Approved: January 27, 2000
Date

MINUTES OF THE SENATE WAYS & MEANS COMMITTEE.

The meeting was called to order by Chairperson Dave Kerr at 9:30 a.m. on January 21, 2000 in Room 123-S of the Capitol.

All members were present except: Senators Lawrence and Downey, who were excused

Committee staff present: Alan Conroy, Chief Fiscal Analyst, KLRD
Norman Furse, Revisor of Statutes
Michael Corrigan, Asst. Revisor of Statutes
Rae Anne Davis, KS Legislative Research Department
Debra Hollon, KS Legislative Research Department
Judy Bromich, Administrative Assistant to the Chairman
Ronda Miller, Committee Secretary

Conferees appearing before the committee: Secretary Connie Hubbell, Department on Aging

Others attending: See attached list

The Chairman invited Secretary Hubbell to continue with her briefing on caseloads and waiting lists. The Secretary noted that clarifications regarding the average monthly number of Medicaid nursing facility residents in FY 1999 was made in her revised testimony. (Attachment 1)

Secretary Hubbell began by reviewing the answer to the three questions posed by the Committee on January 13, 2000. (Attachment 2) She introduced Ms. Janis DeBoer who serves as Director of the Commission of Program and Policy because of her experience with the HCBS waiver and nursing facility entrance. Secretary Hubbell explained that the threshold score necessary for entrance into a nursing facility is 26, and the current threshold score to qualify for the HCBS waiver is 15. The agency has submitted a request to HCFA to raise that score to 26 and they assume it will be approved. She pointed out the activities and risk factors that are measured to determine a client's eligibility for nursing home entrance. (Attachment 2-2)

The Secretary reviewed the numbers of nursing facility residents who have a score below 25, a score of 26-39, and a score of 30-34. She also reviewed the number of Medicare and Medicaid persons who enter nursing facilities with scores in the above ranges. She called attention to the high number of private pay persons who enter the facilities, emphasizing that one reason these numbers are important is because once their spenddown is gone, they become Medicaid clients. Secretary Hubbell said that the lower numbers of Medicaid seniors entering facilities may indicate that they are staying in their homes to receive services. In answer to a question, the Secretary stated that as the agency performs the assessment and determines the score, the senior's plan of care is written to provide the services that are needed to stay in their home on a continuum of care. She pointed out that $1.3 million would be the amount of total savings ($570,000 from the SGF) for those who currently score between 1-25 if the threshold for the waiver is raised to 26.

There was an inquiry about the agency's ability to track whether there would be an impact on the health of those who score between 15 & 26 but would no longer receive home services through the waiver. The Secretary stated that all those who are currently being served will be grandfathered in and that other early intervention programs throughout the state provide services for those who do not score 26.

Secretary Hubbell stated that if the threshold score for the HCBS waiver is raised to 26, persons who become eligible would probably be in need of more services. It was noted, therefore, that the net savings would not be $1.3 million. (Attachment 2-3) In answer to a question, the Secretary stated that people on

the HCBS waiver are reassessed every twelve months and someone who receives services on the waiver would become ineligible if their score fell below the threshold. Ms. DeBoer stated that very few fail to qualify for the waiver on subsequent assessments.

In discussing the wage pass-through program (Attachment 2-6), Secretary Hubbell stated that most of the pass-through monies went toward increased wages, but there is no data yet regarding its impact on employee retention. She added that $9.3 million would have fully funded wage pass-through, but $4.6 million was allocated for FY 2000 and FY 2001.

There was discussion regarding several issues of Targeted Case Management:

- the various ways that case management is handled in different places
- the providers' view that the system is complicated and the paperwork is burdensome
- the viewpoint that the agency may not be making good use of community resources already available for the aging

The Secretary noted that she had met with a number of providers regarding these issues and has an interest in promoting coordination of services at the community level. She stated that several counties have requested that case assessments be a county option rather than a mandate from the Department. Her staff is reviewing who can provide case management, which clients must be reviewed, and the reimbursement level.

The Chairman suggested that perhaps one possibility for reducing the budget in the least harmful way would be to serve persons with a higher score who are not currently being served rather than automatically grandfathering in persons who currently receive services on the waiver but who have a lower score. The Secretary responded that the latter category of persons would perhaps qualify under the Senior Care Act or Income Eligible Program which are state only funded programs but which have a waiting list. She stated that she would like the opportunity to evaluate the potential savings and determine whether there would be a different kind of fallout. Members discussed the costs per person associated with the Senior Care Act and Income Eligible Programs versus the HCBS waiver. In answer to a question, it was stated that the same assessment tool is used to determine who is eligible for the Senior Care Act and Income Eligible Programs. The Secretary told members that the agency plans to leave the current threshold score at 15 for these two programs in order to provide services for clients who may be on the waiver waiting list or to accommodate needs of those persons who don't need a lot of services.

