Approved 4-2-90
Date

MINUTES OF THE House COMMITTEE ON Appropriations.

The meeting was called to order by Bill Bunten at
Chairperson

12:10 ~~a~~x~~x~~/p.m. on March 6, 1990 in room 514-S of the Capitol.

All members were present except: Representatives Vancrum, Kline, and Fuller (all excused)

Committee staff present: Ellen Piekalkiewicz, Legislative Research Department
Jim Wilson, Revisor of Statutes
Sharon Schwartz, Administrative Aide
Sue Krische, Committee Secretary

Conferees appearing before the committee:

Representative Elaine Wells
Lyndon Drew, Department on Aging
Dick Hummel, Kansas Health Care Association
John Alquest, Commissioner, Income Maintenance and Medical Services, SRS
John Grace, Kansas Homes for Aging
Keith Ratzloff, Controller, Kansas State University
Sandy Duncan, Commissioner, Administrative Services, SRS
Al Nemec, Commissioner, Mental Health and Retardation Services, SRS
Others attending: See attached list.

INTRODUCTION OF BILLS

Representative Brady requested introduction of a bill providing that fiscal notes be furnished to the first-named sponsor of the bill (Attachment 1) and a bill pertaining to social welfare establishing a family subsidy program (Attachment 2). Representative Brady moved introduction of the bills. Representative Chronister seconded. Motion carried.

Representative Teagarden requested introduction of a bill regarding planning and zoning by counties which amends K.S.A. 19-2915 to state the board of county commissioners by resolution may establish a planning board for the county and it changes the maximum number of board members from 11 to 15 (Attachment 3). Representative Chronister moved introduction of the bill. Representative Heinemann seconded. Motion carried.

HB 2890 - Long-term health care.

Representative Elaine Wells explained that HB 2890 would establish a pilot program entitled the Kansas Partnership for Long-term Care. She submitted written testimony including a January 1990 status report on the Connecticut Partnership for Long-term Care (Attachment 4). Representative Wells stated HB 2890 is fashioned after the Connecticut statute which combines private insurance and Medicaid funds. Under the program, an individual may purchase a precertified policy which is proportionate with the assets they want to protect. When those benefits are exhausted by a nursing home stay and the individual makes application for Medicaid, the amount of the benefits paid would be excluded in determining eligibility.

Lyndon Drew, Department on Aging, testified that the Department supports the concept of HB 2890 and pledged the cooperation of the Department in development of the outreach component of the program (Attachment 5).

Dick Hummel, Kansas Health Care Association, supports the concept of HB 2890 and noted that currently less than 1 percent of nursing home admissions are paid for by private insurance.

John Alquest, Commissioner, Income Maintenance and Medical Services, SRS, testified in support of HB 2890 (Attachment 6). His written testimony included some suggested changes and clarifications in the bill.

John Grace, Kansas Homes for Aging, appeared in support of HB 2890 and stated his Association would work with the State on implementation of the program.

SB 591 - Increasing certain imprest fund limitations.
SB 590 - Increase in limits of certain change funds.

Keith Ratzloff, Controller, Kansas State University, explained that SB 591 authorizes an increase in the imprest fund limit at Kansas State University from $35,000 to $60,000 and at Pittsburg State University from $22,000 to $35,000 (Attachment 7). The funding source for these increases will be from General Fee revenues. Mr. Ratzloff advised that SB 590 amends current law to authorize the Director of Accounts and Reports to establish a change fund not to exceed $40,000 at each Regents' institution. Current law allows a maximum not to exceed $20,000.

SB 663 - Increasing amount in SRS imprest funds of area office.

Sandy Duncan, Commissioner, Administrative Services, SRS, testified that SB 663, as introduced, increases the limit for the SRS imprest fund from $500,000 to $1,000,000 (Attachment 8). The imprest fund is used to allow area offices to write checks in specific instances where an immediate payment is needed. Mr. Duncan stated due to concern about the status of the State General Fund, the Department recommends that the limit in the bill be amended from $1,000,000 to $750,000.

SB 666 - Work therapy funds for SRS institutions.

Al Nemec, Commissioner, Mental Health and Retardation Services, SRS, explained that SB 666 would allow the continuation of work therapy funds at the State institutions (Attachment 9). "Work therapy funds" are defined as the money or assets used to operate a sheltered workshop or similar vocational training activity.

Representative Solbach moved to amend SB 663 on line 17 by changing $1,000,000 to $750,000. Representative Wisdom seconded. Motion carried. Representative Bunten moved to amend SB 591 and SB 663 to allow that the increased fund limits be taken out of the agency's regular appropriation versus a transfer from the State General Fund. Representative Chronister seconded. Motion carried. Representative Solbach moved that SB 591 and SB 663, as amended, be recommended favorably for passage and that SB 590 and SB 666 be recommended favorably for passage and placed on the consent calendar. Representative Teagarden seconded. Motion carried.

HB 3002 - Behavioral sciences regulatory board, increasing certain maximum fees.

Representative Solbach submitted a balloon amendment on SB 3002 reducing the maximum renewal fees specified in the bill (Attachment 10). Representative Solbach stated the bill does not raise fees because that is done through public hearings and rules and regulations. Representative Solbach moved to amend HB 3002 by adoption of the balloon amendments. Representative Wisdom seconded. Motion carried. Representative Solbach moved that HB 3002, as amended, be recommended favorably for passage. Representative Wisdom seconded. Motion failed.

The meeting was adjourned at 1:20 p.m.

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: 3-6-90

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
John Alquest	DSOB	SRS
Dennis Priest	Topeka	SRS
Linda Perrier	D.St.O. Bldg	S.R.S.
M Kennedy	Topeka	DoB
Cindy Davis	KDOA	
SUSAN PETERSON	MANHATTAN	KANSAS State University
KEITH KATZLOFF	MANHATTAN	KSU
Tim Rousen	Topeka	KSU
Dick Hummel	Topeka	KCACOA
George Kahrl	Topeka	Capital City Task Force AARP
Mark Intermill	Topeka	Kansas Coalition on Aging
Lynda Drew	Topeka	KDOA
Joe Myers	Topeka	Dept of Admin
Gigi Jelin	Top	K-NASW
Larry Hinton	~~To~~peka	SRS
Bob Clawson	Topeka	SRS
AL Nemec	Topeka	SRS/MH&RS
Karen DeVinney	Topeka	SRS
J S DUNCAN	TOPEKA	SRS
M Bohnhoff	Topeka	Div. of Budget
Gil Grace	"	KAHA
Lorin Chapman	Topeka	Budget

BILL NO. ____

AN ACT concerning fiscal notes for certain legislative bills; amending K.S.A. 75-3715a and repealing the existing section.

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

Section 1. K.S.A. 75-3715a is hereby amended to read as follows: 75-3715a. (a) Fiscal notes shall be provided for all bills increasing or decreasing state revenues or the revenues of counties, cities and school districts, making state appropriations or increasing or decreasing existing appropriations or the fiscal liability of the state, or imposing functions or responsibilities on counties, cities and school districts which will increase their expenditures or fiscal liability. Not more than seven ~~(7)~~ days following the first reading of any such bill, the director of the budget shall furnish ~~to the committee or committees to which such bill was referred~~ a statement explaining the fiscal effect of such bill to the committee or committees to which such bill was referred and, in the case of a bill sponsored by one or more members of the senate or house of representatives, to the first-named sponsor of the bill. Fiscal notes are required for original bills only and not for amendments.

(b) The fiscal note shall, if possible, include a reliable estimate in dollars of the anticipated change in revenue, expenditures, or fiscal liability under the provisions of the bill. It shall also include a statement as to the immediate effect and, if determinable or reasonably foreseeable, the long-range effect of the measure. If, after careful investigation, it is determined that no dollar estimate is possible, the note shall contain a statement to that effect, setting forth the reasons why no dollar estimate can be given.

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Attachment 1

Every agency and department of the state is directed to cooperate with the division of the budget in preparation of any fiscal note provided for by this act when, and to the extent, requested by the director of the budget.

(c) No comment or opinion shall be included in the fiscal note regarding the merits of the measure for which the note is prepared.

Sec. 2. K.S.A. 75-3715a is hereby repealed.

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

BILL NO. ____

AN ACT relating to social welfare; establishing a family subsidy program; prescribing powers, duties and functions for the secretary of social and rehabilitation services.

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

Section 1. (a) The secretary of social and rehabilitation services shall establish a program to provide subsidies to families to enable them to care for dependents with handicaps in their own home. This program shall be limited to families with dependents who are under the age of 22 years and who are mentally retarded or who have a related condition and otherwise would require or be eligible for placement in a residential facility. Applications for a family subsidy shall specify the needs of the family and how the subsidy will be used.

(b) An individual service plan for the dependent under the family subsidy program shall be developed by the secretary of social and rehabilitation services and agreed upon by the parents or guardian. A transitional plan shall be developed for the dependent when the dependent becomes age 17 in order to assure an orderly transition to other services when the family terminates services from this program and to assure that an application is made for supplemental security income and other benefits available under state or federal programs.

(c) Subsidy amounts shall be determined by the secretary of social and rehabilitation services. The subsidy may be used to cover the costs of special equipment, special clothing or diets, related transportation, therapy, medications, respite care, medical care, diagnostic assessments, modifications to the home and vehicle, and other services or items that assist the family and dependent. The maximum monthly amount of a family subsidy

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Attachment 2

shall be $250. The secretary may consider the dependent's supplemental security income in determining the amount of the subsidy. A variance may be granted by the secretary to exceed $250 for emergency circumstances in cases where exceptional resources of the family are required to meet the health, welfare or safety needs of the dependent. Any such variance shall be for a period of not to exceed 90 days per fiscal year or the period of three regular assistance payments, whichever is shorter. The secretary may set aside 1% of the moneys appropriated for this program to fund emergency situations.

(d) The secretary shall adopt rules and regulations to govern subsidy applications, criteria for approval, and other areas necessary for the implementation of this program.

(e) As used in this section, "residential facility" means any facility, public or private, regularly providing one or more persons with a 24-hour-per-day substitute for care, food, lodging, training, education, supervision, habilitation, rehabilitation and treatment needs which for any reason cannot be furnished in the person's own home. Residential facilities include, but are not limited to: State institutions for the mentally retarded under the control of the secretary of social and rehabilitation services, foster homes, residential treatment centers, maternity shelters, group homes, residential programs, supportive living residences for functionally impaired adults and schools for handicapped children.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

514 S
Sue for Sharon

Rep Teagarden

9 RS 2736

PROPOSED BILL NO. ____

By

AN ACT concerning counties; relating to planning and zoning; amending K.S.A. 19-2915 and repealing the existing section.

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

Section 1. K.S.A. 19-2915 is hereby amended to read as follows: 19-2915. The board of county commissioners ~~may~~ by resolution may establish a planning board for the county. The board shall consist of not less than five nor more than ~~11~~ 15 members who shall be residents of the county, a majority of whom live outside the corporate limits of any incorporated city in the county. The board of county commissioners shall appoint all members of the planning board. The board of county commissioners shall appoint to the planning board one member of the board of supervisors of a conservation district located within the county who shall be a voting member. The members first appointed shall be appointed for terms of one, two and three years. The terms shall be divided equally or as nearly equally as possible between the members. Thereafter members shall be appointed for terms of three years each. Vacancies shall be filled by appointment for the unexpired term. Members of the board shall serve without compensation for their services.

Sec. 2. K.S.A. 19-2915 is hereby repealed.

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

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Attachment 3

STATE OF KANSAS

ELAINE L. WELLS
REPRESENTATIVE, THIRTEENTH DISTRICT
OSAGE AND NORTH LYON COUNTIES
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CARBONDALE, KANSAS 66414
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TOPEKA

COMMITTEE ASSIGNMENTS
MEMBER: AGRICULTURE AND SMALL BUSINESS
INSURANCE
PUBLIC HEALTH AND WELFARE
PENSIONS, INVESTMENTS AND
BENEFITS

HOUSE OF
REPRESENTATIVES

APPROPRIATIONS COMMITTEE

TESTIMONY
on
HOUSE BILL NO. 2890
March 6, 1990
by
REPRESENTATIVE ELAINE L. WELLS

Thank you Mr. Chairman and members of the committee.

With my fourteen year background in adult care home administration and now nine months in long term care insurance, I've tried to keep up to date on the issues relating to the elderly and especially financing nursing home care. I've followed this year's SRS hearings and know the dilemma we are facing with OBRA, the rising number of Medicaid recipients and the shortfall of state dollars.

