort to propose an alternative to traditional long term care. My activity has enabled me to talk to hundreds of consumers and health care professionals to gain their insights regarding their perceptions of the current system and their desire for suitable alternatives.

As a result of my investigation, I have found that administrators of Kansas nursing homes are a dedicated and honest group of professionals who are doing their level best to provide quality care for their residents. I have also found, however, that Kansas has one of the highest rates of nursing home utilization. In other words, residents in Kansas are more inclined to end up in a nursing home than residents of almost any other state. Despite the commendable efforts by the nursing home profession to elevate the quality of care, there still exists an overwhelming desire by people to seek out alternatives to institutional care. I have learned that there are serious geographic differences in both the propensity to use nursing homes and the overall occupancy of existing homes. There has been significant expansion of home-based alternatives which have enabled more people to stay in their homes. I have also learned that

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there is a change in Kansas and throughout the United States from acute disease problems to chronic disease problems. In other words, as we cure the health problems of middle age, people are living longer, which taxes the resources of our long term care system.

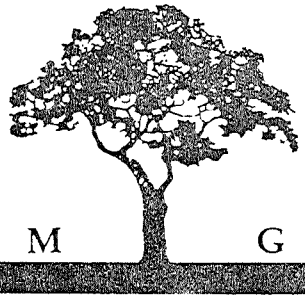
As a result of my research and in anticipation of future trends, Kansas State University and Mobile Care have developed a home-based alternative for long term care. Under our program, a fully accessible modular apartment is connected to the home of a primary caregiver, which could be a son or daughter of the client. This apartment gives the older person all the privacy of their own apartment. However, help from a family member is immediately available in the event it is needed. This combination of privacy when it is desired and help when it is needed is a very appealing solution to many older Kansans.

This modular apartment is available on a rental basis for a short period of time. When it is no longer needed, it is moved to another client's home. The cost of this alternative ranges from $400 to $800 per month. In addition to the apartment, a program of supportive services from home care organizations is available to assist the family with personal care needs.

Mobile Care has found that sometimes older individuals do not have family available to meet their needs. Accordingly, we have developed a foster family program in which a caregiver provides care for one to four individuals in a family-based program of care. This program of family based assisted living is similar to programs developed in Florida, California, and a program in Utah, which was recently featured in the Wall Street Journal. Our family-based assisted living homes provide 24 hour care and supervision in a home-like environment. This is appealing to many clients. In addition, this option is less costly than other more traditional options.

I believe that the proposed moratorium, with the flexibility for the Secretary of Health and Environment to grant waivers of limitation, will provide a stimulus to develop alternatives to traditional care. It is important, however, to allow sufficient flexibility within the proposed moratorium to allow group homes and assisted living arrangements to be developed as an alternative to more expensive forms of health care.

Thank you again for the opportunity to present testimony. I would be happy to answer any questions you may have.



SHALOM GERIATRIC CENTER

March 17, 1993

TESTIMONY

My name is Melvyn Weissman. I have been Executive Director of Shalom Geriatric Center for 25 years. Shalom is a 194 bed skilled nursing facility in Kansas City Missouri. The home was founded in 1912 by the Jewish Community, and is a not-for-profit Corporation providing a variety of therapeutic programs and services including a (47) bed Alzheimer's Unit, comprehensive rehabilitation programs (physical therapy, occupational therapy, and speech therapy) and a highly successful Adult Day Health program.

Shalom serves as a contractor under the Older Americans Act providing both congregate meals and home - delivered meals for those over age sixty. Since 1985 we have been designated as a teaching nursing home with the University of Kansas Medical Center. In cooperation with Shalom, the Medical Center instituted a pioneering geriatric medicine fellowship program leading to a two year specialty in geriatric medicine. Seniors medical student do a two - week rotation and have an opportunity to see all phases of a nursing home operation. Shalom nas a very strong lay leadership and is governed by a dedicated Board Of Directors with strong support from it's Women's Auxiliary and Associate Board.