There was an inquiry about whether different area agencies on aging are consistent in their evaluations. The Secretary stated that the Department uses the same assessment tool, provides training at the central office, and tracks activities. She added that one of her goals is to put together a contract with outcomes for services with area agencies on aging.

The Chairman adjourned the meeting at 10:30 a.m. The next meeting is January 24, 2000.

SENATE WAYS & MEANS COMMITTEE GUEST LIST

DATE: January 21, 2000

NAME	REPRESENTING
JANIS DOBER	KDOA
Doug Farmer	~~KDOA~~ II
Sheli Sweeney	KDOA

State of Kansas
Department on Aging

Connie L. Hubbell, Secretary

for additional information, contact:

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Senate Ways & Means Committee
January 13, 2000

Overview of Aging Programs and Policy Direction

Office of the Secretary
Connie L. Hubbell, Secretary
785.296.5222

REPORT TO THE SENATE WAYS & MEANS COMMITTEE
BY
CONNIE HUBBELL
SECRETARY
KANSAS DEPARTMENT ON AGING
JANUARY 13, 2000

Good morning, Mr. Chairman and members of the committee. Thank you for this opportunity to update you on the Department on Aging's programs and services, as well as our policy direction, now and in the future.

While I am new to the agency, from my visits with KDOA staff, Area Agency on Aging (AAA) staff, seniors, and advocates, I have learned how important the programs and services KDOA provides are to Kansas seniors and their families.

The Department provides a wide array of services to seniors across the state, on a continuum of long-term care. We provide services from information and assistance, to in-home services and nursing facility care. All of the services along the continuum are important and necessary at different stages of people's lives.

KDOA works with not only area agencies on aging and their service providers, but with SRS, KDH&E, KSU, the KU School of Gerontology and many other partners across the state to maximize the variety and scope of services that we are able to provide. Partnering allows us to meet the growing needs of seniors and their families in the state.

Nursing Facilities

The average monthly number of Medicaid nursing facility residents in FY 1999 was 11,340, and in FY2000 to date is 11,498. The average monthly cost per resident in FY 1999 (all funds) was $ 1,841, and in FY 2000 to date is $1,990. Currently, the average long-term threshold score, based on the standardized nursing facility resident assessment formula is 60.

In FY 1999 17.9% of those seeking admission to nursing facilities were diverted into community-based services, while in FY 2000, the percentage to date has been 17%.

The Department provided Medicaid funding for 16,329 unduplicated nursing facility residents across the state for FY 1999, which reflects a decrease of 584 from FY 1998, and 721 from FY 1997.

During FY 1999, there were 2,206 persons who were assessed for potential nursing facility placement, but who continued to reside in community settings.

An average of 52% of nursing facility admissions are Medicaid eligible. We can assume then, that of 2,206 customers who were diverted, 1,147 of those (52%) would have incurred nursing facility costs which would have been paid by Medicaid. The Medicaid savings in diverting 1,147 persons for one month each, is estimated at $1.9 million (all funds.)

The number of Medicaid nursing home days avoided because of customer participation in the senior care act program was 327,581, with an estimated net SGF savings of $2.6 million.

Currently, KDOA is working on several goals in the nursing facility area, including improving the image of nursing facilities statewide by working with the industry associations.

In-Home Services

During FY 1999, the department provided services to more seniors in Kansas than ever before under a variety of funding sources. The services allowed those seniors to remain integrated in their own communities, as an alternative to nursing home care. Some examples of in-home services that help promote independence, security, and dignity include: homemaker services (cleaning, cooking, shopping), attendant care (assistance with bathing, feeding, toileting, and other activities of daily living), home health services, and home-delivered meals.

HCBS Services

The average number of people served under the HCBS/FE Medicaid waiver per month in FY 1999 was 4,284, and the average number served for FY 2000 to date is 4,835. Expenditures for FY 1999 were $34,921,722, while expected expenditures for FY 2000 are $46,573,718.

The average cost per customer per month in FY 1999 (all funds) was $698, while the average monthly cost for FY 2000 to date is $752. We have submitted a waiver application to HCFA with a cost cap of $2,760, so that any new person whose plan of care would exceed $2,760 per month would not be eligible for in-home services. As of January 6, 2000, there were 38 eligible seniors on the waiting list for HCBS services. Attached is a summary of the numbers of customers per fiscal year for the last three years as well as the cost in all funds for serving those customers.