H.B. 2890 is an idea that may begin to address some of the problems, and if it is passed, Kansas will follow suit of nine other states who have developed such a demonstration project because they too "have seen the writing on the wall" of their increasing Medicaid dollars going largely to finance long term care of the elderly. Those nine states are Indiana, Illinois, Wisconsin, Oregon, California, Connecticut, Massachusetts, New York, and New Jersey. H.B. 2890 is fashioned after the Connecticut statute.

Simply put, it establishes the pilot program of the "Kansas partnership for long term care". It combines private insurance and Medicaid funds. Under the program an individual may purchase a pre-certified policy (by the Insurance Commissioner), which is proportionate

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Attachment 4

with the assets they want to protect. When those benefits are exhausted by a nursing home stay and the individual makes application for Medicaid, the amount of the benefits paid (purchased to protect the assets) would be excluded in determining eligibility.

I have attached the information from Connecticut but I know you'll have limited time to read every sheet so there's some of it I'd like to bring to your attention.

The first is the paper by Dr. Mahoney, the project director. He tells of the final report from Connecticut's Governor's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly. Their first recommendation called for the development of an economical, feasible, practical, mutually-beneficial model using public and private funds cooperatively to finance long term care.

The second attachment to my testimony is the Progress Report to the Connecticut General Assembly in January of this year. It describes first their success in implementing the Public and Private Partnership.

Attachment A of the Progress Report describes the federal enabling legislation, specifically the Senate Congressional Record of November 21, 1989, and the bill to allow the nine states to proceed with their demonstration projects. I'd like to read some excerpts taken from Senator Coats of Indiana.

Attachment B of the report includes communications from Connecticut seeking Medicaid eligibility waiver: first, a letter to the Secretary

of HHS from the Governor of Connecticut; second, a letter to the Chairman of the Pepper Commission, and the third letter to request the elibility waiver to be included in the Budget Reconciliation Bill.

Attachment C is the discussion paper of the analysis of spend down patterns in Connecticut of individuals admitted to nursing homes. The first sheet describes the basis that formulated the Research Institute.

The remainder of the Attachment C to the report describes the finding of the research and focuses on the consumption of assets in the spend-down process after an individual enters a nursing home. The "spend-down period" refers to the duration of time from entry into a nursing home to the date of Medicaid eligibility.

In summary, the study analyzed adminissions from 10/1/78 to 9/30/79. The results showed that Medicaid paid for 68% of the total days for those who spend down and 57% of the days for the entire admission cohort. There were two discreet groups of patients: the "wealthy" and the "middle income". The wealthy spend down at a rate of 9% per year and the middle income group spend down at the rate that was ten times faster. The analysis indicated that the median middle income patient would spend down only after 276 days (39 weeks) if patients remained in nursing homes indefinitely.

Some of the paradoxical results included (from page 13).

As you can see, Connecticut is one of the nine states who has taken action to reduce the amount of dollars they spend on financing long term care.

Kansas can follow the lead by establishing the same pilot program by passing H.B. 2890. Using the data from the other states who have already had comparisons to study, the partnership program will enable us to "get into the act" sooner and receive the federal approval necessary to carry out the program.

Implementation will be gradual as several key elements need to be incorporated as outlined in the bill. Section 2 requires SRS to seek appropriate amendments to its Medicaid rules and regulations and state plan and adopt them. Section 3 requires the Insurance Commissioner to pre-certify policies which: offer the option of home and community-based services in lieu of nursing home care; in all home-care plans, offer case management services delivered by a coordination, assessment and monitoring agency or by a home health care agency; offer automatic inflation protection or optional periodic per diem upgrades until the insured begins to receive long-term care benefits; provides for the keeping of records and an explanation of benefits reports on insurance payments which count toward Medicaid resource exclusion; and provides the management information and reports necessary to document the extent of Medicaid resource protection offered. The Insurance Commissioner must adopt rules and regulations to carry out the precertification and evaluate the partnership program.

Section 4 request the secretary of aging to establish an outreach program to educate consumers and Section 5 requires the secretary of SRS to seek foundation funds and federal approvals necessary to carry out the purposes of the Act. Plus, it requires an annual report to the legislature. The report is the same as the one Connecticut requires (Last attachment, page 133 of Connecticut Human Services Committee.)

The whole idea in a nutshell behind the Partnership Program is the incentive for people to purchase insurance covering the cost of long term care. The market is relatively new and most people still feel that they are not going to have to go into a nursing home but the statistics indicate that nationwide, one out of every four people over the age of 65 will spend time in a nursing home before they die and one out of every two over 75 will. The rich will be able to afford to pay for the cost and the poor will have to depend on the state. But, if we can find a way for the middle income to not have to end up on Medicaid then state resources can be better spent on other programs for the truly needy. H.B. 2890 offers a valid solution to Rep. Goossen's concern of where do we get the money. It will take a few years to see the results but they will be there. The nine other states who are seeking the federal waiver are obviously convinced so.

I hope you'll agree and support H.B. 2890. I'll be happy to respond to questions.

seven days. He must order the transfer or discharge if he finds failure to act would endanger the health, safety, or welfare of the resident or other residents. A hearing on compliance with pertinent statute must be held within seven days of the decision.

Involuntary transfers or discharges may not be made before the commissioner makes a determination. His determination is final and may not be appealed.

Chronic Disease Hospital Patient Transfer or Discharge

The act prohibits the transfer or discharge of a chronic disease patient unless (1) it is for documented medical reasons, or (2) the resident, if a self-pay patient, is more than 15 days in arrears. If an involuntary discharge or transfer is made, the facility must give the patient and any known legally liable relative, guardian, or conservator 30 days written notice if the discharge plan has been prepared by the hospital's medical director.

PA 89-352—HB 7608
Emergency Certification

AN ACT CONCERNING LONG-TERM CARE

SUMMARY: This act establishes a six-year pilot program under which individuals may purchase private long-term care insurance that pays for nursing home and home care services and allows them to protect some of their assets if they eventually need Medicaid assistance. But initiating the program depends on the federal government allowing the state to change its Medicaid plan to permit this protection or approving the pilot program through some other means, such as legislation.

The act gives several agencies responsibility for various aspects of the program. The Department of Income Maintenance (DIM) determines when insurance payments can start and the participating individuals' Medicaid eligibility. The Insurance Department precertifies policies (these are the only policies that can provide asset protection). The Department on Aging (SDA) provides public information and consumer education. And the Office of Policy and Management (OPM) is responsible for program coordination, evaluation, and reporting.
EFFECTIVE DATE: July 1, 1989

FURTHER EXPLANATION

Insurance Benefits and Asset Protection

Beginning January 1, 1990, the Connecticut Partnership for Long-Term Care enables an individual to buy a long-term care insurance policy from a private insurer in an amount commensurate with his assets. The policy will provide benefits to pay for nursing home care or approved home or community care services. And it will provide a way to protect personal assets in the event the person needs to go on Medicaid. People who buy or renew precertified policies during the pilot period (January 1, 1990 through December 31, 1994, unless it is ended earlier) receive asset protection for life.

The act ties all asset protection to benefits actually paid as distinguished from the policy's face value. If the person eventually needs to receive Medicaid assistance (because he has insufficient income, exhausts his insurance benefits, or spends his assets), the act requires DIM to exclude the amount of any benefits paid out when it counts his assets to determine his Medicaid eligibility and payments. And, if the insured does receive Medicaid, the state will not seek to recover its medical payments (up to the amount of insurance benefits paid) from his estate when he dies or from any other assets he receives after he becomes eligible.

Under current DIM regulations an individual is ineligible for Medicaid if he has more than either $1,000 or $1,900 in cash assets, depending on whether his Medicaid eligibility is based on receiving cash assistance or he is medically needy. He may also have $1,500 in equity in a car and keep certain household and personal need items. If his assets are above these limits, he must "spend down" to become eligible. The state also tries to recover its payments from the person's estate after death or from other assets he may receive such as legal settlements or lottery winnings.

Insurance payments from precertified policies must meet four criteria in order to be counted toward resource exclusion. They must be (1) for Medicaid-approved services, (2) the lower of the actual charge or the amount paid by the insurer, (3) for nursing home care or home or community-based care that is part of an approved care plan, and (4) for services provided after the person meets DIM's requirements for determining when long-term care coverage begins ("coverage requirements").

The act requires the income maintenance commissioner to adopt regulations for determining Medicaid eligibility and coverage requirements for long-term care.

Required Federal Approvals

The act requires DIM to seek appropriate amendments to its state Medicaid plan and its Medicaid regulations to allow for resource and income protection for people who buy these long-term care policies. It also requires the OPM secretary to seek federal approval necessary to carry out the act's purpose.

The OPM secretary must seek foundation funds necessary to implement the pilot program.

Precertifying Policies

Asset protection is available only under policies precertified by the insurance commissioner. Policies that require prior hospitalization or nursing home admission as a condition for receiving benefits cannot be precertified. To be precertified policies must:

1. alert the purchaser to consumer information and public education provided by SDA,

2. offer a home and community-based care option in place of nursing home care,
3. offer case management services delivered by state-licensed agencies in all home care options,
4. offer either automatic inflation protection or periodic daily payment increases until the individual begins receiving benefits,
5. provide for the insurer s keeping records of and explaining benefit payments that count toward resource protection, and
6. provide for management information and reporting necessary to document the extent of resource protection offered and to evaluate the program.

The act authorizes the insurance commissioner to adopt regulations governing precertification procedures.

Consumer Information

The act requires the Department on Aging to provide information to assist people in choosing appropriate insurance coverage. It must educate consumers about (1) the need for long-term care, (2) mechanisms for financing such care, (3) the availability of long-term care insurance, and (4) asset protection provided under the act.

Reporting Requirements

The OPM secretary must report to the General Assembly on January 1 annually on:

1. the success in implementing the partnership;
2. the number of policies precertified;
3. the number, age, and financial condition of people who bought policies;
4. the number of people who sought SDA's consumer services;
5. the extent and type of benefits paid that could count toward Medicaid resource protection;
6. estimates of the program's effect on present and future Medicaid payments; and
7. the program's cost effectiveness and whether it should be continued.

PA 89-354—sSB 899
Human Services Committee
Government Administration and Elections Committee
Appropriations Committee
Education Committee

AN ACT CONCERNING THE TRANSFER OF THE DIVISION OF REHABILITATION SERVICES FROM THE STATE BOARD OF EDUCATION TO THE DEPARTMENT OF HUMAN RESOURCES

SUMMARY: This act transfers jurisdiction over rehabilitation services from the State Board of Education to the Department of Human Resources (DHR) on July 1, 1990. The transfer includes the Division of Rehabilitative Services (to be designated as a bureau in DHR), the independent living center program and its advisory council, and the Disabled Students Transition Program.

The act (1) requires the DHR commissioner to establish a public information campaign, (2) establishes a toll-free telephone service for the bureau and its clients, (3) requires the bureau to report annually to the Human Services and Appropriations committees, and (4) authorizes the bureau to buy, without complying with the state's competitive bidding procedures, adaptive equipment up to $10,000 per unit and modified vehicles up to $25,000 each.

There are several provisions specifically related to the transfer. The act establishes a 19-member task force to advise the DHR commissioner on managing the transfer. It specifies that the transfer, including contracts, orders, and regulations, and collective bargaining agreements and obligations, is governed by existing law on transferring state agency duties. It states that the transfer does not modify existing collective bargaining agreements and must not be used to change or serve as the basis for changing any employee's classification or collective bargaining designation.

The act makes DHR include housing services in the community-based residential facilities plan required by PA 89-189.

EFFECTIVE DATE: July 1, 1990, except for the task force provisions which take effect July 1, 1989 and the community-based facility provision which takes effect upon passage.

FURTHER EXPLANATION

Public Information

Public education efforts must include informing the public about the bureau's services, policies, and goals. There must be an outreach effort to find people who could benefit from offered services. DHR must provide printed materials to clients at the initial meeting describing their rights. DHR must describe all state programs for people with disabilities and furnish all state agencies that provide services to them with copies of the description. Those agencies must distribute it during each client's initial meeting.

Annual Reporting

The act requires DHR to report annually to the Human Services and Appropriations committees (1) its plans to reduce its counselors' caseloads to reflect the regional average; (2) such client information as their number, age, race, gender, nature of disabilities, and job placements and retention; (3) its efforts to ensure that minorities are served in proportion to their need; and (4) the number, nature, and resolution of complaints. The first annual report is due July 1, 1991. In it, DHR must advise the committees on the cost of transferring the bureau. It must also give both legislative committees a copy of its federal audit.

"The Connecticut Partnership for Long Term Care: An Example of the Public and Private Sectors Working Together"

by: Kevin J. Mahoney, Ph.D.

