Approved 2-15-88
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 3, 1988 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Lois Scibetta, R.N., Ph.D., State Board of Nursing
Terri Roberts, Kansas Nurses Association
Dick Hummel, Ks. Health Care Association
Izena Monk, Cunningham, Ks. Nursing Home Administrator
Richard Morrissey, Dept. of Health and Environment
Ann Rogers, Ks. Assoc. of Nurse Anesthetists (printed testimony)

Chair called meeting to order with announcements. Revisor's office is trying to have HB 2464 ready for discussion and action by meeting time tomorrow. If the bill is not ready, it will then be next Wednesday before we can work the bill.

Hearings began on HB 2654:

Dr. Lois Scibetta noted hand-out, (Attachment No.1) This bill raises fee maximums for licensed mental health Technicians for the Board of Nursing. There was discussion in regard to the specific increases requested. It was noted that maximums are set, and the Agency sets specific fees.

Hearings began on HB 2653:

Dr. Scibetta asked for favorable passage of HB 2653. Nurse Anesthetist in Kansas has a 2 year renewal of RN and ARPN certification. She would like bill to indicate this would take effect beginning January 1989. This would give them time to cycle into the program.

Printed testimony was given out by Ann Rogers, Ks. Association of Nurse Anesthetists, (see Attachment No. 2 for details). She was unable to present testimony in person.

Terri Roberts, Kansas State Nurses Association, gave hand-out, see (Attachment No. 3). She stated that Registered Nurses, (RN) renewal is based on their birth month. If born in even year, you renew in even year, if born in odd year, you renew in odd year. This bill, HB 2653 will allow the Board to align the RN renewal and the ARN renewal. The bill will correct an oversight in the original of SB 179.

Hearings closed on both HB 2654 and HB 2653.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 3, 1988.

Hearings began on HB 2614:-
Dick Hummel, Kansas Health Care Association gave hand-out, (see Attachment No. 4) for details. The purpose of HB 2614 is whether or not to regulate or control the development of long term care beds. Our Association believes this to be in the best interest of the citizens of Kansas. As bed growth continues unfettered, and as occupancy declines, Medicaid costs will increase, and the quality of care will be compromised. He cited problems in other states where no control over bed growth has been developed. He requested favorable reporting of HB 2614, saying there are some who say Kansas facts don't warrant this legislation, but he urged our state should take a lesson from states that are already suffering difficulty because of being over-bedded. He answered numerous questions, i.e., definition of swing beds; no, we were not in favor of the Certificate of Need bill; perhaps we would need to have language to clarify the need for an increase in beds for M.R.'s; the intent of this bill is to put a reasonable limit and to slow for a while, beds already available for nursing home use; yes, if more homes are built, then staffing would have to be spread even thinner than it is at this time.

Izena Monk, Administrator of a nursing home in Cunningham, Ks., gave testimony, (see Attachment No.5). She spoke in support of HB 2614. Building of more nursing home beds in her area will have a negative effect on care of the elderly. Nursing homes must make money to give quality care, to serve good food, and have a clean environment. When revenue drops because of low census, then expenses must be cut. You can't cut salaries, you cut hours, and thus cut care. Their facility sends qualified personnel through nurses training to assure they will have nurses in the future, but she is concerned about how much longer they can afford to do this. Occupancy must maintain a 95% capacity in order to operate in the best manner possible.
She answered numerous questions.

John Grace, Homes for the Aging, (see Attachment No.6). Our people are in opposition to HB 2614. A free market approach can result in more choices for consumers. The fastest growing age group is 75 plus years, however, no one can project how many additional beds will be needed for their care. The question is, "Who decides who will build?". Some homes have trouble with competition. Arizona experiences indicate to us that good homes do well and poor homes do poorly. New providers that built facilities without proper market research have not done well. He answered questions, i.e., yes, they couldn't build the nursing care area, (personal care homes), but those wishing to build independent living homes for private living purposes could go ahead with that type of construction. They also could not build a facility for Alzheimer's care.

Dick Morrissey, Health and Environment, (see Attachment No.7). He stated arguments brought out this date are no different than those raised in 1975/1985 in regard to Certificate of Need. He explained bar graph in hand-out indicating growth in facilities and beds. They use only figures of those who have gone far enough in planning to apply for licensing. There are many policy issues to consider--if occupancy rate decreases, will Medicaid costs increase; does number of beds in market have an impact on quality of care; do we close market to new personal care beds; do we limit market for mental retardation facility beds. Their Department recommends HB 2614 be reported unfavorably. He answered questions.

Chair asked conferees who could not appear this date because of time limitations to please return tomorrow and he would invite their testimony.