Currently, under the waiver, the services that are available are adult day care, sleep cycle support, personal emergency response system and installation, wellness monitoring, healthcare attendant services, and respite care.

If the waiver is renewed, which we expect will occur in the near future, we anticipate the addition of case management, assistive technology, and nurse evaluation.

The waiting list for the HCBS/FE waiver began on July 1, 1999 and on October 18, 1999, KDOA stopped adding persons to that list. The number of applicants on the list totaled 367 at that time. Targeted case managers at the area agencies on aging are contacting the HCBS/FE waiver applicants on the waiting list and services are being coordinated through the area agencies on aging. As of January 6, 2000, the waiting list has been reduced from 367 customers to 38 customers.

KDOA is working to address several HCBS program policy issues, including identifying and clarifying who is the target population for home and community-based services. We want to focus on providing services to those who are most at-risk of entering nursing facilities, and to

provide those essential services needed to prevent customers from entering nursing facilities prematurely. This will involve analyzing whether the current populations that are being served are those most at-risk of entering a nursing facility. We also plan to analyze the services themselves to see if they are those most critical for preventing premature entry into the nursing facility.

KDOA will also analyze HCBS services to determine whether they are consistent with those being provided in other state-funded programs. The agency is working toward streamlining services, so that no matter what the funding source, customers are provided the same types of services. An example of such a service is case management, which would be the same under all funding sources. The only difference may be the target population served and the level of service provided under any funding source.

Finally, the agency is focusing on operating the waiver in a more risk-sharing fashion, so that the customer would be allowed to assume risk for his or her care. Customers would make choices as to the degree of risk he or she would like to assume, so that he or she could receive services even though the services would not guarantee to meet 100% of the customers health, safety and welfare needs in his or her home.

Targeted Case Management

The average number of customers served per month in FY 1999 was 3,744, with an average of 4,373 customers anticipated to be served per month in FY 2000.

The current budgeted amount for targeted case management is $5,048,036. The average cost per month per customer for targeted case management currently is $124.09 and the average number of targeted case management hours per customer per month is currently 3.1 hours.

Targeted case management services include assessment, re-assessment, plan of care development, service coordination, monitoring, gatekeeping, resource development, advocacy, crises intervention, and documentation.

In the handout is a summary of targeted case management showing expenditures for the last three years, and what we expect to spend this year.

We are analyzing alternative funding sources, such as certified match, in an attempt to maximize federal drawdown. We are currently looking at options to provide targeted case management within the budgeted amount.

Senior Care Act and Income Eligible programs

The number of customers served under the Senior Care Act and Income Eligible (IE) programs in FY 1999 was 9,092, with the average annual cost per person for Senior Care Act and IE being $644.02 in FY 1999, or $53.67 average per month.

The agency formed a work group to look at integrating the two programs into one, and I will consider the recommendation of that workgroup and the impact it would have on customers.

Volunteerism

We are looking at efforts to increase volunteerism at the local level, such as utilizing informal support provided to customers by families, neighbors, community organizations and/or churches.

Outcome and Assessment Information Set (OASIS)

OASIS is a federally mandated program which requires providers to accumulate certain statistical information. We are aware that providers are concerned about the impact of OASIS on provision of services to home health customers, and that the program could lead to loss of home health agencies in the state. We are tracking the federal regulations in their development.

Demographic issues

Kansans over age 85, by percentage, are the fastest growing segment of the population. Therefore, although the nursing facility population has been decreasing over the last few years, we anticipate that this trend will reverse itself. In fact, the first five months of FY 2000 indicate an average of 11,498 residents which is a 158-person increase over the FY 1999 average of 11,340.

Impact of Baby Boomers

Americans are living longer and their transition into senior life will not simply be a matter of greater numbers. It will have a dramatic impact on the policies, economics and social structures of the future. Policy makers at all levels need to ensure there are resources, programs, and policies in place to provide much needed support and information for an increasingly older population.

We ought to prepare ourselves for the changing needs of an aging baby boomer generation. Baby boomers will continue to have an enormous impact on our society as we age, but we will age differently than our parents. The fastest growing segment of the elderly population will be those 85 years old and older. In the next 30 years we will see millions more Americans facing the challenges of chronic illnesses and disabilities. It is a great blessing that we are living longer. But despite all the medical advances that have been made, people still age. And because so many more of us are growing old, many of us will need help with basic everyday tasks. We must work together to find ways not only to care for those with long-term care needs, but also to support the caregivers. Kansas, and the nation, is facing a boom in the senior population. This growth means that KDOA and the aging network must focus on providing the best possible long-term care services.