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Plans are under way to develop a replacement facility, assisted living and an independent housing project on the Jewish Community Campus which is located in Overland Park, Johnson County Kansas. The reason for the development of this replacement facility is to be in a better location to serve the Jewish Community. It is our intention to certify the nursing home under both the Medicare and Medicaid programs. Located on the campus are the Jewish Community Center and the Hyman Brand Hebrew Academy as well as a number of other Jewish organizations. Many Jewish families live within a five or six mile radius of the Jewish Community Campus.

Our construction budget is estimated to be around ten million dollars and when we are at full operation we will be employing approximately 150 people.

The way we read the bill, we do not think that we will be allowed to construct our project if this law goes into effect. I have put together some thoughts on some possible language for an exemption.

a. Relocating on land set aside on the Jewish Community Campus for the construction of a nursing home.

b. Operating on not for profit basis.

c. Benefiting members of a recognized religion.

d. Religious tenets require such a facility to provide for the special dietary needs of Kashruth (Kosher food) service for our residents. Our facility will be serving primarily people of the Jewish faith and it will be uniquely designed to meet there needs.

Douglas County

TESTIMONY PRESENTED TO THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE CONCERNING SB 405 ON MARCH 17, 1993

Madame Chair and Members of the Committee:

Douglas County is currently undertaking an effort to simultaneously lower the cost to the taxpayers for nursing home care, and to improve the quality of care. Passage of Senate Bill 405 would probably put a stop to our initiative.

Douglas County is the largest county in the state with a county owned and operated intermediate care facility. Valley View Nursing Home was built by the county in the early 1960's and has been operated by the county ever since with a significant county property tax subsidy. As recently as two years ago, over $400,000 in property taxes was spent annually by Douglas County to operate the home. In addition, the state has always had to reimburse the county at the maximum levels for medicaid patients because our operating costs have always exceeded the ninetieth percentile of all operating nursing homes. Costs over the last two years have been controlled better, but the County tax subsidy necessary to operate the facility in 1993 will be around $200,000.

The quality of care at Valley View has always been relatively high, but the facility has had some basic limitations, including the lack of restrooms adjacent to the patient rooms.

Approximately two months ago, the Douglas County Commission determined that the Valley View facility should be closed as a county-run nursing home. Their hope is that the facility will be closed and that a private for-profit or not-for-profit group will build a new facility. If it does not appear that this will happen, the County Commission will consider proposals to lease or purchase the building to a private party to operate a nursing facility. In fact, several proposals are being actively pursued at this time.

The very possibility of passage of a moratorium on building new nursing homes is endangering Douglas County's initiative to provide better beds at a lower cost. Planning a new facility is difficult, if not impossible with the possibility of a moratorium.

Since the announcement that the County intends to close Valley View as a county-run facility, the number of patients has declined steadily since most persons would rather go to another nursing home, instead of risking having to move if Valley View ultimately closes. As a result, our operating costs per patient are going up, making lease of the facility to another operator less feasible.

Courthouse
Eleventh & Massachusetts / Lawrence, Kansas 66044 / (913) 841-7700

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Douglas County is not over bedded and the population of senior citizens is growing rapidly. Replacement beds for Valley View's 60 beds are needed, but we also anticipate steady growth in the demand for new beds. Based on current vacancy rates, if Valley View is closed and no new home is constructed, at least 40 Douglas County residents will have to find beds in other counties.

Passage of a moratorium will either cause Douglas County to continue to operate Valley View, or will force Douglas County residents to find nursing facilities outside of their home county. In neither case will the taxpayers be well served.

The state should not be considering legislation which makes it difficult to close older, obsolete, and/or inefficient facilities such as Valley View. In the case of Douglas County a moratorium would appear to be working in direct opposition to an effort to provide better care to Douglas County senior citizens at lower cost to its taxpayers.

Sincerely,

BOARD OF COUNTY COMMISSIONERS
OF DOUGLAS COUNTY, KANSAS

Mark A. Buhler, Member

MAB:rw

Testimony Before The
Senate Public Health & Welfare Committee
March 17, 1993

Good morning, I am Richard Reding, representing Life Care Services Corporation of Des Moines, Iowa. Life Care Services Corporation is the nation's largest developer/manager of continuing care retirement communities. Presently, Life Care Services Corporation has development or management interest in 40 communities in 22 states.