Meeting adjourned at 3:10 p.m.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-3-88

NAME	ORGANIZATION	ADDRESS
D. Jan F. Kerbella	KSBN	FOU Mc Pherson, Ks
Marilyn Bradt	KINH	Lawrence
Lila Varlay	ARC	Topeka

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Bonnie Howard, R.N., M.A.
Practice Specialist

Janette Pucci, R.N., M.S.N.
Educational Specialist

TO: Representative Marvin Littlejohn, Chairman
& Members of the House Public Health and
Welfare Committee

FROM: Dr. Lois Rich Scibetta, Ph.D., RN
Executive Administrator

RE: HB 2654

DATE: February 2, 1988

Thank you Mr. Chairman for the opportunity to speak to HB2654.

The Bill raised the statutory fee maximums for Licensed Mental Health Technicians for the Board of Nursing.

The Board does not object to the Bill, however, no fee increase has been planned for this group who will all renew their licenses in December 1988. The computerized licensure forms have been printed for 1988. It is possible of course, that the Board will consider a fee increase at a later date.

I will be happy to respond to questions.

LRS:bph

LICENSURE REGULATION PUBLIC BOARD OF NURSING TRUST LEGISLATION EDUCATION

Attm #1
PH & CW
2-3-8

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

Date: February 3, 1988

To: House Public Health & Welfare Committee

From: Kansas Association of Nurse Anesthetists by Ann Rogers, RNA.

RE: HB 2653, Section 3 (a) concerning licensure dates.

Section 3 of HB 2653 is fully endorsed by the Kansas Association of Nurse Anesthetists. The nurse anesthetist in Kansas has a 2 year renewal of the RN license, the ARNP certification and RNA authorization and we feel it is essential to have all of these renewals occur at the same time for the sake of simplicity. All of the renewals require continuing education hours and it would be a nightmare attempting to keep track of hours and dates for three different periods of time.

Thank you for reading my written testimony since I am unable to attend the hearing on Wednesday, February 3, 1988.

Ann J. Rogers

Ann J. Rogers, R.N.A.

Attm. #2
2-3-8
P&W.

KSNA
the voice of Nursing in Kansas

FOR FURTHER INFORMATION CONTACT:

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
820 QUINCY, SUITE 520
TOPEKA, KANSAS 66612
(913) 233-8638

FEBRUARY 3, 1988

H.B. 2653

TESTIMONY BEFORE THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Representative Littlejohn and members of the House Public Health and Welfare Committee, my name is Terri Roberts, J.D., R.N., I am a registered nurse representing the Kansas State Nurses' Association.

H.B. 2653 adds additional language to section 3 of K.S.A. 65-1155, which addresses the renewal period for RNA authorizations. The specific language that is being added is:

> "to provide for a system of biennial authorizations to practice as a Registered Nurse Anesthestists that expire at the same time as the license to practice as a Registered Nurse, the board may provide by rules and regulations that authorizations to practice issued or renewed for the first time after the effective date of this act may expire less than two years from the date of issuance for renewal. In each case in which an authorization to practice is issued or renewed for a period of time less than two years the Board shall pro-rate to the nearest whole month the authorization to practice issuance or renewal fee established persueant to K.S.A. 1987 Supp. 55-1154 and ammendments there to."

H.B. 2653 corrects a slight oversight in the original S.B. 179 passed in the 1986 Legislative Session. All Kansas RNA's had to be authorized under the 1986 law beginning January 1, 1987. Most of the RNA renewals fall in the January, 1987, month and year and do not currently correspond to the license renewal date for their RN license.

This bill simply gives statuatory authority to enable the Board of Nursing to pro-rate fees for RNA's authorization and reduce the time for the authorization from a two year period to allign with the RN renewal period. Current RN renewal periods are the birthdate of the licensee and correspond with an even or odd birthdate year.

THANK YOU.

Attm. #3
P/H+W
2-3-8

Kansas Health Care Association
Member of ahca

TESTIMONY PRESENTED BEFORE THE HOUSE
PUBLIC HEALTH AND WELFARE COMMITTEE

BY
DICK HUMMEL, EXECUTIVE VICE PRESIDENT
KANSAS HEALTH CARE ASSOCIATION

WEDNESDAY, FEBRUARY 3, 1988

HOUSE BILL NO. 2614
LIMIT ON THE DEVELOPMENT OF LONG TERM CARE BEDS.

CHAIRMAN LITTLEJOHN AND COMMITTEE MEMBERS:

THANK YOU FOR THIS OPPORTUNITY TO APPEAR IN SUPPORT OF H.B. 2614 ON BEHALF OF THE KANSAS HEALTH CARE ASSOCIATION (KHCA), A VOLUNTARY, NON-PROFIT ORGANIZATION WHICH REPRESENTS OVER 200 LICENSED ADULT CARE HOMES AND HOSPITAL BASED LONG TERM CARE UNITS IN THE STATE, BOTH TAX-PAYING AND NOT-FOR-PROFIT FACILITIES.