Currently, Kansas is fifth in terms of states with the highest percentage of residents over the age of 85. Kansas is eleventh in the nation in terms of states with the highest percentage of residents over 65 years of age. By the year 2010, 14% of the Kansas population will be over the age of 65. To put that into better perspective, one in five Kansans will be over the age of 65 by 2020.

Health Insurance Counseling

The Senior Health Insurance Counseling for Kansas (SHICK) program put more than $1.27 million back into the pockets of elderly and disabled Kansans during the federal fiscal year that ended september 30, 1999. Under the SHICK program, a program funded by the department and operated by the Kansas insurance department, via a contract with KDOA, trained volunteers help Medicare eligible Kansans deal with the often-perplexing Medicare rules and forms. Without this program, seniors and disabled Kansans on fixed incomes would have spent nearly $1.3 million more on prescriptions and insurance premiums during FY 1999 -- an increase of 37 percent over the savings that SHICK found for Kansans on Medicare during FY 1998. SHICK helped more than 7,000 seniors and disabled Kansans during FY 1999, an increase of 55 percent over FY 1998.

Management Information Systems

During 1999, KDOA worked on developing the Kansas Aging Management Information System (KAMIS) for use by AAA's, service providers for aging programs, and KDOA staff. KAMIS will replace the Client Assessment and Referral System (cars), an older system which has problems. KAMIS will use Internet technology to provide low-cost, high-function access to our customers and service providers. KAMIS will perform the functions our users need at an acceptable response level.

Program of All-Inclusive Care for the Elderly (PACE)

Federal regulations have been issued and SRS and KDOA are working jointly to establish a PACE program in Kansas. PACE provides all needed care in the most appropriate setting for customers who are eligible for nursing home care. Services include primary care, social work, and restorative therapy, all of which are provided at a central location, in a customer's home or at a facility. Specialty and ancillary medical services are also provided, as well as long-term services such as transportation, meals, and personal care.

Nutrition Voucher Pilot Project

KDOA is developing a pilot project for use of nutrition vouchers in urban and rural locations. Vouchers could be used at a restaurant or other location, contracted by an Area Agency on Aging. Vouchers will provide more nutrition options and choices to seniors. If the pilot project is successful, voucher programs will be offered in other areas of the state.

Caregiver Support Project

Family members, friends and neighbors, are often caregivers for seniors. Caregiving can be physically and emotionally stressful, and to alleviate some of the "burnout" that caregivers experience, KDOA plans to provide several resources to assist caregivers in their difficult daily tasks. Some of the resources we plan to provide are:

- Develop internet resources for caregivers, including a "chat" room where information and problem solving between caregivers can take place;
- Create a library of resources for use by individuals, community groups and businesses;
- Develop training for current and potential caregivers in areas such as hands-on caregiving,

mentoring caregivers, and for businesses who may have employees who are caregivers; and
- Caregiver support groups.

Mental Health and Substance Abuse Among Older Americans

Among the issues that cannot be ignored which affect a person's health are substance abuse and mental health. These issues are a much bigger problem than most people realize. Substance abuse involves up to 17% of older Americans and mental health issues are facing up to 25% of our seniors. A new area of focus for the Kansas department on aging will be to find ways to promote awareness and understanding about the issues and identify ways to help aging services and mental health and substance abuse professionals work together.

Meeting the Needs of Rural Kansans

We know that one-fourth of America's population lives in rural areas. Compared with urban Americans, rural residents have higher poverty rates, a larger percentage of elderly, tend to be in poorer health, have fewer doctors, hospitals, and other health resources, and face more difficulty getting to health services. We must look for ways to improve access to care, to attract primary care physicians and other health care providers to rural areas, to increase our health promotion and disease prevention efforts, and to organize our services for vulnerable rural populations.

Future Direction of KDOA

We must seek to coordinate and collaborate with other state agencies that serve our customers, including the Kansas Department of Social and Rehabilitation Services (SRS), the Kansas Department of Health and Environment (KDHE), the Kansas Insurance Department, the Long-Term Care Ombudsman, and others. We must improve our communication with all our partners, and most importantly, with our customers. We will be re-examining our focus, our management techniques, service delivery systems, and internal structure. Identifying the situation is only part of the solution. We must also now equip ourselves with the tools to address the needs of tomorrow. For that reason, we have formed a partnership with the Kassebaum Center for Gerontology at the University of Kansas Medical School, to develop a map that will envision the sociographic and demographic landscape of the next three decades.

Finally, there are three primary goals that will serve as the driving force for KDOA for the future:

- To develop and support an integrated system of long-term care services that will maximize individual choice in care, ensure appropriate placement, and effectively leverage our resources.
- To develop proactive public information initiatives to inform and educate Kansans about aging issues, and to enhance KDOA's visibility and our efforts to help provide for the needs of our elders.
- To increase the effectiveness and efficiency of the service delivery system through improved management and accountability at all levels.

