Approved :February 11, 2003
Date

MINUTES OF THE SENATE PUBLIC HEALTH & WELFARE COMMITTEE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on January 22, 3003 in Room 231-N of the Capitol.

All members were present except:

Committee staff present: Mr. Norm Furse, Revisor of Statutes
Ms. Margaret Cianciarulo, Administrative Assistant

Conferees appearing before the committee: Mr. Kevin Robertson, Kansas Dental Association
Mr. Mike Heim, Legislative Research

Others attending: see attached guest list

Recognitions

Upon calling the meeting to order, Chairperson Wagle welcomed Senator Karin Brownlee, the new Committee Member replacing Senator Sandy Praeger.

Introduction of Bills

The Chair then stated that before the overview of the long term care services task force, she did want to have bill introductions. For the first bill she called upon her Vice-Chair, Senator Jim Barnett to explain the bill that he brought to the Committee.

Senator Barnett announced he would be introducing a bill dealing with the transfer of hospital assets and a creation of a foundation based upon this act that would deal with the sale of Health Midwest. Before he explained the bill, he wanted to take a special pause to express appreciation on the part of the entire Public Health &Welfare Committee for the cooperation between the Governor's office and the Attorney General's office on this proposal, having worked closely together.

Senator Barnett then went on to say that as of yesterday, January 21, 2003, a settlement was reached with Missouri which only gave the State of Kansas 10% of the hospital assets. The feeling was, that this was an unfair amount and it should be more in the line of 20%. The Governor's office and the Attorney General's office have agreed upon a recommended introduction of this bill to create a foundation.

This foundation would consist of 18 members:

Five Governor appointees,
Five from the Attorney General,
Three from the Senate President,
Three from the Speaker of the House,
One Minority Leader in the Senate, and
One Minority Leader in the House of Representatives.

He concluded by stating special language was included in this bill so that the foundation could not be involved in any type of political activity and that in essence was the bill.

Chairperson Wagle then asked if there were questions or comments of the Committee about the bill. Senator Haley echoed some of Senator Barnett's comments and concern about equity and the ability for two branches of our government to work together, the Governor and the Attorney General and seconded the motion to introduce the bill. The Chair then said that there was a motion by Senator Barnett to introduce this bill and a second by Senator Haley. The motion carried

She then stated that this bill was on the fast track and that there would be a joint republican and democratic caucus after they meet on the Senate floor today with the intention of moving it through the Senate and the Committee of the Whole.

The Chair then recognized Mr. Kevin Robertson, Kansas Dental Association, who stated that he had a bill that the Kansas Dental Association and the Kansas Dental Hygienists Association, had been working on for a year. This bill would allow dental hygienists, who are qualified, to acquire a permit and work in schools, nursing homes, health clinics, correctional facilities, homebound care, and so on, under a lesser amount of supervision than they currently work under. A copy of the bill draft is (Attachment 1) attached hereto and incorporated into the Minutes by reference.

The Chair then asked for questions of the Committee about the bill draft. As there were none, Senator Salmans made a motion to introduce the bill. Senator Jordan seconded and the motion carried.

Overview - Long Term Care Services Task Force Recommendations

As there were no more bill introductions, the Chair recognized Mr. Mike Heim from Legislative Research, to present a "Report of the long-term Care Services Task Force to the 2003 Kansas Legislature. Mr. Heim began by providing some background information on the long-term Care Task Force, how the members are picked, the actual membership, the task force's activities, conferee concerns and issues, EBRI Study (income needs of the elderly) and its results, Kansas ElderCount 2002, year 3 - conclusions and recommendations, year one goals, defined long-term care and six goals to be achieved by the end of 2005. A copy of his report is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

The Chair then asked for questions or comments from the Committee for Mr. Heim. Questions were asked from Senators Barnett and Brownlee regarding durable medical equipment (how much of this could be recouped and is legislation needed to bring this about), and in recommendation one, there are two agencies being asked to work together in their data collection (SRS & KDHE), why would data not be collected under the Department of Aging. As the Committee's Revisor and some Committee members had to leave early, Chairperson Wagle said that these questions will be brought to the Committee at a later date, and copies of the bills that have been written will be brought to the Committee for introduction hopefully by sometime next week.

Adjourned

As there was no further business, the meeting was adjourned. The time was 2:15 p.m.

The next meeting is scheduled for January 23, 2002.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

37 in att.