Life Care Services Corporation is presently developing a continuing care retirement community in Prairie Village, Kansas, called Claridge Court.

Claridge Court is a wholly privately funded retirement community registered as a continuing care provider with the Insurance Department. When completed, Claridge Court will have 135 apartment units and a 35-bed nursing facility located on a single campus. Claridge Court residents, through this residency contract, are provided an apartment unit of their choice, a package of services and amenities, and guaranteed long term nursing care under an insurance-like arrangement. Some 60% of the apartment units have now been reserved with escrowed cash deposits, and construction is expected to begin this July.

Though Claridge Court is in the final stages of development and expects to close on financing in June and start construction this July, we are very concerned that Senate Bill 405 might be enacted prior to either the close of financing or the start of construction, thus potentially denying licensure for the 35-bed health center. Because the residency contract guarantees long term care services to residents, the inability to license and operate the health center component would effectively terminate this entire $30 million project.

We are aware that Senate Bill 405 addresses "continuing care contract homes," like Claridge Court, and excludes them from the definition of medical nursing facilities. Because Claridge Court already has received a certificate of registration from the Insurance Department, and is not defined as a medical nursing facility, it appears that in Section 2 it could be exempted from the moratorium and thus receive licensure for the 35-bed health center. However, we find this interpretation to be convoluted and we are concerned that without a more explicit exemption, Claridge Court might still be denied licensure when construction is completed in mid 1994. We are further concerned that some tightening of the moratorium might also occur before the facility is licensed and again we would like some clear assurance that we can proceed with this project and ultimately receive licensure when it is completed.

We maintain it would be very unfair that Claridge Court, which has been under development for more than three years, might potentially be stopped by the moratorium in the very final phases of completion. Further, we wish to emphasize that Claridge Court is a wholly privately funded retirement communities, which will not participate in the Medicaid program and, in addition, guarantees its residents long term care without having to resort to Medicaid. Therefore, we believe that providing these assurances would not affect the content of the moratorium.

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KSNA

the voice of Nursing in Kansas

March 17, 1993

Senator Sandy Praeger
Capitol Bldg. Room 128-S
Topeka, KS 66612

Dear Senator Praeger:

I am writing to urge your **support of the HB 2073 Subcommittee Report.** The Senate Public Health and Welfare Subcommittee has combined HB 2073 (which would change the composition of the Board of Nursing to include an ARNP/RNA) and HB 2072 (which would delete specific ARNP continuing education provisions) into HB 2073.

Because there has been a 16% increase in the RN population over the last five years and because four new RN schools have opened, the workload of the Board of Nursing in reviewing new programs and licensees for disciplinary action has dramatically increased. It is particularly important to designate a Board of Nursing position for an ARNP or RNA, as there are currently three new ARNP programs within the State.

While we applaud the intent of the original HB 2072 to safeguard the public who receive prescription medications ordered by ARNP's, we believe the logic of the original legislation as proposed was flawed. As you might imagine, ARNP's practice in a variety of settings and geographic areas. Many do not transmit prescription orders, and instead have very specific continuing education needs unrelated to pharmacology content. Because so few ARNP-level continuing education (CE) programs are available in our state, most ARNP's, and especially those in rural areas, would experience hardship in obtaining specific content if it were required. We support the increased flexibility for ARNP's to obtain continuing education (CE) for relicensure that is being recommended by the subcommittee.

Please support the HB 2073 Subcommittee Report. Feel free to contact me if you have any questions.

Sincerely,

Linda Sebastian

Linda Sebastian MN, ARNP
Chair, Advanced Practice Conference Group

a:hb2073.let
Blue Testimony

Kansas State Nurses' Association Constituent of The American Nurses Association

700 S.W. Jackson, Suite 601 • Topeka, Kansas 66603-3731 • (913) 233-8638 • FAX (913) 233-5222
Michele Hinds, M.N., R.N.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

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