Thank you for the opportunity to brief you on the important work KDOA is doing for Kansas seniors. I will now stand for questions.

STATE OF KANSAS

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BILL GRAVES
Governor

Connie Hubbell
Secretary of Aging

January 19, 2000

Senator Dave Kerr, Chair
Senate Ways & Means Committee
Room 120-S, 300 SW 10th Street
Topeka, KS 66612

Dear Senator Kerr:

The following is in response to questions raised by the Senate Ways and Means Committee during testimony given by the Department on Aging on January 13, 2000. Since the responses contain some amount of detail and several charts, they are included as attachments to this letter.

Question: How many people are in nursing facilities and on the waiver with scores between 26 and 30? How much money does that cost? What would be the cost saving if the score were increased?
Response: See Attachment 1.

Question: What led to the increase in cost per person on the waiver? What led to the increase in cost per person in nursing facilities? What drives those costs?
Response: See Attachment 2.

Question: Did wage pass through program lead to increase wages of NF staff and decrease in turnover? How is program administered and monitored?
Response: See Attachment 3.

Thank you for the opportunity to respond to questions from the committee. If I can be of further assistance, please feel free to contact me at 296-5222.

Sincerely,

Connie Hubbell
Secretary of Aging

c: Mike Hammond
Sheli Sweeney

Senate Ways and Means Committee

Date January 21, 2000

Attachment # 2

Increasing the Long Term Care Threshold Score:

The minimum threshold score of 26 for the nursing facility (NF) program is included in the Kansas Medical Services Manual, published by the Department of Social and Rehabilitation Services. To our knowledge, the Federal Health Care Financing Administration (HCFA) did not specifically approve this score. Kansas Department on Aging (KDOA) would have the ability to change the eligibility score.

It should be noted that the minimum threshold score of 26 for the Home and Community Based Services-Frail Elderly (HCBS-FE) program was included in the waiver application submitted to HCFA. The application is pending approval.

KDOA was asked to determine how many NF residents and HCBS-FE customers have a level of care score of 26 to 29 and what the cost of services are, and what the cost savings would be if the threshold score was raised to 30 and 35. Attached is a summary of the residents/customers impacted and the estimated savings if the threshold scores were raised.

The HCBS-FE cost cap would most likely increase if the threshold score were raised. Residents with higher level of care scores are frailer and need more services. If the threshold is raised, the average cost of the remaining residents will most likely increase. This would raise the HCBS-FE cost cap in relation to the cost increase for NF services.

The following items need to be considered when reviewing the attached data:

- A minimum long term care threshold score must be met for both community based customers and nursing facility customers prior to Medicaid payment for services.

- The long term care threshold score measures a customer's ability to perform activities using the following: bathing, dressing, toileting, transfer, mobility, eating; meal preparation, shopping, money management, transportation, telephone usage, laundry and housekeeping, and medication management. In addition, five risk factors are considered: bladder incontinence, abuse, neglect, and exploitation, support unavailability, impaired cognition, and falls.

- The community based program uses the Uniform Assessment Instrument (UAI) to derive the score. The nursing facility program initial score is derived from the CARE (Client Assessment and Referral Evaluation) program, and the quarterly scores are derived from the MDS (Minimum Data Set) assessment data. It is important to note that the scores from the MDS data do NOT address four critical components of the threshold criteria. As such, nursing facility scores as reflected in this testimony do not directly correspond to the community based scores.

- **The four critical components not included in the MDS formula** are as follows: bathing, money management, abuse, neglect, and exploitation, and support unavailability. When the four critical components are considered in the long term care threshold score for nursing facility customers, the scores have been found to increase.

Kansas Department on Aging
Program and Policy Commission
Change Level of Care Scores For Nursing Facility (NF) and Home and Community Bases Services-Frail Elderly (HCBS-FE) Eligibility and the Estimated Fiscal Impact

Medicaid Residents' Level of Care Score Based on NF Assessment Formula

Level of Care Score	Number of Residents	Per Diem Daily Cost	Estimated Annual Savings
0 to 25	130	$68.33	$3,242,259
26 to 29	53	68.33	1,321,844
30 to 34	85	68.33	2,119,938
Total Estimated Savings	268		$6,684,041
Total Estimated State General Fund Savings (40%)			$2,673,616

The average daily Medicaid payment was used to determine the estimated savings of lowering the level of care score. The average per diem daily cost represents the average Medicaid rate ($84.36) less the resident liablity ($16.03). Resident liability is the residents income, eg Social Security, interest income, etc., which is applied against the Medicaid bill.