THE PURPOSE OF THIS BILL, AND THE CENTRAL QUESTION BEFORE YOU TODAY, IS WHETHER OR NOT IT IS IN THE BEST INTERESTS OF THE CITIZENS OF KANSAS TO REGULATE OR CONTROL THE DEVELOPMENT OF LONG TERM CARE BEDS (NURSING HOME AND HOSPITAL BASED LONG TERM CARE UNITS AND SWING BEDS) IN KANSAS.

Attm. #4
2-3-8
PHW

"We Care"

221 SOUTHWEST 33rd ST. • TOPEKA, KANSAS 66611 • 913/267-6003

WE BELIEVE SO AND WISH TO SHARE WITH YOU BED DATA SINCE THE EXPIRATION OF THE CERTIFICATE-OF-NEED PROGRAM IN 1985, SOME INDICATORS FROM OTHER STATES' EXPERIENCES WITH UNCONTROLLED BED DEVELOPMENT AND THE ECONOMIC AND QUALITY OF CARE CONSEQUENCES FROM AN "OPEN MARKET" SYSTEM.

LONG TERM CARE BED DATA. KANSAS HAS NOT EXPERIENCED AN OVERALL EXPLOSIVE GROWTH IN NEW NURSING HOME CONSTRUCTION SINCE JULY 1985; HOWEVER, IT IS SOMEWHAT DIFFICULT TO TRACK THE ACTUAL EXPERIENCE SINCE NO PUBLIC ENTITY IS OFFICIALLY MONITORING THE SITUATION.

OUR COMPILATION REFLECTS ABOUT AN 8-9% INCREASE (2092 NURSING HOME BEDS) SINCE THE EXPIRATION OF CON; NOT INCLUDED IS A 26% INCREASE IN HOSPITAL BASED LONG-TERM CARE BEDS (FROM 1134 TO 1425 BEDS), THE UTILIZATION OF HOSPITAL "SWING BEDS" FOR NURSING HOME USE (ABOUT 2400 ACUTE BEDS ELIGIBLE FOR PARTICIPATION) OR ABOUT 400-500 DELICENSED NURSING HOME BEDS WHICH MAY RE-ENTER THE SYSTEM AT ANYTIME.

EXTRAORDINARY GROWTH, HOWEVER, HAS OCCURRED AS EXPECTED IN THE THREE MAJOR METROPOLITAN AREAS OF TOPEKA, KANSAS CITY AND WICHITA. FOR THE PERIOD 1985-1986, WICHITA SAW A 28% INCREASE IN BEDS (2586 TO 3311). DURING THIS SAME PERIOD THE POPULATION OVER AGE 65 IN SEDGWICK COUNTY INCREASED BY 2.6%. WHETHER THIS IS GOOD OR BAD REMAINS

TO BE SEEN, FOR A KEY UNKNOWN AND UNANSWERED QUESTION IN SEDGWICK COUNTY AND IN KANSAS IS "WHAT IS THE BED NEED?"

OTHER STATES' EXPERIENCES WITH UNREGULATED BED GROWTH.

STATES' MOVEMENTS HAVE BEEN TO A DE-REGULATED ENVIRONMENT IN HEALTH CARE. APPROXIMATELY EIGHT, WITH THE LIST GROWING, HAVE ABOLISHED THEIR CERTIFICATE-OF-NEED PROGRAM. SOME HAVE EXECUTED A MORATORIUM ON NURSING HOME CONSTRUCTION, FROZEN NEW MEDICAID BEDS, OR USED OTHER TEMPORARY RESTRAINTS.

THE RESULTANT CONSEQUENCES FROM TWO OF THESE STATES ARE WORTH OBSERVING AS AN INDICATOR OF TRENDS WHICH WILL MATERIALIZE INTO FACT WITH UNCHECKED BED GROWTH. (IT IS NOTED THAT THE STATES' ELDERLY AND DEMOGRAPHIC CHARACTERISTICS ARE UNIQUE AND NOT ANALOGOUS TO KANSAS.)

ARIZONA - DEREGULATED NURSING HOMES IN 1982. A 72% INCREASE IN THE NUMBER OF BEDS SINCE THEN AND A 54% INCREASE IN MEDICAID EXPENDITURES. QUALITY OF CARE DIMINISHED.

UTAH - FROM 1985-1987 BEDS INCREASED FROM 5000 TO 6400 (30%). STATE SUPPORTED EFFORTS HAVE BEGUN TO REDUCE NURSING HOME REQUIREMENTS BY 20% AS A RESULT OF BUDGET CONSTRAINTS AND PROGRAM COSTS.