In June of 1987 Governor O'Neill's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly issued its final report. The first recommendation called for the development of an economical, feasible, practical, mutually-beneficial model using public and private funds cooperatively to finance long term care.

To meet this goal, Connecticut applied for and received one of the first Robert Wood Johnson "Long Term Care Insurance Program" grants. Our two year planning period got underway in August, 1987. At the beginning of our planning process, we established a Policy Steering Committee - composed of representatives from state government, the legislature, senior advocacy groups, academia, the health care delivery system, the private insurance industry and major employers. This cooperative approach has, in and of itself, been one of our major accomplishments.

After examining a full menu of possible public/private cooperative approaches, the Policy Steering Committee developed and refined a model which has come to be known as the Connecticut Partnership for Long Term Care.

The Connecticut Partnership for Long Term Care (LTC) would encourage individuals to plan for their LTC needs by purchasing insurance protection in an amount commensurate with their assets. Thus an individual with $25,000 in assets might buy $25,000 in insurance protection, while another individual with $150,000 in assets might buy $150,000 in insurance protection. If and when an individual needs Medicaid assistance, each dollar that the insurance policy has paid out in accordance with state policy will be

tracted from the assets the individual still has so that the assets would not be recognized or considered in determining the individual's eligibility for Medicaid. Once on Title XIX, individuals will receive life-long coverage of health and long-term care needs, and will be able to keep control of assets up to the amount that insurance paid; income will still have to be applied toward LTC expenses. (If the case ever arose where the individual needed Medicaid assistance prior to exhausting insurance benefits, he or she could disregard assets equal to what the insurance had already paid out and retain one additional dollar in income for each additional dollar the insurance policy paid for approved expenses.) This resource protection could be available to the elderly and non-elderly alike.

In our view, the Connecticut Partnership for Long Term Care has several major merits. It:

- Provides individuals with a way to plan ahead to meet their particular long term care needs - without having to impoverish themselves. The protected assets can spell the difference between autonomy and dependence;
- Gives individuals of all income groups an extra incentive to buy insurance;
- Extends means-sensitive assistance:
  - The rich will never automatically get publicly-financed care as in some proposals currently before the Congress.
  - Those who qualify for the public program via insurance can have assets they would have otherwise exhausted. <u>But, Medicaid eligibility will not start any earlier than it would have in the absence of insurance</u>.

— Persons of limited means will find insurance more affordable because they would be able to purchase lower amounts of asset protection.

- Stimulates private insurers to develop products for a wider market — for the poor as well as the rich. (Connecticut's approach puts a premium on competition among private insurers and rapid product development.)
- Appears to save federal and state Medicaid funds. Every simulation we ran showed overall and long term public savings.
- Influences the types of coverage offered under private long term care insurance. Pre-certification would only be available to policies which offer comprehensive care while discouraging inappropriate utilization. (The conditions of precertification, listed in Connecticut Public Act 89-352 meet key consumer demands for home care, inflation protection and adequate consumer information.)

Connecticut's planning grant ended in July 1989. In addition to developing and refining a model for public/private cooperation, we were able to agree on the definition of the "insured event"; enunciate the requirements and standards for case management; and develop a comprehensive plan for the public education and consumer information services to be administered by the State Department on Aging. In June of 1989 enabling legislation unanimously passed our State General Assembly. In July we received a three year demonstration grant from the Robert Wood Johnson Foundation.

Now we would like to implement and evaluate our model. Federal enabling legislation is still needed, but, if approved, the Connecticut Partnership for Long Term Care could begin early in 1990. We do not claim that our approach is the panacea, but we do

believe it can improve the lot of many elderly persons - making it possible for them to plan ahead to meet their long term care needs without fear of impoverishment. We do believe this demonstration can answer some key implementation, marketing and utilization questions and provide some critical data to inform the debate over a national approach for financing long term care.

cc: Mark Meiners, PhD

STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

The Connecticut Partnership for Long Term Care
A PROGRESS REPORT
TO THE GENERAL ASSEMBLY

JANUARY, 1990

Anthony V. Milano
Secretary

William A. O'Neill
Governor

566-8340

Phone:
80 Washington Street • Hartford, Connecticut 06106
An Equal Opportunity Employer

4-12

January 1, 1990

TO: The Honorable John Larson, Senate President
The Honorable Richard J. Balducci, Speaker of the House

FROM: Anthony V. Milano
Secretary
Office of Policy and Management

RE: Annual Progress Report on the Connecticut Partnership for Long Term Care

Section 5 of Public Act 89-352 stipulates that each year, on January 1, I shall report to the General Assembly on the progress of the Connecticut Partnership for Long Term Care. This is the first such annual report. I am pleased to say that, even though the program has not yet been implemented, we have made major progress and we are hopeful about securing the necessary federal approval early in 1990.

As Public Act 89-352 asks for information on a number of specific topics, I have organized this report to address those areas of interest:

1) *Success in Implementing the Public and Private Partnership*

Project Status

Three things were needed to implement the Partnership: state enabling legislation, foundation funding, and federal Medicaid eligibility waivers allowing individuals to disregard assets equal to what their long term care insurance paid out in approved benefits.

Public Act 89-352 passed the Connecticut General Assembly, unanimously, last June. In July of 1989 the Robert Wood Johnson Foundation agreed to fund a six year demonstration and awarded the State of Connecticut nearly $1.8 million dollars for the first three years. But the federal approval has been slower in coming. S1998 (Attachment A) passed the U. S. Senate, again without dissent, on November 22; this bill awaits the U. S. House of Representative's approval when Congress returns in late January 1990. Obtaining the federal waiver has been a priority for Governor O'Neill and we have enjoyed strong bi-partisan support from Connecticut's entire delegation. (Copies of key communications seeking federal Medicaid waivers are contained in Attachment B.) Whereas the ideal form of federal approval would be through legislation, the state is simultaneously exploring regulatory (state Medicaid plan change), and research and demonstration approaches.

In the meantime, we have proceeded to put all the pieces in place so that the first precertified policies can be offered soon after the federal "go-ahead" is received.

Achievements To Date

Internally, most of the personnel authorized under the grant from the Robert Wood Johnson Foundation have been hired; equipment has been purchased; Memoranda of Understanding have been signed between the Office of Policy and Management and the other state agencies involved in the project (i.e., Aging, Health Services, Income Maintenance and Insurance); and, in general, the mechanisms needed to coordinate, monitor and evaluate the program's performance have been put in place. In late November, as it became obvious that we would not have the necessary federal approval in 1989, we made a conscious decision to postpone, where possible, the filling of any vacancies funded through the grant and to delay until the new year expenditure of state General Funds dedicated to public information and volunteer services.

Externally, we have continued, with the advice and guidance of our Policy Steering Committee, to work with consumers, insurers, providers, researchers and state officials to address a multitude of implementation issues. As of this writing, the Insurance Department's regulations establishing the standards for precertified policies are ready for publication in the Connecticut Law Journal, and the Medicaid regulations which detail program eligibility are nearing this stage. The Department of Health Services is about to publish planned revisions in the Coordination, Assessment and Monitoring licensure regulations. Officials from the Department of Health Services have been meeting with insurers to discuss the need for standards and the special role of case management in long term care insurance. Finally, the Department on Aging formalized its plans for the public information and the individualized consumer education function it is charged with under Section 4 of this Act.

We would be remiss if we failed to mention the state's success in creating policy-oriented data sets linking nursing home, home care and Medicaid payment data. These data sets have been invaluable in developing our model. They will be even more useful in evaluating the Partnership. An example of their use can be found in Attachment C.

National Attention

Finally, it is important to note the degree of national attention being focused on our efforts. Most recently Cable News Network (CNN) ran a story describing our state's leadership role in developing this public/private partnership and WEZN in Bridgeport aired a half hour interview with the Project Director, Dr. Kevin Mahoney. Altogether more than thirty articles have appeared on our efforts and presentations on the Connecticut approach have been featured in a numerous state, regional and national conferences including:

The U. S. Public Health Statistics Conference	July, 1989
The American Public Welfare Association	September, 1989
The National Health Policy Forum	September, 1989
The Annual Conference on the Legal Problems of the Elderly	October, 1989
The National Association of Social Workers	October, 1989
The American Public Health Association	October, 1989
The Annual Meeting of the Robert Wood Johnson Foundation Program to Promote Long Term Care Insurance for the Elderly	October, 1989

The Greater Hartford Chamber of Commerce	November, 1989
The National Association of Health Data Organizations	November, 1989
The Annual Meeting of the Gerontological Society of America (four separate sessions)	November, 1989
The Greater Hartford Probate Forum	December, 1989

2) *Number of Policies Precertified* and 3) *Characteristics of Individuals Purchasing Precertified Policies*

Answers to these questions must await the implementation of the Partnership. As of this writing, we can report that many of Connecticut's major insurers - including Aetna, Blue Cross, CIGNA and The Travelers - are committed to offering precertified policies.

4) *Number of Individuals Seeking Consumer Information Services*

The Department on Aging has made presentations to senior centers, municipal agents, areas agencies on aging, the Coalition on Aging, financial planning seminars, interfaith caregivers and the full aging network. At a minimum, 600 people have been introduced to the partnership concept. In addition, literature was distributed at Governor's Day on State Services for the Elderly where more than 10,000 seniors were on hand.

5) *Benefits Paid Under Medicaid Resource Protection*

None.

6) *Estimated Impact of Present and Future Medicaid Expenditures and*
7) *Cost-Effectiveness of the Program*

Whereas there is no impact on current Medicaid expenditures, we do anticipate future savings. The demonstration will test that hypothesis. As we told the House Energy and Commerce Committee:

"Every microsimulation run we have done (utilizing the Brookings-ICF Long Term Care Financing Model) suggests major Medicaid savings. It appears that the model generates savings because some individuals insure housing assets that may or may not be attached by Medicaid, while others overestimate the amount of assets they would have to protect at the point they entered an institution.

Beyond these technical modeling factors there are sound logical reasons why savings may be achieved:

a. A decrease in transfer of assets. A good part of the rationale for transferring assets disappears if one can plan ahead and protect critical resources. Transfer of assets means loss of control; the purchase of long term care insurance (under the Connecticut Partnership approach) does not.

b. More efficient utilization of long term care services prompted by mandated case management.

c. The (new) income from protected assets must be used to defray the costs of care.

In estimating Medicaid savings it is important to remember that the only insurance expenditures that will count toward Medicaid asset exclusion are those that are for services that parallel what Medicaid would pay for its own beneficiaries."

8) *Determination Regarding the Appropriateness of Continuing the Program*

The Office of Policy and Management strongly supports the implementation of the Partnership. The approach has won the support of consumers, insurers, providers and state officials. It deserves the chance to prove its worth. At the very least the Partnership will demonstrate the extent to which private insurance can help to resolve the long term care financing problem; it will provide Connecticut's seniors with an opportunity to plan ahead to meet their long term care needs without wiping out a lifetime of savings.

cc: Clerk of the Senate
Clerk of the House
Chairs and Ranking Members of Committees of Congnizance

ATTACHMENT A

FEDERAL ENABLING LEGISLATION
S.1998

poverishing themselves to pay for long-term care.

Although there is some variation in the public/private partnerships in these nine States, they all need authority to waive Medicaid eligibility requirements as to income and assets for seniors who purchase a qualifying policy. Let me explain how it would work in Indiana. If someone purchased a policy that provided a minimum level of long-term care coverage, the State would agree to cover them with Medicaid if they still needed long-term care after their policy benefits expired. The advantage for the senior is that instead of being forced to spend down to $1,800 in assets, the Senior could keep assets that equal the value of the benefits paid by the policy.

Mr. President, everybody wins under this proposal. Individuals get the security of knowing that their long-term care needs will be taken care of without spending down to Medicaid eligibility levels if they purchase qualified insurance. The State and Federal Government will save enormous amounts of money Medicaid would otherwise be forced to spend on individuals who did not have this incentive to purchase long-term care insurance. The program works because all qualified policies cover a longer period than the average patient stays in a nursing home.

Under current law, there are no provisions allowing HCFA to waive Medicaid income and asset eligibility standard for these demonstration programs. In 1988 when I was a member of the other body, I was joined by a number of Congressman in requesting an extended waiver. HCFA denied that request. This amendment would give the Secretary of HHS the authority to grant such a waiver if the requesting State met several conditions including budget neutrality.

The Indiana program, like all of these plans, has strong cost control features. A coordinated case management component will insure that participants are guided to wise choices among the range of nursing home and community based services that will be available. This is a particularly important feature because participants often are frail or in ill health when these services are needed. A case manager can identify the most cost effective service that meets the persons needs.