HCBS-FE Level of Care Score

Level of Care Score	Number of Customers	Average Cost Per Month	Estimated Annual Savings
0 to 25	457	$241.62	$1,325,044
26 to 29	502	265.61	1,600,035
30 to 34	688	302.67	2,498,844
Total Estimated Savings	1,647		$5,423,923
Total Estimated State General Fund Savings (40%)			$2,169,569

EXPENDITURE INCREASES IN THE WAIVER AND NURSING FACILITY PROGRAMS

Home and Community Based Services - Frail Elderly (HCBS-FE) Program:

Three factors can result in higher expenditures in the HCBS-FE program. They are caseload increases, additional services required by the customers, and provider rate increases. These factors can happen in conjunction with each other or separately.

The Medicaid caseload increases when additional customers apply for services and are determined functionally and financially eligible. As the population of senior Kansans grows in the future, there will be a greater demand for the services.

Second, the frail elderly entering the program and those aging in the program may have greater needs requiring additional services. This can increase the amount of services approved in the care plan to adequately meet customers' needs.

The last factor is a provider rate increase for the services delivered. The HCBS-FE waiver reimburses providers based on fees for services. The fees were not increased after the waiver was implemented in January 1997, until July 1999. At that time, there was a six-percent increase in the fee for each service.

Nursing Facility (NF) Program:

The NF program has four main factors that can increase expenditures. They are caseload increases, heavier care requirements by the residents, rate increases resulting from increased NF costs, and a reduction of the portion of the bill covered by resident's obligation. These factors can happen in conjunction with each other or separately.

As the population of senior Kansans grows, it will put a greater demand on the need for NF services. However, in the recent past there has been a steady decline in the number of residents due primarily to two factors. The first factor is the CARE program, which requires a resident assessment before admission to a NF. One of the goals of this program is to help people find appropriate long-term care services. Information provided through the CARE program has contributed to decreasing the number of nursing facility placements as evidenced by the program's diversion statistics. A second factor contributing to the decrease in the number of nursing facility residents is the availability of home and community-based services. Despite these recent trends, at some point, the sheer numbers in the aging population will create an additional demand for NF services.

Senior Kansans are staying out of NF's longer. When they do need this level of care, they are more frail and have greater medical needs. This can increase the cost of caring for the residents.

Nursing facilities are reimbursed using a cost based payment methodology. Providers submit an annual cost report that is used to set upper payment limits and rates. As NFs incur higher costs, they are reported and passed on in the form of higher Medicaid payment rates. The higher costs can be a result of federal legislation (*e.g.* higher minimum wage rates) or state legislation (*e.g.* Nursing Facility Quality Enhancement Wage Pass-Through Program). Cost increases can also be incurred at the discretion of the operator.

The last factor is the amount of resident obligation that is applied to the Medicaid bill. Resident obligation is retirement (*e.g.* Social Security) or other income (*e.g.* interest income) that is applied to the cost of Medicaid services. Generally, the Medicaid resident is allowed to retain $30 per month for personal need items. As the NFs Medicaid payment rates increase at a greater pace than the resident obligation, the Medicaid program picks up a larger percentage of the bill. The percentage of resident liability was approximately 22% in FY 1994 and is currently about 19%.

Response to Senate Ways & Means Committee
RE: Wage Pass-Through Program
(1/13/00)

The Kansas Department on Aging (KDOA) is administering the Quality Enhancement Wage Pass-Through program for nursing facilities (NF) and nursing facilities for mental health (NF-MH). KDOA staff worked with staff members from the Department of Social and Rehabilitation Services (SRS) and representatives from the Kansas Association of Homes and Services for the Aging (KAHSA) and the Kansas Health Care Association (KHCA) to plan the administration of the program.

A significant issue discussed at length during the meetings was the period of funding. The appropriations bill stated that the funding was for the fiscal year ending June 30, 2000. The Medicaid State Plan and application stated that the funding is for state fiscal year 2000 and there may not be additional funding in FY 2001.

Applications were received from 228 of the 357 eligible NFs and all of the 14 NF-MHs. Total requests exceeded the budget appropriation. Thus, funding requests were pro-rated to stay within the budget allocation for the program. NFs received approximately 47% of requested funding and NF-MHs received approximately 29%. This meant that a $4.00 request (the maximum allowed by SB 126) amounted to $1.90 for NFs and $1.19 for NF-MHs. The wage pass-through factor was then added to each facility's current Medicaid rate and is being paid out as services are billed.

SB 126 requires that nursing facilities participating in the program file quarterly reports within 45 days of the end of each quarter. Reports were created that provide for documentation of the enhancements that a facility implements with the wage pass-through money. Forms are included for reporting wage increases, benefits, and new staff enhancements. Based on the information collected, KDOA is able to closely monitor program expenditures.