WHAT CAN BE LEARNED FROM THIS? FIRST IS THAT AS BED GROWTH CONTINUES UNFETTERED AND AS OCCUPANCY DECLINES, MEDICAID COSTS WILL INCREASE. SECOND, QUALITY OF CARE WILL BE COMPROMISED.

KANSAS: ECONOMIC AND QUALITY OF CARE IMPLICATIONS.

WE HAVE PROJECTED THAT FOR EVERY ONE PERCENT DECLINE IN AVERAGE, STATEWIDE NURSING HOME BED OCCUPANCY, THE MEDICAID PROGRAM WILL INCUR A COST OF $962,724. (A NURSING HOME'S COSTS FOR BUILDING, MAINTENANCE, MORTGAGE PAYMENTS AND EQUIPMENT REMAIN THE SAME AND MUST BE PAID WHETHER IT IS FULL OR HALF EMPTY. AS THE NUMBER OF PATIENTS DROP, THE COST PER PATIENT RISES TO MEET THE FIXED COSTS.) (SEE ATTACHMENT, "HOW PATIENT CENSUS AFFECTS MEDICAID COSTS.")

THERE WOULD APPEAR TO BE AN ECONOMIC REASON FOR THE STATE TO CONTROL BED SUPPLY TO ENSURE SATISFACTORY OCCUPANCY LEVELS IN ORDER TO PREVENT UNNECESSARY HEALTH CARE COST INFLATION.

ALSO, A RESTRICTED BED SUPPLY WOULD ENCOURAGE THE DEVELOPMENT OF MORE COMMUNITY-BASED ALTERNATIVES. A DRAMATIC INCREASE IN THE SUPPLY OF NURSING HOME BEDS WOULD BE A DISINCENTIVE TO THIS POLICY AS INCREASED COSTS TO THE MEDICAID BUDGET FOR NURSING HOME CARE WOULD DIVERT

FUNDS AWAY FROM SUCH ALTERNATIVES.

EQUALLY IMPORTANT ARE QUALITY OF CARE CONSIDERATIONS.

"ARIZONA. THE CONSUMER IS BEGINNING TO FEEL THE EFFECTS OF OVER-BEDDING, WHICH HAS BEEN ACCOMPANIED BY A DECREASE IN OCCUPANCY RATES. IN SOME FACILITIES WITH LOW CENSUS, STAFFING IS EITHER INADEQUATE OR OF MARGINAL QUALITY SINCE THE REVENUE IS LESS THAN NEEDED TO OPERATE. THE AVAILABILITY OF LICENSED STAFF WILL ALSO INFLUENCE THE QUALITY OF CARE; NURSING HOMES ARE NOT ONLY IN COMPETITION WITH EACH OTHER FOR QUALIFIED STAFF, BUT WITH OTHER PROVIDERS AS WELL."

("THE NEED FOR REGULATION OF NURSING HOME BEDS", FLORIDA NURSING HOME BED NEED TASK FORCE, 1987.)

A SUBJECTIVE DEBATE CAN CONTINUE AD INFINITUM ON WHETHER OR NOT QUALITY OF CARE WILL BE ENHANCED OR DIMINISHED IN AN UNREGULATED ENVIRONMENT. QUALITY OF CARE IS A CONSIDERATION FOR ALL OF US. AS MORE-AND-MORE FACILITIES COME ON LINE, THE ALREADY ACUTE SHORTAGE OF PROFESSIONAL NURSING PERSONNEL WILL BECOME MORE PRONOUNCED. WHERE AND HOW WILL WE FIND THESE ESSENTIAL PERSONNEL -- ALL INDICATIONS ARE THAT THE CURRENT SHORTAGE WILL TAKE FIVE YEARS TO CORRECT ITSELF -- IN ORDER FOR US TO MEET OUR OBLIGATION TO KANSAS' ELDERLY POPULATION?

WE RESPECTFULLY REQUEST YOUR FAVORABLE REPORTING OF H.B. 2614. WHILE THERE MAY BE THOSE WHO STATE THAT THE KANSAS "FACTS" DON'T WARRANT THIS MEASURE, LET US LEARN AND HEED THE LESSON FROM THOSE STATES WHICH HAVE NOW HAD SOME EXPERIENCE WITH UNCHECKED BED DEVELOPMENT. THE HARBINGERS OF WHAT WILL HAPPEN ARE EVIDENT FOR KANSAS -- IF NOT NEXT YEAR, THEN NOT TOO FAR AWAY.

WE OFFER AS AN ADDITIONAL CONSIDERATION TO THE COMMITTEE A SUGGESTION THAT IF THE BILL ISN'T APPROVED THAT THIS SUBJECT BE REFERRED FOR INDEPTH STUDY DURING THE INTERIM SESSION.