The quality of services is addressed in the Indiana plan through a series of standards that insurance plans must meet that exceed those established by the National Association of Insurance Commissioners [NAIC]. For example, insurers must clearly disclose the availability of State sponsored counseling, consumer education, complaint handling and appeal mechanisms. Also, policies must guarantee consumers the option of buying inflation protection or must provide another mechanism by which the value of coverage

MEDICAID LONG-TERM DEMONSTRATION PROJECT

Mr. HEINZ. Mr. President, I send a bill to the desk on behalf of Senator COATS and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A bill (S. 1994) to provide for Medicaid long-term care demonstration project waiver.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

MEDICAID LONG-TERM CARE INSURANCE DEMONSTRATION PROJECT

Mr. COATS. Mr. President, this amendment would allow nine States to proceed with an innovative demonstration project that would make long-term care insurance more appealing to the consumer and, at a minimum, be cost neutral for Medicaid.

There are currently a total of nine State projects to test a public/private partnership to fund nursing home care, and a continuum of community based services. Eight of these, including the program in Indiana, have been funded in part by the Robert Wood Johnson Foundation, which has a well deserved reputation for sponsoring creative ideas in health care.

All of these States must give the Secretary of Health and Human Services assurances that their proposal is revenue neutral. However, all of them been designed to save Medicaid millions of dollars. I believe that it is incumbent on us to pursue every credible means to lower health care costs, especially when we can help people avoid the painful humiliation of im-

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will keep pace with changes in the cost of care.

We are all concerned about the budget impact of all the legislative proposals we consider, and I am pleased to state that this amendment would be budget neutral in fiscal year 1990. CBO Director Robert Reischauer made this determination in an October 5, 1989 letter to Chairman BENTSEN. I would like to ask unanimous consent that this letter be included in the RECORD with my statement.

Mr. President, this amendment deserves our support if we are serious about cutting the cost of health care and increasing the quality of services available to our seniors. We simply cannot afford to ignore innovative public/private partnerships that take advantage of the resources and flexibility of States and the private sector. I urge my colleagues to support this amendment.

The PRESIDING OFFICER. The bill is before the Senate and open to amendment. If there be no amendment to be proposed, the question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 1998

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this act may be cited as the "Medicaid Long-Term Care Demonstration Project Waiver Act of 1989."

SEC. 2. MEDICAID LONG-TERM CARE INSURANCE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall provide for a demonstration project in the States of Indiana, Illinois, Wisconsin, Oregon, California, Connecticut, Massachusetts, New York, and New Jersey. Such project shall allow individuals with income and resources above eligibility levels for receipt of medical assistance under title XIX of the Social Security Act to receive long-term care benefits under the State plan for medical assistance if such an individual purchases a State approved long-term care insurance policy covering long-term care for a period preceding such an individual's eligibility for medical assistance under title XIX of the Social Security Act.

(b) WAIVER OF CERTAIN REQUIREMENTS.—The Secretary in providing for the demonstration project described in subsection (a), shall waive the following requirements in title XIX of the Social Security Act with respect to such projects:

(1) Sections 1901, 1902(a)(10) (A) and (C), 1902(a)(1), and 1903 (f), relating to categorical and income eligibility limits.

(2) Sections 1902(a)(10) (A) and (D), relating to amount, duration, and scope of services; and to diagnosis, type of illness, or condition.

(3) Sections 1902(a)(23), relating to freedom of choice.

(4) Sections (a)(1), relating to statewideness.

(5) Sections 1902(a)(10), matter following (E) and 1902(a)(17), relating to comparability.

(6) Sections 1902(a)(14), relating to premiums.

(7) Section 1902(a)(18), relating to liens and recovery of assets.

(8) Sections 1902 ((30) and ((31), relating to personal needs allowance, protection of community spouse, and transfer of assets.

(c) STATE ASSURANCES.—The State shall provide assurances to the Secretary that—

(1) the estimated average per capita and aggregate expenditures for long-term care services for individuals under the waiver will not exceed estimated average per capita and aggregate expenditures for such services for such individuals under the State plan in the absence of the waiver;

(2) it will continue to make long-term care services available under the plan to any individual who would be entitled to long-term care services under the plan as in effect before the waiver (except to the extent that subsequent Federal legislation specifically requires changes in eligibility for such services under the plan); and

(3) it will not approve a long-term care insurance policy unless it meets standards at least as stringent as those set forth in the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Modal Act as of June 1988.

(d) APPLICATION, DURATION, AND EXTENSIBILITY.—

(1) The Secretary shall either approve or disapprove the application of the State to participate in a demonstration project described in this section within 90 days of receipt of such application. The Secretary shall award the demonstration project in a budget-neutral manner.

(2) The demonstration project under this section shall be for an initial period of 5 years. The Secretary shall provide for renewal of those demonstration projects for an additional 5 years which the Secretary determines have met the requirements of this section.

(3) An individual who participates in a demonstration project under this section shall remain eligible for long-term care services under the State plan after the expiration of such project.

(e) ANNUAL STATE REPORTS.—The State shall annually (during the duration of such project) report to the Secretary on—

(1) the number of individuals enrolled in the demonstration project in such State;

(2) the number of enrollees actually receiving long-term care services under such demonstration project (whether through long-term care insurance or medical assistance under title XIX of the Social Security Act);

(3) the number of enrollees actually receiving long-term care in the form of medical assistance;

(4) the average income, age, and assets of each enrollee; and

(5) the number and characteristics of private insurers with policies approved by the State under the demonstration project.

(f) SECRETARY'S REPORT.—The Secretary shall report to Congress on the demonstration project established under this section not later than 4 years after the date of enactment of this section. Such report shall summarize and analyze information reported by the State under subsection (e), and shall evaluate the cost effectiveness of the demonstration project and make recommendations with respect to the desirability and appropriateness of authorizing any State to make long-term care services available on a similar basis.

Mr. MITCHELL. Mr. President, I move to reconsider the vote by which the bill was passed.

Mr. HEINZ. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

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ATTACHMENT B

COMMUNICATIONS SEEKING MEDICAID

ELIGIBILITY WAIVERS

STATE OF CONNECTICUT
EXECUTIVE CHAMBERS
HARTFORD, CONNECTICUT

CLASSIC CONNECTICUT

WILLIAM A. O'NEILL
GOVERNOR

July 21, 1989

The Honorable Louis W. Sullivan
Secretary
Health and Human Services Department
200 Independence Ave. SW, Room 615F
Washington, DC 20201

Dear Secretary Sullivan:

The financing of long term care for the elderly and disabled is one of the most pressing problems facing both the individual states and our nation. It is a problem which frightens our senior citizens; it is also a problem which increasingly strains state and federal financial resources.

My deep concern over this issue led me to assemble a special commission to examine private and public responsibilities for financing long term care. (Copies of the final report and my action plan are enclosed.) The Commission's first recommendation was that we attempt to develop a public/private partnership that would pool and coordinate the resources of both sectors to allow older people to plan ahead to meet long term care needs without having to impoverish themselves. With the help of a planning grant from the Robert Wood Johnson Foundation we have developed just such a model. The Connecticut General Assembly has unanimously enacted enabling legislation; the Robert Wood Johnson Foundation has agreed to fund a demonstration. But we need federal Medicaid waivers before this effort can proceed.

I seek your support for this effort. Connecticut - along with California, Indiana, Massachusetts, New Jersey, New York, Oregon and Wisconsin - is seeking legislation to this end. We believe that demonstrations of various models of public/private partnerships can help answer key questions that need to be resolved before a national system can be put in place. We believe that models, such as the Connecticut Partnership for Long Term Care, can save federal as well as state dollars. We request your support to test and evaluate these promising ideas.

On behalf of the State of Connecticut, I want to thank you for your prompt and careful consideration of this request.

Sincerely,

WILLIAM A. O'NEILL
Governor

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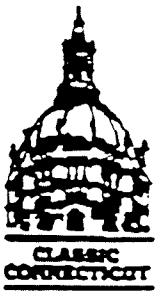
STATE OF CONNECTICUT
EXECUTIVE CHAMBERS
HARTFORD, CONNECTICUT



WILLIAM A. O'NEILL
GOVERNOR

November 15, 1989

The Honorable John D. Rockefeller IV
Senator
Chairman, The Pepper Commission
140 Cannon House Office Building
Washington, DC 20515

Dear Senator Rockefeller:

As you and the other members of the Bipartisan Commission on Comprehensive Health Care address the question of how to finance long term care for the elderly and disabled. I would like to commend to your attention the public/private partnership approaches that have been developed by states such as Connecticut. I believe that a demonstration and evaluation of these models can yield information that is vital in shaping a national system.

Let me give an example. If you believe it is important to have a private market, and if you believe it is legitimate for government to stimulate and shape this private market, then these public/private partnerships afford a unique vehicle for influencing the demand for and supply of good products, and then testing the extent to which the private market can expand. In other words, if government makes it more attractive to purchase coverage, will people buy? The answer to this question can then guide the construction of a cost-effective public benefit.

I would welcome the opportunity to meet with the Bipartisan Commission to explain our promising approach. In the meantime I am enclosing a brief description of the Connecticut Partnership for Long Term Care. Our state enabling legislation passed both houses of our General Assembly - unanimously. The Robert Wood Johnson Foundation gave us a three year, $1.8 million, award to implement the Partnership, but we cannot go forward without federal Medicaid eligibility waivers. As microsimulations show the Connecticut Partnership leading to federal and state savings, and as the Partnership can answer many questions which are critical to the design of a national program. I ask your support in securing the necessary federal legislation.

Sincerely,

Will O O'N

WILLIAM A. O'NEILL
Governor

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WAYS AND MEANS
SUBCOMMITTEE
ON TAX REVENUE MEASURES
HUMAN RESOURCES

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE

704 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-2265

ONE CORPORATE CENTER
HARTFORD, CT 06103
(203) 240-3222
FTS (203) 244-3222

Congress of the United States
House of Representatives
Washington, DC 20515

November 15, 1989

Senator Bob Packwood
United States Senate
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The State of Connecticut has been a leader in developing a public/private partnership approach for financing long term care. The Office of Policy and Management working with the Governor's Task Force on Long Term Care has developed a model which has won the approval of consumers, insurers, and providers. The enabling legislation for this program passed both houses of our General Assembly unanimously. The Robert Wood Johnson Foundation found our model so promising they awarded Connecticut $1.8 million dollars to implement and evaluate it.

As microsimulation shows the Connecticut Partnership for Long Term Care leading to federal and state savings, we can be assured that this waiver will be at least budget neutral and probably save federal dollars.

We therefore ask you to give every consideration to including these Medicaid eligibility waivers in the Budget Reconciliation Bill. State initiatives, such as the Connecticut Partnership, provide a unique opportunity to test the extent to which private insurance can be part of the solution to the long term care financing dilemma. The data generated by evaluating such public/private partnerships can lead toward a carefully-formulated federal policy.

Thank you for your consideration.

Sincerely,

Barbara B. Kennelly
BARBARA B. KENNELLY
Member of Congress

SAM GEJDENSON
Member of Congress

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JOHN G. ROWLAND
Member of Congress

CHRISTOPHER SHAYS
Member of Congress

NANCY L. JOHNSON
Member of Congress

BRUCE A. MORRISON
Member of Congress

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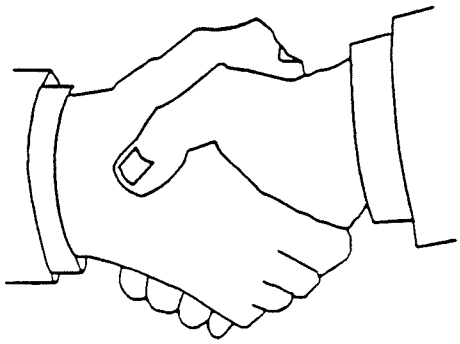
ATTACHMENT C

PAPER ANALYZING THE RATE AT WHICH
PRIVATE NURSING HOME PATIENTS
EXHAUST THEIR ASSETS
AND BECOME MEDICAID RECIPIENTS

AN EXAMPLE OF THE POLICY ANALYSES
MADE POSSIBLE BY LINKING PROGRAM WITH FUNDING DATA

THE CONNECTICUT PARTNERSHIP FOR LONG TERM CARE



RESEARCH INSTITUTE
Discussion Papers

Leonard Gruenberg
Ken Farbstein
Paul Hughes-Cromwick
Christine Pattee
Kevin Mahoney

AN ANALYSIS OF THE SPEND-DOWN PATTERNS OF INDIVIDUALS ADMITTED TO NURSING HOMES IN THE STATE OF CONNECTICUT

DP #1-89

STATE OF CONNECTICUT
William A. O'Neill
Governor

Office of Policy and Management
Anthony V. Milano, Secretary

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THE CONNECTICUT PARTNERSHIP FOR LONG TERM CARE

RESEARCH INSTITUTE

The Partnership

The **Connecticut Partnership for Long Term Care** is a joint public - private program which encourages individuals to plan for their LTC needs by purchasing insurance protection in an amount commensurate with assets, or more precisely, the amount of assets he or she wishes to protect. If and when an individual exhausts insurance benefits, he or she can apply for Medicaid and each dollar that the insurance policy has paid out in accordance with state policy will be subtracted from the assets the individual still has so that those assets would not be recognized or considered in determining the individual's eligibility for Medicaid.