The program was implemented effective September 1, 1999 and the first quarterly report reflecting expenditures for September was due on or before November 15, 1999. KDOA staff are currently finishing the review process for the first set of reports and are beginning to receive the second set which will cover the period from October 1 to December 31, 1999. Each report is reviewed for accuracy and the information provided is verified by supporting documentation, which includes payroll registers and state unemployment tax reports. When errors are discovered or there is insufficient supporting documentation, expenditures are adjusted and the facility is notified in writing.

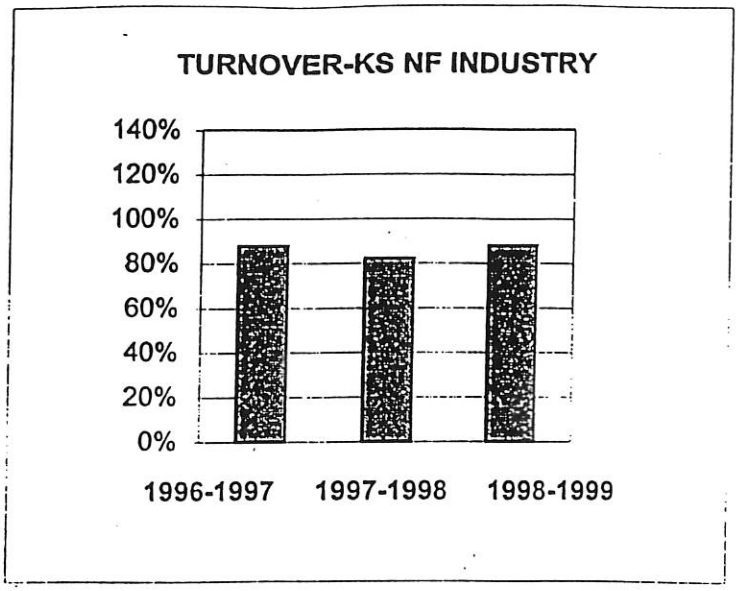
Validated expenditures will be accumulated through the end of state fiscal year 2000. After final reports have been received and reviewed, there will be a one-time settlement to charge facilities for wage pass-through dollars that were received but not earned. Facilities that overspend will not receive an adjustment.

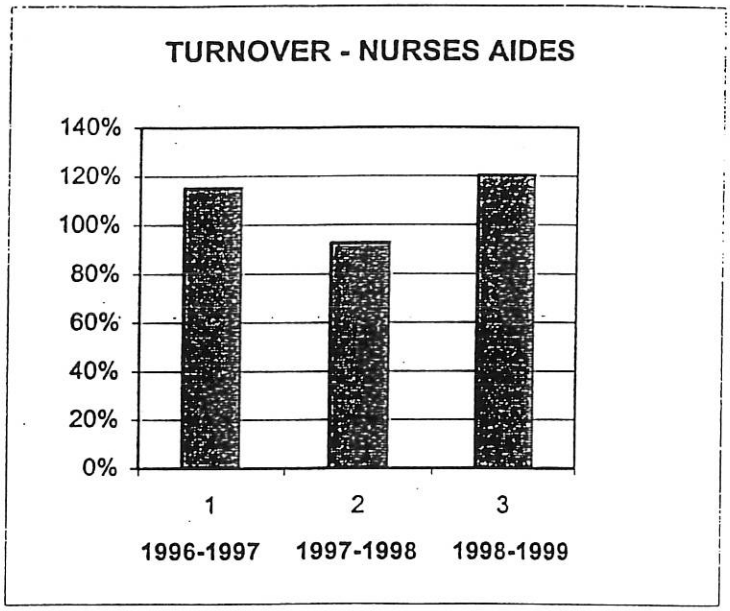
Some observations have already been made on the use of program funds. An initial review of the quarterly reports showed that most facilities chose to use the funds to raise the wages of frontline staff. Other uses have included adding new positions, increasing benefit contributions, and establishing new benefits for employees.