THANK YOU FOR THIS OPPORTUNITY. ATTACHED ALSO IS A SUGGESTED AMENDMENT TO THE BILL.

HOW PATIENT CENSUS AFFECTS MEDICAID COSTS

The following is an example of how a lower patient census increases the Medicaid costs of an individual facility.

License level = ICF (Intermediate Care Facility)

Beds = 100

Average patients = 93

Yearly inpatient days = 33,945

Yearly costs to run facility = $1,138,854.75

Per patient day cost = $1,138,854.70 / 33,945 = $33.55 (State Average)

Medicaid Rate = $33.55 (Maximum ICF Medicaid rate is around $44.43)

If a 100 bed home has had an average of 93 residents and their occupancy drops by 1% to an average of 92 residents, their cost for staff, physical plant, property costs, housekeeping, and administration will remain the same.

Personnel costs, which make up most of the costs a facility incurs, will not change due to the present shortage. On any day the Topeka Capital Journal will be filled with help wanted ads by nearly every nursing home in the area. These costs will actually increase as more new facilities open. While the new facilities will have a low occupancy at first, they still will need 24 hour licensed nursing, nurse aides, food service workers, and housekeeping personnel. This shortage will tend to drive personnel costs up as providers try tp compete for the existing personnel. Nursing homes are already being charged $18.00 an hour for an LPN from an employment agency pool.

An exception to this would be raw food costs which generally make up 4% to 8% of the costs to run a nursing home. However, a lower patient total would not lower the costs for food service workers.

Average residents = 92

Yearly inpatient days = 33,580

Yearly costs to run facility = $1,138,854.75

Per patient day costs = $33.91

Medicaid rate = $33.91

The Medicaid rate for this facility at 93 residents was $33.55 vs. $33.91 at 92 residents, a difference of $.36 due simply to a lower patient census. This amount is significant when you consider that the state's Medicaid program pays for between 4,500,000 and 5,000,000 patient days a year.

Not all providers would receive a Medicaid rate increase due to lower patient census because their costs are already at one or more of the cost center limits used by SRS to set rates. However, their higher costs will serve to drive up the cost center limits and will cost the Medicaid program even more in the out-years.

KHCA has calculated that if every facility in the state has a decrease of 1% in their occupancy rate and their costs remain the same, a one year cost to the Medicaid program would be **$962,724.00**; subsequent years would cost the program even more. Data in other states that have had unregulated bed growth would indicate that this figure is on the conservative side.

A discussion of occupancy data:

Since the sunset of C.O.N. the number of inpatient days have remained fairly stabile. An example is that the 3rd quarter of 1985, the first quarter after the sunset of C.O.N., the number of inpatient days in Kansas nursing homes was 2,224,611; the 3rd quarter of 1986 there were 2,192,147; the 3rd quarter of 1987 is not available yet. The inpatient days for 1st and 2nd quarter of 1984 were 2,198,104 and 2,247,575 respectively.

In the same time period there had been 23 new facilities and 2,297 beds either built or under construction.

To look at the occupancy percentage only is misleading due to the fact that a Medicaid facility is penalized on its Medicaid rate if the occupancy is below 85%; therefore, facilities decertify nursing home beds just to have the appearance of having an occupancy rate of 85% or better. These beds which are decertified can be recertified at a later date. It is obvious that, while inpatient days have remained fairly stabile since the sunset of C.O.N., there has been a boom in the number of nursing home beds.

EXHIBIT "A"

less than 92%.

(d) Notwithstanding the other provisions of this section to the contrary, any adult care home licensed prior to the effective date of this act may increase its bed capacity by 10% of current capacity or by no more than 10 beds in any two-year period.

(e) The following shall not be subject to the provisions of this section: (1) A facility project submitted within 60 days after the effective date of this act to the department of health and environment with evidence of the permanent financing of the project; and (2) available unlicensed beds as described in paragraph (2) of subsection (f).

(f) As used in this section:

(1) "Construction area" includes all adult care home beds and all certified hospital swing beds within a 25-mile radius from the center of the closest incorporated community or city as determined by utilizing the state map prepared by the Kansas department of transportation and the department of commerce.

(2) "Available beds" includes all licensed or unlicensed adult care home beds in the construction area which had been licensed as adult care home beds within the previous ten-year period and are still available for licensure.

~~(h)~~ *(g)* This section shall be part of and supplemental to the adult care home licensure act.

Sec. 2. K.S.A. 39-926a is hereby repealed.

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

DATE: February 3, 1988

TO: House Public Health & Welfare Committee

RE: Amendment to H.B. 2614

FROM: Kansas Health Care Association

Change to read... all adult care home beds, certified hospital swing beds, and hospital based long term care units certified for participation as a skilled nursing facility or intermediate care facility under Title XVIII and Title XIX of the Social Security Act.