Demonstration Project

The **Connecticut Partnership for Long Term Care** is a six year, statewide demonstration and evaluation project. It was launched in August 1989 with a three year grant of nearly $1.8 million from the **Robert Wood Johnson Foundation.** Connecticut is the first state to implement such an ambitious initiative to make long term care insurance benefits available to many of its residents by combining private insurance coverage with state Medicaid funds. The project will also sponsor six special studies ranging from surveys of individuals denied insurance or dropping coverage, to a survey of recent nursing home admissions and the collection of baseline information on those newly insured. Because this project is intended to inform the national debate over how to finance long term care, the demonstration will include a process evaluation and an examination of how the **Partnership** affects the demand for insurance and the utilization of LTC.

Research Institute

The Research Institute was formed so that descriptive and analytical papers that grow out of this Program can be efficiently distributed. The **Institute** will issue three types of products: Discussion Papers; Reprints (of published papers); and Special Reports. These papers have not undergone official review by the state of Connecticut; any opinions expressed are those of the authors alone./ Comments and requests for copies should be directed to:

Kevin J. Mahoney, Ph.D., Project Director Paul Hughes-Cromwick, Research Director

Connecticut Partnership for Long Term Care
Office of Policy and Management
80 Washington Street Hartford, CT 06106 (203) 566-8340

AN ANALYSIS OF THE SPEND-DOWN PATTERNS OF INDIVIDUALS ADMITTED TO NURSING HOMES IN THE STATE OF CONNECTICUT

DP-1

by
Leonard Gruenberg, Ph.D.*
Ken Farbstein, M.P.P.*
Paul Hughes-Cromwick**
Christine Pattee, Dr.Ph.***
Kevin Mahoney, Ph.D.**

September 1989

Work on this paper was supported by
the State of Connecticut Office of Policy and Management
and by the Robert Wood Johnson Foundation

* The Long Term Care Data Institute, 681 Main Street, Waltham, Massachusetts 02154
** Office of Policy and Management, State of Connecticut
*** Department of Health Services, State of Connecticut

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Abstract

The spend-down process for all patients admitted to Connecticut nursing homes for the first time during the period 10/1/78 - 9/30/79 is analyzed from longitudinal data in the Connecticut Nursing Home Patient Registry. The data included records of all admissions and discharges to nursing home periods that occurred from the date of admission until 9/30/86. Three-quarters of all admissions were found not to receive Medicaid when they were first admitted. Among private payers, 21% spent down. It was found that the total time spent in nursing homes during the study period by the spend-down population was 4.3 years, which is more than twice as long as the average patient admitted during that period. Medicaid paid for 68% of the total days in nursing homes for persons who spent down, and 57% of the days for the entire admission cohort.

A double decrement life table was constructed to examine how many persons would hypothetically spend down if they did not have an early discharge. The spend-down rate was found to decline and then remain constant with longer lengths of stay in a nursing home. The decreasing and subsequently flattening spend-down rate is hypothesized to result from the existence of two discrete groups of patients: the "wealthy" and the "middle income." It was found that nearly 60% of all admissions were "wealthy" and spent down at a rate of 9% per year. The "middle income" group spent down at a rate that was ten times faster.

The level of available resources of elderly people who require long term care is of critical concern to state government decision-makers, academics, and insurers concerned with the finance of long term care. Even more important than the level of such private resources is the degree to which individuals apply their resources to finance their long term care. Consumers need to know the likelihood of exhausting their resources through spend-down to Medicaid as they consider whether to purchase long term care insurance. Insurers need to know what maximum periods and deductibles they should offer in their long term care insurance products. Designers of public-private partnerships for long term care insurance are interested in all these questions. Researchers need to disentangle contradictory findings about spend-down patterns. Medicaid policymakers need to know the makeup and payment sources of their nursing home populations.

In this paper, "Medicaid spend-down" refers to the exhaustion of income and assets of a nursing home patient to the point at which they fall beneath the state's Medicaid financial eligibility maximums. State's Medicaid regulations differ, but the income maximum is generally set at or below the federal poverty line; the (financial) asset maximum is most commonly $1,800 for an individual (Medicaid Sourcebook, 1988). This paper focuses on the consumption of assets in the spend-down process after an individual enters a nursing home. The "spend-down period" refers to the duration of time from entry into a nursing home to the date of Medicaid eligibility.

This study analyzes the spend-down patterns of all persons who were admitted to Connecticut nursing homes for the first time during the period October 1, 1978 - September 30, 1979. The data trace the complete utilization history for these persons, including all records of discharges and readmissions to other facilities through the period ending September 30, 1986.

The major issue addressed by this study is the likelihood that spend-down will occur. After summarizing basic statistics that elucidate the frequency of occurrence of spend-down and the number of nursing home days paid for by Medicaid and by private resources, the paper determines the probability of spend-down. The influence of varying lengths of stay is disentangled from the occurrence of spend-down in a life table analysis in order to elucidate the spend-down pattern.

DATA

This study analyzes data from the 1978-79 admission cohort of the Connecticut Nursing Home Patient Registry. The Registry reports the demographic characteristics and lengths of stay for all patients in skilled nursing facilities and intermediate care facilities in Connecticut since 1977. The Registry is unique in providing longitudinal data over a period spanning more than

eight years on both private-paying and Medicaid nursing home residents and in linking nursing home utilization data with Medicaid eligibility and payment records.

The initial data file consisted of annual summaries from each facility of demographic, health status and disability level information, as well as admission and discharge dates (where applicable) for all persons using the facility in the year. Medicaid eligibility dates from the files of the Connecticut Department of Income Maintenance were merged with comprehensive utilization data from the Department of Health Services.* A merge with death records was also performed. From these data, a longitudinal person-level file was created to facilitate analysis. This file contains all records of a person's lifetime nursing home use in the state, including all subsequent re-admissions and transfers to other facilities. To further improve the database, the State of Connecticut is continuing to add data on each succeeding year of all patients' nursing home use and Medicaid eligibility.

Registry data on all 11,066 admissions to nursing homes during the period October 1, 1978 - September 30, 1979 were used for this analysis. Since service utilization data on 332 cases (3.0%) were found to contain errors, these data were discarded. Hence, the findings of this analysis reflect the experience of the remaining 10,734 admissions.

Since the Registry was begun on October 1, 1977, it is possible that some persons who were recorded in this study to have first been admitted to a nursing home in the 1978-79 period, actually had a prior admission before the 1977 starting date. However, this is likely to be a very small number, since this misclassification could only occur if the individual did not reside in a nursing home during the period October 1, 1977 - September 30, 1978 (for if they did, they would not have been identified as a first admission during the 1978-79 period).

Of the 10,734 admissions studied here, 9,461 persons (88%) had been discharged and had not been subsequently readmitted as of September 30, 1986. Their lengths of stay are defined as the total time spent in long term care facilities from the date of their first admission until the date of their last discharge. The remaining 1,273 persons (about 12%) who were admitted during the time in question were residing in a long term care facility on September 30, 1986, the latest date for which complete data were available at this time. Their lengths of stay were defined as the total time spent in long term care facilities from the first admis-

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* The merging of the data files and other enhancements were funded by the Robert Wood Johnson Foundation. The merge is described at more length in Pattee, 1989.

sion until September 30, 1986. Such lengths of stay can be calculated because the Registry traced individuals as they moved in and out of nursing homes, even if they went to different nursing homes, or were discharged and later readmitted. Days spent in the hospital or community are subtracted so that the length of stay in the nursing home alone could be calculated. The lengths of stay discussed in the paper therefore include the total period spent in any nursing home, at any period from October 1, 1978 to September 30, 1986.

Table 1 presents a description of the population of patients who were admitted to Connecticut nursing homes between October 1, 1978 and September 30, 1979.

TABLE 1: CHARACTERISTICS OF PATIENTS ADMITTED TO CONNECTICUT NURSING HOMES

At admission, proportion who are	
under age 65	11.3%
65 - 74	18.8%
75 - 84	39.0%
85 - 94	28.5%
95 or older	2.4%
TOTAL	100.0%
Average age at admission	77.9 years
Men	34.9%
Women	65.1%
TOTAL	100.0%
Proportion staying	
less than six months	45.6%
six months - one year	9.4%
one year - two years	10.5%
two years - four years	13.4%
four years or more	21.0%
TOTAL	100.0%
Mean length of stay	728 days
Median length of stay	268 days
Number of admissions	
One	48.9%
Two	22.3%
Three or more	28.8%
TOTAL	100.0%

Perhaps the most notable characteristics of the population include the high proportion of admitted patients who have a subsequent admission in the next eight years (51.1%), and the high proportion who stay in a nursing home for four years or more. These high proportions are found because of the Registry's long timespan which facilitates the linkage of patient records, including multiple stays in different nursing homes. They exemplify the ways that the admission cohorts of the Connecticut Registry will change researchers' understanding of service utilization and spend-down patterns.

DESCRIPTIVE FINDINGS

Table 2 shows the distribution of admissions according to payment class. There are three payment classes, defined as follows:

(1) **Always Private Pay** - these individuals did not have any indicated date of Medicaid eligibility; they may have had other payment sources such as Medicare or private insurance for part or all of their stay, but they were never on Medicaid.

(2) **Always Medicaid** - these individuals had a Medicaid eligibility date which either preceded or precisely coincided with the date of their first admission to a nursing home.

(3) **Spend-Down** - these individuals became eligible for Medicaid some time after their first entry into the nursing home.

These data show that the majority of persons admitted (59%) remained private pay during their entire nursing home stay. The remaining persons (41%) had Medicaid as a source of payment during at least some part of their stay. Most of these (25% out of the 41%) were Medicaid upon admission, while the remaining ones (16% out of the 41%) were the "spend-down patients."

TABLE 2: NUMBER OF PERSONS ADMITTED TO NURSING HOMES IN 1978-79 BY PAYER GROUP

Payer Group	Number	Percent
Private	6,354	59.2%
Medicaid	2,660	24.8%
Spend-down	1,720	16.0%
Total	10,734	100.0%

These data show that about one-sixth of admitted patients will spend down. This conflicts with a common public perception that

their total stay is 4.3 years.

TABLE 4: BREAKDOWN OF LENGTH OF STAY OF SPEND-DOWN POPULATION: PRIVATE AND MEDICAID

Payer Group	Mean Length of Stay	Percentage of Total Patient Days
Private	497.3	31.7%
Medicaid	1,071.6	68.3%
Total	1,568.9	100.0%

The data from Tables 3 and 4 can be combined to give a complete picture of what proportion of total days are paid for by Medicaid out of the entire admission cohort. The Medicaid days include persons admitted to nursing homes as Medicaid patients plus persons who spend down. The results of combining these days are shown in Table 5.

Table 5 first shows the proportions of privately- and Medicaid-financed care for those 4,380 patients for whom Medicaid paid any days. It separates the patients who entered as Medicaid eligible from those who spent down to Medicaid eligibility. The table then considers the 8,074 patients who ever paid any days from their private resources. It separates the ones who remained private pay throughout their stay from those who spent down to Medicaid at some point. (Of course, the total of 4,380 ever-Medicaid patients and the 8,074 ever-private patients exceeds the total number of patients because 1,720 patients spent down from privately paying to Medicaid-financed care.)

Table 5 shows that nearly three-fifths (57.1%) of the patient days of the admission cohort are paid for by Medicaid, with the remaining 43% paid for by private payers. Among the Medicaid days, 40% (i.e., 23.6% out of the 57.1% that are Medicaid days) are to be attributed to the individuals who spent down. In other words, if privately financed insurance covered all the days of nursing home care for everyone who spent down to Medicaid, 40% of all Medicaid days would instead be privately financed. This may help Medicaid planners to estimate the maximum saving to Medicaid that is hypothetically possible through widespread privately financed long term care insurance.