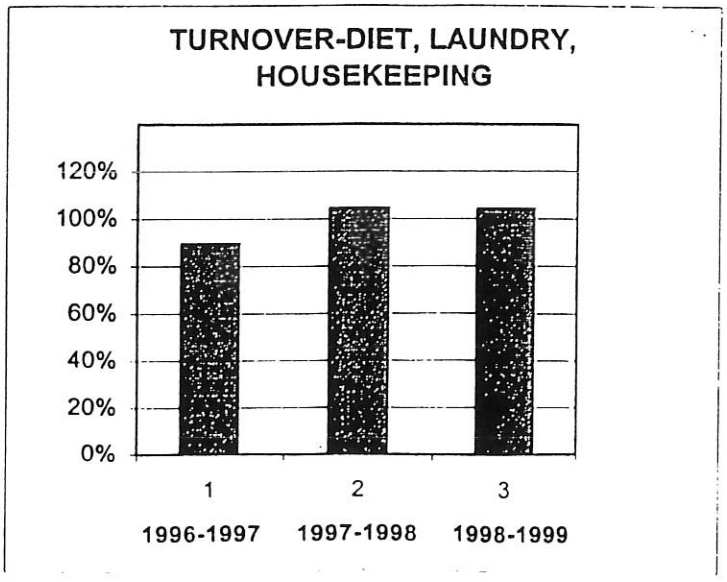
Staff turnover in the nursing facility industry has been a major problem, especially for those staff often directly responsible for resident care. During fiscal years 1997, 1998, and 1999, turnover for the industry statewide has been at 88%, 82%, and 88% respectively. Additionally, positions with salaries typically at or near minimum wage tend to have even higher rates of turnover. For example, turnover for nurse aides during these same three years was 115%, 93%, and 120%.

A report form collecting information on turnover has been incorporated into each quarterly pass-through report. This report includes data on employees in each of the 9 target positions (nurse aides, medication aides, restorative-rehabilitation aides, licensed mental health technicians, plant operating/maintenance personnel, dietary personnel, laundry staff, housekeeping staff, and activity staff). Data collected on employee turnover will be used to calculate turnover statistics for facilities participating in the program.

We will be analyzing the information collected on turnover both regionally and statewide to determine the impact of the pass-through program. KDOA also plans to follow up with nursing facilities that reflect a constant low turnover rate to assess what other factors may be prevalent. Data collected in the September quarterly report will serve as a baseline for the program. Data from the second set of quarterly reports, which are due February 14, 2000, should be processed by mid April. The information collected from the second quarter will assist KDOA in determining the effectiveness of the wage pass-through in reducing turnover.


TURNOVER-KS NF INDUSTRY
140%
120%
100%
80%
60%
40%
20%
0%
1996-1997
1997-1998
1998-1999


TURNOVER - NURSES AIDES
140%
120%
100%
80%
60%
40%
20%
0%
1
2
3
1996-1997
1997-1998
1998-1999


TURNOVER-DIET, LAUNDRY, HOUSEKEEPING
120%
100%
80%
60%
40%
20%
0%
1
2
3
1996-1997
1997-1998
1998-1999

ADULT CARE HOME
TURNOVER SUMMARY REPORT
JUNE, 1996 - JUNE, 1999

1996-1997

CLASSIFICATIONS	BEG # OF EMPL	EMPL HIRED	EMPL TERM	OTHER	END # OF EMPL	TURNOVR
Administration	1,440	477	443	6	1,468	31%
Plant Operating	707	366	367	1	705	52%
Diet/Laundry/Housekeeping	7,763	6,781	6,964	(152)	7,732	90%
Nurses (RN & LPN)	4,868	3,462	3,221	77	5,032	66%
Aides/Licensed MH Techs	10,819	12,604	12,471	(20)	10,972	115%
Other*	2,300	1,578	1,064	432	2,382	46%
Total	27,897	25,268	24,530	344	28,291	88%

1997-1998

CLASSIFICATIONS	BEG # OF EMPL	EMPL HIRED	EMPL TERM	OTHER	END # OF EMPL	TURNOVR
Administration	1,487	629	593	-	1,523	40%
Plant Operating	698	342	334	-	706	48%
Diet/Laundry/Housekeeping	7,544	7,832	7,891	(195)	7,680	105%
Nurses (RN & LPN)	4,929	3,204	3,061	(58)	5,130	62%
Aides/Licensed MH Techs	10,666	11,472	9,904	2,023	10,211	93%
Other*	2,593	1,397	1,200	7	2,783	46%
Total	27,917	24,876	22,983	1,777	28,033	82%

1998 - 1999

CLASSIFICATIONS	BEG # OF EMPL	EMPL HIRED	EMPL TERM	OTHER	END # OF EMPL	TURNOVR
Administration	1,433	593	561	-	1,465	39%
Plant Operating	676	340	347	-	669	51%
Diet/Laundry/Housekeeping	6,627	7,632	6,906	-	7,353	104%
Nurses (RN & LPN)	4,852	2,924	3,014	-	4,762	62%
Aides/Licensed MH Techs	9,740	12,171	11,726	-	10,185	120%
Other*	2,530	577	239	-	2,868	9%
Total	25,858	24,237	22,793	-	27,302	88%