RATIONALE: Hospital based long term care units should be included since they provide nursing home care services under the federal act.

Testimony By: Izena Monk, Nursing Home Owner and Administrator

Occupation: Administrator of a 76 Bed Intermediate Care Nursing Home, located in Cunningham, Kansas

Experience: Fourteen years in Nursing Home Field - Ten years as an Administrator

I am in favor of Bill 2614 which will place a limit on construction of nursing home beds. I believe this bill needs to be considered because the construction of more nursing home beds in my area is going to have a negative effect on the care of the elderly.

A nursing home must make money to give quality care, to serve good food and have a clean environment. Revenue comes from residents and if your home has a low census, you have low income. While running a nursing home isn't that simple, it is a fact you cannot give good care without funds.

I took a survey of 12 Intermediate Care Nursing Homes within a 50 mile radius of my home and not one was full. The average census was 85% with the lowest 69%. Within this 50 mile radius a 60 bed Intermediate Care Facility is in the process of construction and another 60 bed home is being considered.

Obviously, more beds are not needed in our area. That in itself would not be a problem if the existing homes could give quality care with a low census, but we cannot.

With the construction of new homes in this area there will be a multitude of problems for both the new homes and the existing homes.

First, there is already a severe shortage of professional nurses and qualified nursing personnel in nursing homes. Every nursing home in my area has a help wanted ad in the newspaper every day. I'm not sure what response the other homes have, but I have not even had a nurse apply at my home for two years. When there is a shortage of staff, residents are not going to have even the basic care they deserve

attm #5
PHCC
2-3-8

and need. I am talking about very fundamental things like bathing, walking, eating and activities of daily living.

I am sending qualified personnel through nurses training to assure we will have nurses in the future, but if our census continues to be low, I don't know how much longer I can afford to do this.

Second, when the census is down the home must try to scale down its expenses and there are only certain areas to cut. Wages usually can't be cut and since salaries is the largest expense you have, you cut hours. When you cut hours you will hurt the quality of care. Food costs can be cut by serving a cheaper meal and this is so sad bcause for many of our residents, food is their major enjoyment in life.

Hilltop Manor is owned by ten people who built the home eleven years ago as a service to the community. The owners have never made money from the home, in fact, they have not gotten their original investment back. All they have wanted was for the home to be self-sufficient and to continue to be a good home for the people who need it. For the home to do this, it must maintain an occupancy of at least 95%. With all the resources available to the elderly to help them stay in their homes and with the advanced medical technology which enables people stay healthy longer, the existing homes are having a very hard time maintaining a high census. Perhaps that is the heart of the problem for us. I am all for people staying home as long as possible and I think medical technology is wonderful but because of it we do not need more nursing home beds. The very fact the government is spending more and more money on these programs should be reason enough for the government to look at the construction of nursing homes to see if there is really a need.

KAHA

The Organization of
Nonprofit Homes and
Services for the Elderly

Kansas Association of Homes for the Aging
641 S.W. Harrison
Topeka, Kansas 66603

913-233-7443

John Grace, Executive Director

Kansas Association of Homes for the Aging
The organization of not-for-profit retirement and adult care homes in Kansas.

We are opposed to H.B. 2614.

In 1985 we spoke against the extension of CON and in favor of free market.

A free market approach can result in more choices for consumers, both on type, quality, and quantity of services. In a free market, providers can either expand existing services or build new facilities to meet the growing demand. Arizona experience has shown that good homes do well and poor homes do poorly. New providers that built facilities without proper market research have not done well.

The fastest growing age group is the 75+. Since 1983, this group has grown from 142,000 to 1990, 173,000; a 22% growth. In January 1985 we had .17 Beds per every person age 75+ statewide.

In 1990 based upon the 2500 new beds projected by Health & Environment to come on line, we'll have .17 beds per every person over age 75+.

The growth of home health care, and alternative services will have an impact on the number of beds required. The point is; no one can project how many beds will be needed.

The real question is "Who decides who will build? Under CON, health planning board made up of community representatives" would decide and the state could veto. HB 2614 leaves the decision entirely up to the state based upon one element: Occupancy. What happens to the good home that has a waiting list of people to move in, but can't build because the other homes are under 92%? Personal Care Facilities could not be built under this bill.

Some homes will have trouble with competition. They have trouble staffing, their care is poor, and they are poorly managed. New homes perhaps did poor market research. It is a providers responsibility to research the market, and to provide high quality of care.

In summary, we simply do not believe passage of this bill will be a step forward in the care of our older Kansans.