TABLE 5: AVERAGE NUMBER AND PERCENT OF NURSING HOME PATIENT DAYS BY SOURCE OF PAYMENT BY PAYMENT GROUP

Payer	Payer Group	# of Patients	# of Days	% of Total Days
Medicaid Days	Always Medicaid	2,660	984.6	33.5%
	Spend-Down	1,720	1,071.6	23.6%
	Total	4,380	1,019.1	57.1%
Private Financed Days	Always Private	6,354	393.4	32.0%
	Spend-Down	1,720	497.3	10.9%
	Total	8,074	415.4	42.9%
Total	All	10,734	728.3	100.0%

LIFE TABLE ANALYSIS

The above analysis shows how many people remain private-pay and how many become dependent on Medicaid, but it cannot take into account the many short-stayers who did not have time to spend down. The major hurdle to overcome in understanding spend-down dynamics and their influence on payment patterns is some method for cleanly disentangling the length of stay from the length of time before spend-down.

A life table model--specifically, a double-decrement model--is admirably suited to such a problem, for it can isolate the length of time before spend-down and express it in a single summary statistic. This statistic, known as Q(x), represents the contingent probability that a person will spend down in the interval between point x and point x+1, assuming that their length of stay is at least x.

The theoretical work underlying this approach was developed to study mortality data when there are two or more causes of death (Jordan, 1967). In this case, the two hazards are: (1) leaving the nursing home for the last time, and (2) spending down to Medicaid. These are completely parallel to two causes of death in the more traditional double-decrement approach. In calculating the spend-

down probability, one should determine how many people spend down during that interval, and divide that number by the average number of persons who stayed in nursing homes for at least that amount of time. A summary of the analysis is shown in the tables below.

Table 6 presents the portion of the full life table that is needed to calculate the contingent probability of spending down (Q(x)) during a particular time interval. Toward this end, two tabulations are first compiled. One tabulates the number of patients who spend down in each interval. The second tabulates the total number who are discharged and/or spend down in each interval. The total number who are still in the nursing home in private pay status at the beginning of the second and succeeding intervals is decremented by the number who exit in the appropriate period. Next, the mid-interval population remaining is computed. This will become the denominator of the crude spend-down rate M. The numerator of M is the number, tabulated in the first step, who spend down in each period. This figure is adjusted to reflect the fraction of the interval that patients who depart in the interval stay in the interval, resulting in Q(x). This probability is shown in the last column of this table.

TABLE 6:
LIFE TABLE FOR SPEND-DOWN OF CONNECTICUT NURSING HOME PATIENTS

Interval	# who spend down or are discharged in interval	# private pay in NH at start of interval	# who spend down in interval	rate of spend-down in interval Q(x)
0 - 30	2,126	8,074	204	0.0286
31 - 60	1,012	5,948	145	0.0263
61 - 90	582	4,936	99	0.0211
91 - 182	1,013	4,354	230	0.0578
183 - 365	869	3,341	285	0.0928
366 - 730	932	2,472	335	0.1532
731 - 1,095	500	1,540	181	0.1310
1,096 - 1,460	352	1,040	116	0.1253
1,461 - 1,825	207	688	57	0.0930
1,826 - 2,190	152	481	36	0.0851
2,191 - 2,555	139	329	24	0.0884
2,556 - more	190	190	8	

The table shows that very few persons maintain private stay status until the last interval, but this is mainly due to the fact that persons are discharged. In fact, the probability of spending down is quite low. The spend-down rates are more clearly presented in Table 7, which shows a standardized monthly rate of spend-down for each interval.

TABLE 7: STANDARDIZED MONTHLY SPEND-DOWN RATE

Time Period	Probability of Spend-down During Interval	Monthly Spend-down Rate
0-30 Days	0.0286	0.029
31-60 Days	0.0263	0.027
61-90 Days	0.0211	0.021
90 Days - 6 Months	0.0578	0.019
6 Months-1 Year	0.0928	0.015
1 - 2 Years	0.1532	0.012
2 - 3 Years	0.1310	0.010
3 - 4 Years	0.1253	0.010
4 - 5 Years	0.0930	0.007
5 - 6 Years	0.0851	0.007
6 - 7 Years	0.0884	0.007

It is interesting to note that the spend-down rate decreases over time through four years and then remains constant at a very low probability. Spend-down occurs initially at a 3% monthly rate, and declines to only 0.7% per month after seven years.

To determine how long individuals' resources could last, it is necessary to somehow take into account persons who are discharged before exhausting their resources. A basic assumption was that persons who were discharged after various periods of time did not differ from one another in their ability to pay for their own care. In simple terms, this means that if persons whose length of stay was observed to be (for example) six months were to stay for three years, the proportion of them who would have spent down would be the same as that proportion for persons who actually stayed for at least three years.

To proceed, a hypothetical population that stays in nursing homes indefinitely was constructed. It was assumed that they all began as private pay patients, and that they spend down at a rate given by the probability determined in Table 6. The construction of this hypothetical cohort enables us to disentangle the spend-down process and the issue of variable discharge rates. Consequently, the line of analysis in the remainder of this paper uses this hypothetical nursing home population and should not be used to estimate spend-down in an actual population.

Table 8 shows how this hypothetical population of 100,000 would spend down. The number of remaining private pay persons shown in this table was computed by subtracting the number of persons who spent down during the previous interval from the number of private payers at the beginning of the interval. The number

spending down in an interval was determined by multiplying the probability of spend-down by the average number of persons who were private pay during the interval.

The results show that 50% of these persons would remain private pay even after four full years in the nursing home. Even after seven years, almost 40% of these persons would continue to pay privately.

TABLE 8: SPEND-DOWN LIFE TABLE FOR LONG STAYERS

Time Period (Days)	Probability of Spend-Down	# Private Pay at Beginning	# Spending Down in Interval
0 - 30	0.0286	100,000	2,864
31 - 60	0.0263	97,136	2,552
61 - 90	0.0211	94,584	1,994
91 - 182	0.0578	92,590	5,351
183 - 365	0.0928	87,239	8,098
366 - 730	0.1532	79,141	12,123
731 - 1095	0.1310	67,018	8,782
1096 - 1460	0.1253	58,237	7,298
1461 - 1825	0.0930	50,938	4,736
1826 - 2190	0.0851	46,202	3,930
2191 - 2555	0.0884	42,272	3,738
2556 & over	1.0000	38,534	

These results illustrate the dominance of patients' own resources as a source of payment for most individuals. The median hypothetical nursing home patient becomes eligible for Medicaid only after using private resources for four full years (because roughly half of the initial population--50,938--are still privately paying at the beginning of the next time period).

It is interesting to note that the spend-down rate decreases over time through four years, and then remains constant at a very low probability. This pattern is highly counterintuitive. One might expect that the spend-down rate would <u>increase</u> throughout institutionalization, or at least remain constant, as resources are exhausted. Instead, the rate first decreases, and then flattens. Patients who still pay privately at the longest lengths of stay are extremely unlikely to spend down. Other patients spend down quite soon.

It is likely that the observed spend-down pattern is due to differences among patient's financial resources. If so, it would be consistent with an evolutionary pattern tracing the emergence of two groups among the population of private pay patients, as observed in a study of lengths of nursing home stay by Keeler, Kane

and Solomon (1981). These authors found that nursing home admissions at the national level fall into two groups: a short-stay and a long-stay group. The data suggest that a similar pattern occurs in relation to spend-down behavior. We hypothesize that two groups enter nursing homes as private payers; we will call these two group "the rich" and "the middle class." The middle class patients spend down rapidly, while the rich spend down at a much slower rate.

The simplest model of this nature is based upon an assumption that each group has its own constant rate of spend-down. The two groups are initially highly co-mingled; by the last interval, seven years later, all of the middle income group have spent down. There are three parameters in this model: the rates of spend-down for the rich and for the middle class and the proportion of persons who are in the rich group. They were determined as follows.

We noted that the spend-down rate after five years was quite constant. We assumed that by that period, all middle class persons had spent down. The spend-down rate of the rich was determined by regressing the logarithm of the number of privately paying patients remaining against time. The fit was very good; it produced an r-squared of .993. The spend-down rate of the wealthy was found to be .0071 per month.

We further assumed that no wealthy patients would spend down in the first 24 30-day periods. This assumption was made to take account of the policy that is in place in many states that would disallow Medicaid payments in behalf of individuals who have transferred assets for a period of 24 months after the asset transfer took place. We assumed that the wealthy would not begin to spend down until this two-year period of asset transfer was completed.

In principle, asset transfer could occur before a person enters the nursing home. Additionally, some persons might transfer assets surreptitiously, and Medicaid eligibility could be determined before the 24 month period. In our method of accounting, these persons would be counted among the middle class. There is not sufficient data available to distinguish these persons from others who spent down during the first two years.

To derive the initial population of wealthy people, we then applied their constant spend-down rate backward from the beginning of the last interval to the beginning of the third year. This implied that the population of privately paying wealthy patients at the beginning of the 25th 30-day interval was 59,797. Since no wealthy people spent down in the first 24 periods, the starting population of wealthy people was also 59,797.

The initial privately paying middle income population was then calculated by subtraction to be 40,203. The middle income

population at each period was computed by subtraction. Then the logarithm of the middle income population was regressed against time to determine their rate of spend-down. We used the first four years of data in making this estimate This calculation, which obtained a r-squared of .991, finds that the constant spend-down rate of the middle income group is 0.0761 per month, which is about ten times as rapid as the spend-down rate of the wealthy. These changes in the predicted income composition of privately paying institutionalized population are shown in Table 9.

TABLE 9: CHANGE IN THE COMPOSITION OF PRIVATE PAY PATIENTS: THE RICH VS. THE MIDDLE CLASS PATIENTS

interval (days)	expected # rich at start of interval	expected # middle class at start of interval	total
1 - 30	59,797	40,203	100,000
31 - 60	59,797	37,259	97,056
61 - 90	59,797	34,530	94,327
91 - 120	59,797	32,001	91,798
121 - 180	59,797	29,658	89,455
181 - 360	59,797	25,473	85,270
361 - 720	59,797	16,140	75,937
721 - 1,080	59,797	6,480	66,277
1,081 - 1,440	54,600	2,601	57,201
1,441 - 1,800	49,854	1,044	50,898
1,801 - 2,160	45,521	419	45,940
2,161 - 2,520	41,564	168	41,733
2,521 -	37,952	68	38,019

This model attributing distinct constant spend-down rates to the two groups fits the pattern observed from the life table analysis quite well: the Pearson correlation between the predicted total number of privately paying patients at the beginning of a given interval and the total in that period who were observed in the life table was .99.

Note that after seven full years, only 37% (21,845 of 59,797) of the rich population have spent down. The middle class patients, by contrast, have spent down much more quickly. Indeed, this analysis indicates that the median middle income patient would spend down after only 276 days (39 weeks), if patients remained in nursing homes indefinitely.

Discussion and Conclusions

The analysis presented here shows a simple and interesting structure in the spend-down patterns of persons admitted as private

patients to nursing homes in Connecticut. An elucidation of this structure provides a key to the understanding of some seemingly paradoxical results.

First, although relatively few persons entered nursing homes as Medicaid patients (one-quarter) and even fewer (16%) spent down during their stay, nonetheless Medicaid pays for a large proportion of the patient days in nursing homes. For example, in Connecticut in 1986, on the day of the Connecticut nursing home survey of that year, Medicaid was a payer for 60% of the patients in long term care facilities.

These apparently conflicting results are reconciled by two findings. First, persons on Medicaid had much longer lengths of stay than did persons who remained private pay. Second, for persons who did spend down, Medicaid paid for close to two-thirds of their total nursing home days. This explains why Medicaid plays such an important role as a payer, and why the spend-down population is so significant, even though these patients do not account for a large proportion of the admissions

The second major inference drawn from this analysis is that the population entering nursing homes in Connecticut as private payers appears very bimodal. Nearly 60% of the admissions can continue to pay privately almost indefinitely - they spend down at a minuscule rate of 9% per year. The remaining 40% display spend-down patterns that resemble the simulated analysis of Branch and coworkers (1988). In the Connecticut data, the median time before spend-down of these "middle class" patients is thirty-nine weeks. This is a rate of spend-down somewhat less than Branch's simulation produced, but that is not surprising, since our data are from another State, included intermediate care as well as skilled nursing facilities, and included all nursing home admissions. Branch's analysis, by contrast, examined the likely pattern for several modal types of persons, e.g., 75-year old females living alone).