Thank You, Mr. Chairman.

attm #6
PH&W
2-3-8

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2614

BACKGROUND INFORMATION

The control of capital investments and new beds in hospitals and nursing homes through the Certificate of Need Program ended on July 1, 1985. As many of you remember, that decision was made after significant debate, occurring over several sessions of the Legislature. As might be expected, the arguments to reinstate controls on new nursing home beds are not different than those of several years ago.

Since Congress repealed the National Health Planning and Development Act, twelve states have repealed certificate of need statutes and the debate on repeal of those statutes is active and at least ten others. At the same time, many other states are taking action to limit the scope and coverage of their Certificate of Need programs.

In 1985, Kansas led the move to abolish capital controls and bed controls in the health care industry. The trend toward deregulation of the hospital and nursing home market has not abated, but in fact, is growing.

Attachment I is a bar graph showing the number of new adult care home beds applied for in Kansas from 1985 through 1987. These are all beds for which a formal licensure application has been filed, including payment of the fee consisting of $50 per application plus $7.00 per bed. The beds are displayed in terms of those added to existing facilities and those proposed in new facilities. The 3,363 beds shown on the chart represent 12.5% increase in the number of beds licensed on July 1, 1985.

Attm. #7
2-4-8
Attached

The number of applications for new facility beds has dropped significantly in 1987, while the number of beds added to existing facilities is comparable to the number added in 1985. These figures appear to indicate that the boom in new beds is ending.

Attachment 2 displays the statewide adult care home occupancy rate by quarter for 1985, 1986, and the first two quarters of 1987. Also shown is the annual occupancy rate for both 1985 and 1986. Until the third and fourth quarter data is available, we won't know if the statewide occupancy rate has dropped slightly or held steady in 1987. In addition, since most of the new beds will not come on line until sometime in 1988 or early 1989, speculation on their impact on the occupancy rate is premature.

ISSUES

Is the building boom likely to continue? The sharp drop in the number of beds applied for in 1987 would indicate that the building boom is drawing to a close. Those operators that were restrained by the Certificate of Need program have undertaken the construction that had been prevented.

If the statewide occupancy rate does decrease, will that increase Medicaid costs? The Medicaid Program now has a control to avoid paying the excess costs generated by low occupancy. If the primary policy concern is the effect of new beds on Medicaid cost, we should look to the Medicaid program to maintain controls to prevent paying inappropriately for low occupancy.

Does the number of beds in the market have an impact on the quality of care? When the market for nursing home beds is tightly constricted and new construction is controlled, existing operators are rewarded with relatively high occupancy and protection from new competition. In this situation, the incentives to compete for customers by offering new or higher quality services is severely limited. Conversely, the market situation where operators are forced to compete to fill their beds maximizes the incentives to offer new and higher quality services. We hear about the health care market as not competitive, but this observation must be tempered with respect to the adult care home market. It is accurate that price competition is limited because the Medicaid program dominates pricing in the market; however, there is the potential for price competition in the private pay market and there is the potential for significantly increased competition among facilities to fill beds.

Do we want to close the market to new personal care beds? In the last year, we have revised the adult care home regulations for personal care and boarding care home beds with an eye toward encouraging the development of these beds as alternatives to the higher cost of intermediate and skilled care. The bill, as written, would include personal care beds, boarding care beds and one and two-bed facilities within its restrictions.

Do we want to limit the market for mental retardation facility beds? Both Kansas and the federal government are encouraging the development of small 15-bed or less facilities for the mentally retarded with medical needs.

Lines 39 and 40 of the bill would require that we predict the occupancy rate in an area after the new beds were built. This would be impossible.

The definition of a construction area beginning on Line 58 includes all certified swing beds. Certified hospital swing beds are not included in the definition of available beds beginning on Line 53. Since it is impossible to calculate an occupancy rate for swing beds, they could not be included in the base used to determine the occupancy rate for any given area.

The definition of available beds includes unlicensed beds. Since there is no definition of unlicensed beds, and no way to accurately track beds that may have been licensed at some point in time, there would be no reliable way to include such beds in an occupancy rate formula.

Because a construction area is defined as a radius of 25 miles from the nearest town, there are obviously a very large number of construction areas and nearly infinite number of overlapping areas between construction areas. In the case of overlapping construction areas with different occupancy rates, there would be no method to resolve the conflict nor to determine a priority between operators within the different areas.

Perhaps more important, when the occupancy rate in a particular area such as Topeka, does reach the threshold, there would be no way to determine priority among competing applications to add beds.

The 25 mile definition for a construction area may be appropriate for urban areas and even rural areas in eastern Kansas but it well may not be appropriate for the longer distances in western Kansas.