The data suggest that a moral hazard effect operates in Connecticut, with larger proportions of persons with ample means entering and staying in nursing homes than middle income persons who cannot finance their entire stay. This may be happening because nursing homes were able to selectively admit persons with sufficient means, during the period in question. Alternatively, it may be that persons with more limited means are deterred from entering and staying in nursing homes because of an unwillingness to spend all their resources on nursing home care.

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STATE OF KANSAS

DEPARTMENT ON AGING
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Mike Hayden
Governor

Esther Valladolid Wolf
Secretary of Aging

TESTIMONY FOR THE HOUSE APPROPRIATIONS COMMITTEE
ON HB 2890
MARCH 6, 1990

Good afternoon Rep. Bunten, Rep. Chronister, members of the committee I'm Esther Valladolid Wolf, Secretary on Aging, and would like to thank you for the opportunity to testify today in support of HB 2890.

House Bill No. 2890 creates the Kansas Partnership for Long Term Care, coordinated by the Secretary of Social and Rehabilitation Services. The bill provides that long term care insurance benefit payments shall not be considered in determining eligibility for Medicaid, the amount of Medicaid payment, or recovery by the State of payment for medical services. The bill establishes requirements for the precertification of long term care insurance policies by the Commissioner of Insurance and requires myself to establish a long term care outreach education program.

Widespread public misconceptions about Medicare reimbursement for long term care services and attitudinal barriers have greatly affected individual perceptions of long term care. Through the long-term care outreach education program, consumers will become educated on the need for long term care, the mechanisms for financing such care, the availability of long term care insurance, and the asset protection provided under the act, all of which are important to our older Kansans. The quality of decisions made by these consumers depends upon the degree in which the consumer can make an informed decision. It is through the outreach component of this program that informed decisions are made possible.

The development of the outreach component requires the expansion of the existing half-time public health educator position to a full-time position with a fiscal impact of $24,000. This cost would include aproximately $14,000 for salary, $6,000 for communication and travel, and $4,000 for printing expenses. Through the work of our existing public health educator, I feel confident of the component success.

HA
3-6-90
Attachment 5

The demands of program outreach are very familiar to the department. By experience we have exhibited successful administration of several programs which include outreach components. The success of our outreach programming capabilities can be demonstrated through of our nutrition programs, our legal assistance programs, our older worker employment programs, our Alzheimer's Helpline and our most recent success program - the Senior Care Act.

To accomplish the outreach objectives, the public health educator will use several aging networks. The networks include senior centers, libraries, Area Agencies on Aging, nutrition programs, legal programs, Senior Care Act programs, organizations and agencies dedicated to aging issues, and several media networks. State-wide strategies include, but are not limited to, the development of written material, seminars, lectures, press releases, trainings and our toll free 1-800 telephone number.

I make available to you myself and my public health educator to answer any questions you may have at this time.

5-2

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Winston Barton, Secretary

Testimony before
House Appropriations Committee on House Bill 2890

March 6, 1990

John W. Alquest
Commissioner, Income Maintenance
and Medical Services
(913) 296-6750

HA
3-6-90
Attachment 6

Department of Social and Rehabilitation Services
Winston Barton, Secretary
Statement regarding: H.B. 2890

Title:
An act covering long-term care of persons having certain insurance.

Purpose:
The bill appears to provide an incentive for purchasing long-term care insurance. It would allow for a person's assets to be exempted in determining Medicaid eligibility based on the amount of benefits paid out under an approved insurance policy. The special provision would be in effect for all policies issued or renewed from January 1, 1991 to December 31, 1994. The bill also provides for the criteria under which long-term care insurance would be approved as meeting the provisions for resource exclusion by the Commissioner of Insurance and for an outreach program to be conducted by the Department on Aging to educate consumers about the need for and financing of long term care.

Background:
Current Medicaid statute and regulations require that all of an individual's available nonexempt resources be considered in determining his or her eligibility. For the aged and disabled population, the resource policies and standards of the SSI program are applicable. These policies allow for the exemption of certain resources including the home, a car, and a limited amount of life insurance. All other resources must generally be considered and their total value cannot exceed $2000 for an individual for eligibility purposes.

Medicaid rules also permit a State to adopt more liberal resource methodologies than those employed in the SSI program. Thus, it is possible to adopt a methodology which would disregard or exempt more of a person's resources than allowed in the SSI program as is being proposed in the bill.

It should be noted that a married couple is allowed to protect a portion or all of their assets and income and thereby gain Medicaid eligibility when one of the members requires long-term care. This is known as the "spousal impoverishment" provision in Medicaid statute and superseded the State's division of asset law last year. In addition, for Medicaid clients who are covered by long-term care insurance, such insurance is viewed as first payor with Medicaid picking up any remaining costs.

Effect of Passage:
The bill could potentially provide a savings to the Department by increasing enrollment in private long-term care insurance and thereby lowering Medicaid expenditures. As mentioned in the Background section above, more liberal resource exemptions can be established in the Medicaid program subject to approval by the Health Care Financing Administration (HCFA). If the methodology addressed in the bill were denied, the agency would be unable to adopt the provisions of the bill without facing potential fiscal sanctions and possible compliance action. Because of the possibility that the methodology would not be approved, the provisions of the bill should not be implemented until that approval is received.

The bill's intent appears to be to help protect a person's resources although a statement about income protection is made in Section 2. It should be noted that more liberal treatment of income is not permitted for persons in long-term care. Medicaid regulations require that all of the individual's income must be considered each month in determining his or her share of the cost of care. For persons in nursing facilities, all income except $30/month must go to pay the care cost.

The Department's primary issue concerning the bill is how the resource exclusion would operate. This exclusion is based on the amount of insurance benefits paid out of the long term care policy. Section 2(d) of the bill appears to indicate that insurance benefits would not be counted toward the resource exclusion until the client is eligible for Medicaid. This interpretation would not likely help anyone as they would not be Medicaid eligible until they had used all of their assets. For example, if an individual has $10,000 in savings, he or she would not be Medicaid eligible until the savings was reduced to $2000. Any insurance benefits paid out before the savings was depleted would not be considered under this interpretation.

A second interpretation would be to consider insurance benefits paid before the individual applies for Medicaid. Using the above example with the individual who has $10,000 in savings, if the policy paid $1000/month, he or she could then qualify for Medicaid after 8 months. The policy would have paid a total of $8000 over this time, thus creating an $8000 resource exemption. The client would then only have $2000 in countable assets ($10,000 - $8,000 insurance payment).

The bill could also be interpreted to allow for the consideration of insurance benefits which would be paid out over the life of the policy. For example, if the policy was time-limited to paying benefits for 2 years and the benefit level was $1000/month, the individual would be allowed a $24,000 resource exemption up front.

Because of the differing interpretations, we would recommend this issue be clarified in the bill based on the committee's intent.

We are also unclear as to the definition of formal services provided to persons in the community as part of a care plan approved by SRS which is reflected in Section 2(c). Is it intended that this be limited to the home and community based services (HCBS) program or be open to any type of managed home care? It would appear that the bill may also be establishing a new type of home care program for purposes of allowing a broader allowance for insurance benefits. Once again, clarification concerning this issue is needed.

Finally, in regards to Section 5 of the bill, it is unclear as to what is intended regarding the term "foundation funds" in line 34. We also believe that the reporting requirements need to be developed as a joint effort between all of the departments involved in implementing the bill's provisions. The Commissioner of Insurance will be in the best position to comment on the success of the public and private partnership as he has been given that responsibility in Section 3. Also the Commissioner will have records of the number of policies that are precertified, the number, age, and financial circumstances of persons purchasing such policies, and the extent and type of benefits paid under the policies that qualify for the resource exemption. The Secretary of Aging will also be in the best position to gauge the number of individuals seeking consumer information services. This department would then report on the Medicaid cost impact and cost effectiveness with all of the agencies involved in the determination of the appropriateness of continuing the program.

Recommendations:

The Department would support passage of the bill if the above listed concerns and issues are addressed.

John W. Alquest, Commissioner
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MEDICAID ELIGIBILITY COMPARISON
CURRENT POLICY VS. H.B. 2890

CASE SCENARIO: Individual enters nursing home on March 15. Has $10,000 in savings and receives $450/month in Social Security.
Cost of nursing home care - $1200/month (SRS rate)
$1500/month (private rate)

CURRENT POLICY

I. Client has no long term care insurance.

- Client ineligible until $10,000 savings brought down within $2000 level.
- Client pays private rate for 6 months

$1500 x 6 mos. = $9000

$10,000 savings - 9,000 expenses = $ 1,000 remaining

- Client eligible for Medicaid at end of 6 months.
- Has obligation of $420/month to nursing home

$450 income
- 30 protected needs level
= $420 obligation

Medicaid picks up remaining $780 of cost.

$1200 SRS rate
- 420 client obligation
= $ 780 Medicaid payment

H.B. 2890

II. Client has long term care insurance which pays $500/month. Benefits paid prior to Medicaid application count toward resource exclusion.

- Client ineligible for Medicaid until $10,000 savings brought down within $2000 level.
- Combination of insurance payment and client payment over 6 months brings countable resources below $2000.

$500/mo. insur. payment x 6 mos. = $3000 total benefits

$1000 client pymt. x 6 mos. = $6000 total client pymt.

$10,000 savings
- 3,000 resource exclusion
- 6,000 client payment
= $1,000 countable resources

- Client eligible for Medicaid after 6 months.
- Has obligation of $420/month to nursing home.
- Insurance picks up $500 of cost and Medicaid picks up remaining $280

$1200 SRS rate
- 420 client obligation
- 500 insurance payment
= $ 280 Medicaid payment

4-9

RECOMMENDED CHANGES TO H.B. 2890

1. Section 2
   Line 29
   Remove the words "and income"

2. Section 2
   Item C - Lines 40 through 43
   Revise to say:

   (c) are for nursing home care or home and community based care that is part of an approved care plan, approved by the secretary of social and rehabilitation services.

3. Section 2
   Item d - Lines 1 through 4
   Revise to say:

   (d) are for services received prior to and following the first month of medicaid eligibility for long term care as established by the secretary of social and rehabilitation services.

4. Section 6
   Lines 4 and 5
   Revise to say:

   Sec. 6. This act shall take effect upon approval by the federal government and shall thereafter be in force from and after its publication in the statute book.

6-5

KANSAS STATE UNIVERSITY

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Senate Bill No. 590 and 591
Testimony Provided
To The House Appropriations
by Keith L. Ratzloff
Controller, Kansas State University
March 6, 1990

Mr. Chairman, members of the Committee. Thank you for the opportunity to testify on behalf of the amendment to K.S.A. 75-3078 and K.S.A. 75-3057.

IMPREST FUNDS (S.B. 591)

Imprest Funds are funds that the Board of Regents' institutions are authorized to maintain in local bank accounts at each institution. These checking accounts, which are approved by the Pooled Money Investment Board, provide funds for advances for international travel and support University sponsored student group travel for such activities as debate tournaments, livestock judging, etc. In addition, these Imprest Funds are used to respond to immediate needs for cash disbursements which cannot be made on a timely basis through the normal process (i.e., via state warrants issued by the Division of Accounts and Reports). Imprest Funds may also be used to pay amounts due of less than $5, which cannot be paid by state warrant (K.S.A. Supp. 75-3732). Imprest Funds may also be used to pay amounts to employees to correct payroll errors. Finally, the Imprest Fund is used to fund the Change Fund needs at each institution. I will address this need later in this narrative.

Monthly, each institution files with the Division of Accounts and Reports a reconciliation statement of the imprest account and a voucher documenting the payments made. Accounts and Reports then issues a warrant to restore the fund to its original balance and to charge the institution's operating funds for the expenses made.

The amendment to K.S.A. 75-3057 is requested to increase the Imprest Fund from the current authorized amount of $35,000 to $60,000 for Kansas State University and from $22,000 to $35,000 for Pittsburg State University. This increase is necessitated by the fact that the demands placed on the Imprest Funds have increased significantly over the past few years. The need to pay for the amounts under $5 and increased international travel have had the biggest impact on the funds available.

The funding source for this increase will be from General Fee revenues.

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CHANGE FUND (S.B. 590)

K.S.A. Supp. 75-3078 authorizes the Director of Accounts and Reports to establish a maximum Change Fund of $20,000 at each Regents' institution, upon request by the institution. This Change Fund is established by drawing a check against the institution's Imprest Fund. These change funds are used exclusively for making change from customer receipts. Such Change Funds are used by our institutions to make change at locations such as copy centers, theater and concert ticket outlets. Additional uses are student registration, and at Kansas State University, in particular, at the County Extension offices.