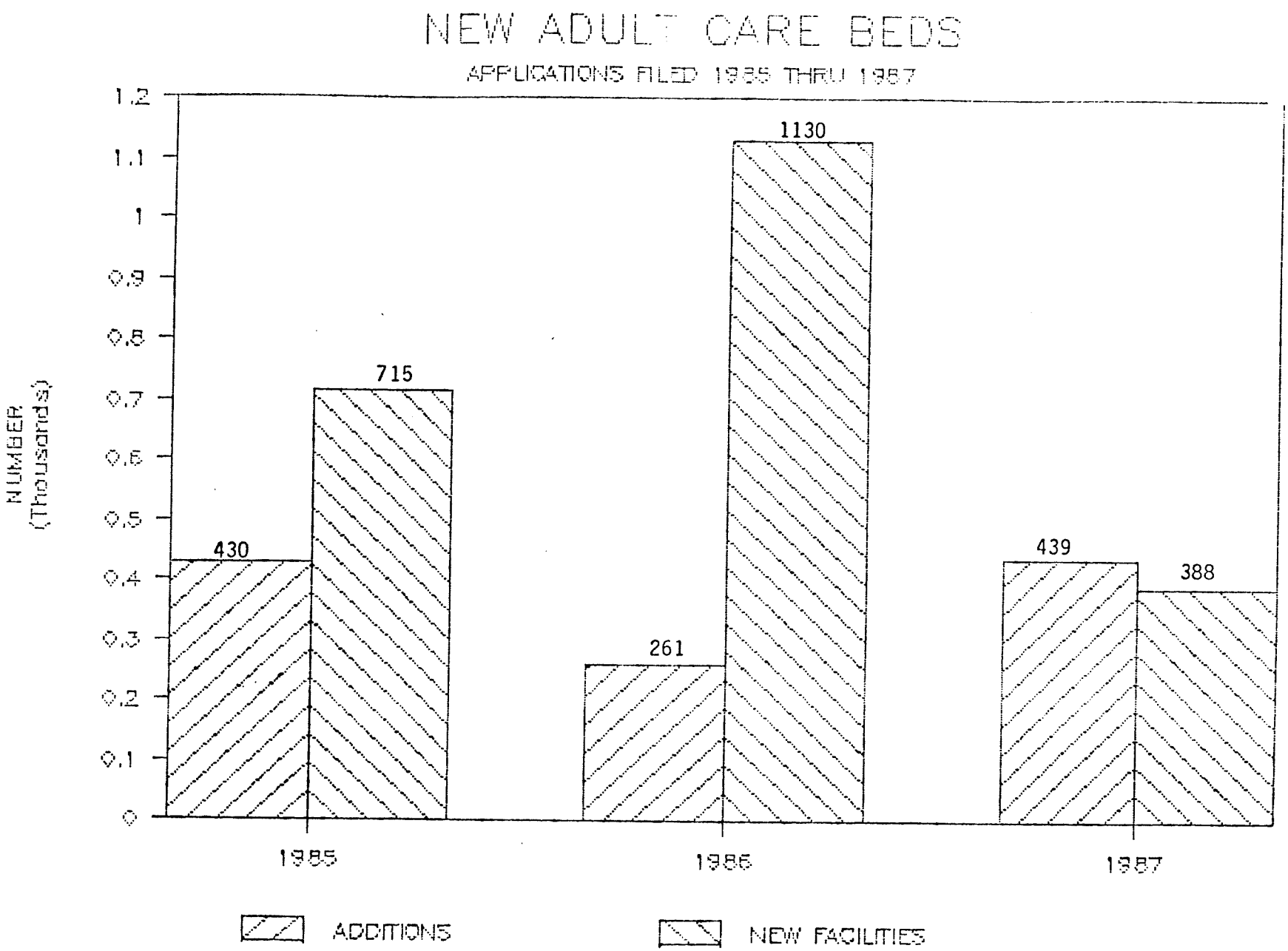
All of these last observations were considered and debated at great length in developing the health planning and Certificate of Need programs during the 1970's. In fact, it proved to be not possible to develop a simple formula as envisioned by this bill that accomplished the goal fairly.

RECOMMENDATION

It is not clear from the available data on beds and occupancy that a new regulatory program to control entry into the nursing home market is necessary. If we do conclude at some point that the expansion of the nursing home market is having a negative effect on quality and cost, we should explore other alternatives to address those problems. We recommend that House Bill 2614 be reported unfavorably.

Presented by: Richard J. Morrissey, Director
Bureau of Adult and Child Care
February 3, 1988

Attachment 1



Attachment 2

ADULT CARE HOME

OCCUPANCY REPORT

by Percent

	1st Quarter	2nd Quarter	3rd Quarter	4th Qtr.	Annual
1985	90.01	90.02	90.33	90.59	90.17
1986	90.60	90.48	89.92	89.08	90.22
1987	89.41	90.06			

Source: Adult Care Home
Quarterly Report
Bureau of Adult and Child Care
Kansas Department of Health and Environment

January 1988