Our Change Funds at Kansas State University currently total $19,200 out of a maximum allowed of $20,000. This allows us little flexibility to meet our ever increasing needs to provide more Change Fund capability. Therefore, we are requesting that this maximum be increased from the existing $20,000 to $40,000. The new $40,000 maximum would be available to all Regents' institutions, as the current statute is uniformly applicable. Please note that this request, in part, is what prompted the need to increase the Imprest Fund limits as requested in Senate Bill No. 591 due to the fact that the Change Fund is funded from the Imprest Fund.

Thank you again for the opportunity to testify before you on these matters.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Winston Barton, Secretary

March 6, 1990

Statement Regarding: S.B. 663

TITLE:
AN ACT concerning imprest fund for area offices of the department of social and rehabilitation services.

PURPOSE:
To permit the secretary of social and rehabilitation services to establish an imprest fund in each area office, the total of such funds not to exceed $1,000,000.

BACKGROUND:
SRS has established an imprest fund from which each area office can write checks in specific instances where an immediate payment is needed. The fund is then replenished from the appropriate source. The primary use of the fund is for issuance of child support checks in non-AFDC cases. An absent parent sends a support check to the courts; the courts in turn send the funds to SRS for issuance to the custodial parent. Federal regulations require that this entire process not exceed 15 days. Because of this deadline, SRS must sometimes issue the support checks before the court's check has cleared.

The current statutory limitation on the imprest fund is $500,000. Because of recent rapid growth in the non-AFDC child support collection program, this limit is no longer adequate for the volume of checks we are processing.

EFFECT OF PASSAGE:
Increasing the statutory limit on the imprest fund would give the department additional flexibility in the issuance of child support checks. The department would still be required to go through the state regulation process to increase the accounts when needed. We believe this restriction will still allow legislative control over the monies. The bill will have a fiscal impact of about $7,600 to the State General Fund for each $100,000 of imprest fund authority used, which represents interest which would otherwise be earned on these funds.

RECOMMENDATION:
Because of concern about the status of the state general fund, SRS recommends that amount of money in line 17 be changed from $1,000,000 to $750,000. The department requests passage of this legislation as amended.

J. S. Duncan
Commissioner of Administrative Services
3272

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DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TESTIMONY BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

REGARDING

SENATE BILL 666

ON

MARCH 6, 1990

Room 514
State Capital Building

Al Nemec, Commissioner
Mental Health & Retardation Services
Department of Social and Rehabilitation Services

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DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
WINSTON BARTON, SECRETARY

Statement Regarding: S.B. 666

TITLE:
AN ACT relating to work therapy projects and work therapy project funds.

PURPOSE:
This bill would allow state hospitals to continue to operate work therapy projects for their patients in the same manner as canteens are operated. Work therapy projects are operated either on-campus in the same manner as a sheltered workshop, or off-campus in the community as a means of helping clients integrate into community placement. A local bank account would be used to handle finances subject to oversight of the budget approval process by the Division of Accounts and Reports, and through regular audits by the legislative Post Auditor.

BACKGROUND:
Prior to FY 1990 the hospitals used their canteen accounts to handle the finances of their work therapy projects. During the 1989 legislative session the state Division of Accounts and Reports determined that the use of the canteen accounts as work therapy funds was improper. The prior practice of using canteen accounts had been based upon 15 years of unwritten agreements to use them in that manner. As a temporary means to correct the problem the appropriations bill for the hospitals was amended with a proviso allowing the hospitals to operate the projects in the same manner as the canteen funds are operated.

For a number of years our hospitals have operated sheltered workshops and other similar ventures as a means of providing prevocational training for our clients. While the projects vary between the institutions, each of them is focused toward providing an opportunity for clients to have a work training environment to help them develop skills that will aid their future placement into the community. The projects often involve manufacturing or services provided that are reimbursed by contracts with vendors or through sales to the public. The projects generally fulfill treatment recommendations by the treatment teams at each of the institutions.

EFFECT OF PASSAGE:
Create a statutory basis to operate existing work therapy projects.

RECOMMENDATIONS:
The Department of Social and Rehabilitation Services supports this bill.

Session of 1990

HOUSE BILL No. 3002

By Committee on Appropriations

2-14

AN ACT concerning the behavioral sciences regulatory board; relating to maximum fees for examinations, applications, renewals and reinstatements administered by the board; amending K.S.A. 74-5311 and K.S.A. 1989 Supp. 65-5808, 65-6314, 74-5310, 74-5319, 74-5339, 74-5349, 74-5365 and 74-5367 and repealing the existing sections.

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

Section 1. K.S.A. 1989 Supp. 65-5808 is hereby amended to read as follows: 65-5808. (a) The board shall fix by rules and regulations the following fees:

(1) For application for registration, not more than ~~$75~~ *$250;* $175

(2) for examination, not more than ~~$100~~ *$250;* $200

(3) for renewal of a registration, not more than ~~$75~~ *$250;* $175

(4) for reinstatement of a registration, not more than ~~$75~~ *$250;* $175

(5) for replacement of a registration, not more than $20;

(6) for application for endorsement in a specialty, not more than ~~$100~~ *$250;* and $175

(7) for biennial renewal for endorsement in a specialty, not more than ~~$100~~ *$250.* $175

(b) Fees paid to the board are not refundable.

Sec. 2. K.S.A. 1989 Supp. 65-6314 is hereby amended to read as follows: 65-6314. The following license and examination fees shall be established by the board by rules and regulations in accordance with the following limitations:

(a) Renewal fee for a license as a social work associate shall be not more than ~~$75~~ *$250.* $175

(b) Application or renewal fee for a license as a baccalaureate social worker shall be not more than ~~$75~~ *$250.* $175

(c) Application or renewal fee for a license as master social worker shall be not more than ~~$75~~ *$250.* $175

(d) Application or renewal fee for a license in a social work specialty shall be not more than ~~$75~~ *$250.* $200

(e) Examination fee for a license as a baccalaureate social worker, for a license as a master social worker or for a license in a social

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work specialty shall be not more than ~~$75~~ *$250.* If an applicant fails an examination, such applicant may be admitted to subsequent examinations upon payment of an additional fee prescribed by the board of not more than ~~$75~~ *$250.*

(f) Replacement fee for reissuance of a license certificate due to loss or name change shall be not more than $20.

(g) Temporary license fee for a baccalaureate social worker, master social worker or a social work specialty shall be not more than $50.

Sec. 3. K.S.A. 1989 Supp. 74-5310 is hereby amended to read as follows: 74-5310. (a) The board shall issue a license as a psychologist to any person who pays a fee prescribed by the board, not in excess of ~~$100~~ *$250*, which shall not be refunded, who either satisfies the board as to such person's training and experience after a thorough review of such person's credentials or who passes a satisfactory examination in psychology. Any person paying the fee must also submit evidence verified by oath and satisfactory to the board that such person: (1) Is at least 21 years of age; (2) is of good moral character; (3) has received the doctor's degree based on a program of studies in content primarily psychological from an educational institution having a graduate program with standards consistent with those of the state universities of Kansas, or the substantial equivalent of such program in both subject matter and extent of training; and (4) has had at least two years of supervised experience, a significant portion of which shall have been spent in rendering psychological services satisfying the board's approved standards for the psychological service concerned.

(b) The board shall adopt rules and regulations establishing the criteria which an educational institution shall satisfy in meeting the requirements established under item (3) of subsection (a). The board may send a questionnaire developed by the board to any educational institution for which the board does not have sufficient information to determine whether the educational institution meets the requirements of item (3) subsection (a) and rules and regulations adopted under this section. The questionnaire providing the necessary information shall be completed and returned to the board in order for the educational institution to be considered for approval. The board may contract with investigative agencies, commissions or consultants to assist the board in obtaining information about educational institutions. In entering such contracts the authority to approve educational institutions shall remain solely with the board.

Sec. 4. K.S.A. 74-5311 is hereby amended to read as follows: 74-5311. Examinations for applicants under this act shall be held by

the board from time to time but not less than once each year. The board shall adopt rules and regulations governing the subject, scope, and form of the examinations or shall contract with a national testing service to provide an examination approved by the board. The board shall prescribe an initial examination fee not to exceed ~~$200~~ *$250*. If an applicant fails the first examination, such applicant may be admitted to any subsequent examination upon payment of an additional fee prescribed by the board not to exceed ~~$200~~ *$250*. The examination fees prescribed by the board under this section shall be fixed by rules and regulations of the board.

Sec. 5. K.S.A. 1989 Supp. 74-5319 is hereby amended to read as follows: 74-5319. Upon receipt of such application blank, a licensee shall fill out, sign and forward the application to the board, together with a renewal fee fixed by rules and regulations of the board of not to exceed ~~$200~~ *$250*. Upon receipt of such application and fee, the board shall issue a renewal license for the period commencing on the date on which the license is issued and expiring on June 30 of the next even-numbered year. Initial licenses shall thus be for the current biennium of registration.

Sec. 6. K.S.A. 1989 Supp. 74-5339 is hereby amended to read as follows: 74-5339. After one year from the date of a revocation of a license, an application for reinstatement may be made to the board, and it may order such reinstatement. The board shall prescribe by rules and regulations a reinstatement fee of not to exceed ~~$200~~ *$250*.

Sec. 7. K.S.A. 1989 Supp. 74-5349 is hereby amended to read as follows: 74-5349. (a) In accordance with the provisions of this section, the board may establish specialties within the practice of psychology and provide for the endorsement of ~~certified~~ licensed psychologists in such specialties. The board shall adopt rules and regulations applicable to the endorsement of specialties which:

(1) Establish categories of specialties within the practice of psychology which are consistent with specialties recognized by the profession of psychology;

(2) establish education, training and qualifications necessary for endorsement for each category of specialty established by the board at a level adequate to assure the competent performance by certified psychologists of the specialty such person is authorized to perform; and

(3) define each category of specialty established under this section and establish limitations and restrictions on each category, as appropriate. The definition of each category of specialty established under this paragraph (a)(3) shall be consistent with the education, training and qualifications required to obtain an endorsement in that

category of specialty and shall be consistent with the protection of the public health and safety.

(b) The board may fix by rule and regulation an application fee for endorsement in a specialty and shall fix a biennial renewal fee for endorsement in a specialty. The application fee and biennial renewal fee shall not exceed ~~$100~~ *$250*. Any such fee shall be in addition to other fees collected by the board under the certification of psychologists act.

(c) A certified psychologist holding an endorsement from the board in a specialty within the practice of psychology may represent to the public that such person is endorsed in such specialty. It shall be unlawful for any person not endorsed in a specialty within the practice of psychology to intentionally represent to the public that such person is endorsed in such specialty.

(d) This section shall be part of and supplemental to the certification of psychologists act of the state of Kansas.

Sec. 8. K.S.A. 1989 Supp. 74-5365 is hereby amended to read as follows: 74-5365. The application and renewal fee for registration under this act shall be fixed by the board by rules and regulations in an amount not to exceed ~~$100~~ *$250.*

Sec. 9. K.S.A. 1989 Supp. 74-5367 is hereby amended to read as follows: 74-5367. (a) The board may issue a temporary permit to practice as a registered masters level psychologist to any person who pays a fee prescribed by the board under this section, which shall not be refunded, and who: (1) Meets all the requirements for registration under this act as a registered masters level psychologist, but whose application for registration is pending; or (2) meets all the requirements for registration under this act as a registered masters level psychologist except the requirement of postgraduate supervised work experience or current employment, or both.

(b) A temporary permit issued by the board under clause (1) of subsection (a) shall expire at such time as final action on the application is completed, but all such temporary permits shall expire one year after the date of issuance of the permit. A temporary permit issued by the board under clause (2) of subsection (a) shall expire six months after the date of issuance and may be renewed for one additional six-month period if the board finds that satisfactory progress toward the supervised experience requirement is being met.

(c) The board shall fix by rules and regulations fees for application and renewal of each type of temporary permit under this section. The application and renewal fee shall not exceed ~~$100~~ *$250* except that the fee for application for and renewal of the two-year temporary permit under clause (1) of subsection (a) shall not exceed ~~$200~~ *$500.*

(d) The application for a temporary permit may be denied or a temporary permit which has been issued may be suspended or revoked on the same grounds as provided for suspension or revocation of a registration under K.S.A. ~~1987~~ *1989* Supp. 74-5369 *and amendments thereto*.

Sec. 10. K.S.A. 74-5311 and K.S.A. 1989 Supp. 65-5808, 65-6314, 74-5310, 74-5319, 74-5339, 74-5349, 74-5365 and 74-5367 are hereby repealed.

Sec. 11. This act shall take effect and be in force from and after its publication in the Kansas register.