GUEST LIST

DATE: January 22, 2003

NAME	REPRESENTING
Don Gaches	KDHA
Rick Guthrie	Health Midwest
Josie Torrez	KACIL
Gina McDonald	KACIL
Carla Lehmer	The Cedars Inc
Linda Peters	Bethesda Home. Gorsse I
Lee Wedell	The Cedars, Inc.
JACLYN REISH	SRS/HCP/CSS
Matt Hickam	LTC Ombudsman office
KEVIN ROBERTSON	KANSAS DENTAL ASSN.
Shali Sweeney	K.D.O.A.
Patrice Maben	KDHE
Frank Kopecky	Larksfield Place
Vicki Wilson	Larksfield Place
Connie Burns	Dameron & Assoc.
Brad Burke	P.T.'s
Robert Moser MD	Kansas Academy Family Physicians
Jan Byrnes	Ass Sr. St Programs
Cindy Lash	Legislative Post Audit

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: 1-22-03

NAME	REPRESENTING
Linda Kenney	KDHE
JERRY UNRUH, ADM	PRESCOTT COMM HOSP DIST NO 1
RALPH L. GARRISON	" " " "
Janice Rutherford	Sen. pres. office
Bob Williams	Ks. Pharmacists Assoc
	KGC

Att 1

Kansas Dental Association / Kansas Dental Hygienist Association

65-1456. Dental hygienists; suspension or revocation of licenses, when; notice and hearing; practice of dental hygiene defined; rules and regulations; supervision defined; issuance of permits for dental screening; authorized activities, requirements.

(a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) The practice of dental hygiene shall include those educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci. Included among those educational, preventive and therapeutic procedures are the instruction of the patient as to daily personal care, protecting the teeth from dental caries, the scaling and polishing of the crown surfaces and the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus and such additional educational, preventive and therapeutic procedures as the board may establish by rules and regulations.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under the provisions of K.S.A. 65-1423 and amendments thereto.

(d) Except as otherwise provided in this section, the practice of dental hygiene shall be performed under the direct or general supervision of a licensed dentist at the office of such licensed dentist. The board shall designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under general supervision of a licensed dentist. As used in this section: (1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance; and (2) "general supervision" means a Kansas licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the 12 calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under part (2) of this subsection.

(e) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility, client or patient thereof so long as:

(1) A licensed dentist has delegated the performance of the service, task or procedure;

(2) the dental hygienist is under the supervision and responsibility of the dentist;

Senate Public Health & Welfare Committee
Date: January 22, 2003
Attachment 1

(3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care;

(4) the supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during the 12 calendar months preceding performance of the procedure; and

5) nothing in this subsection (e) shall be construed to prevent a dental hygienist from providing dental ~~education~~ ***hygiene instruction or visual oral health screenings*** in a school ***or community based*** setting.

(f) The practice of dental hygiene may be performed at a public school or accredited non public school , as defined in KSA 72-89b02, and amendments thereto, head start program, state correctional institution, local health department or indigent health care clinic, as defined in KSA 65-1466, on a student who meets the requirements of medicaid, healthwave or the federal free and reduced lunch program, an inmate, client or patient thereof so long as:

1) the dental hygienist has received an "extended care permit I" from the Kansas Dental Board specifying that the dental hygienist has performed 1,800 hours of dental hygiene care or has been an instructor at an accredited dental hygiene program for four semesters during the three years prior;

2) the dental hygienist shows proof of professional liability insurance;

3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit;

4) the tasks and procedures are limited to: a) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; b) the application of fluoride; c) dental hygiene instruction, d) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries; and other abnormalities, and; e) other duties as may be delegated verbally or in writing by the sponsoring dentist consistent with this act.

5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute comprehensive dental diagnosis and care;

6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in subsection (f);

7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in subsection (f);

8) nothing in this subsection (f) shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health screenings in a school or community based setting.

(g) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, or at the home of a homebound person who qualifies for the federal Home and Community Based Service (HCBS) Waiver on a resident of a facility, client or patient thereof so long as:

1) the dental hygienist has received an "extended care permit II" from the Kansas Dental Board specifying that the dental hygienist has: a) performed 1,800 hours of dental hygiene care or has been an instructor at an accredited dental hygiene program for four semesters during the three

years prior, and; b) completed six hours of training on the care of special needs patients or other training as may be accepted by the board;

2) the dental hygienist shows proof of professional liability insurance;

3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit;

4) the tasks and procedures are limited to: a) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; b) the application of fluoride; c) dental hygiene instruction; d) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities, and; e) other duties as may be delegated verbally or in writing by the sponsoring dentist consistent with this act.

5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute comprehensive dental diagnosis and care;

6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in subsection (g);

7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in subsection (g);

8) the dental hygienist completes a minimum of six hours of education in the area of special needs care within the board's continuing dental education requirements for relicensure, and;

9) nothing in this subsection (g) shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health screenings in a school or community based setting.

~~(f) The board may issue a permit to a licensed dental hygienist to provide dental screening under such terms and conditions as the board may reasonably establish in such permit. Such permit shall be subject to renewal at the time the license for dental hygiene is renewed.~~

~~(g)~~ *(h)* In addition to the duties specifically mentioned in subsection (b) of K.S.A. 65-1456, and amendments thereto, any duly licensed dental hygienist may:

(1) Give fluoride treatments as a prophylactic measure, as defined by the United States public health service and as recommended for use in dentistry;

(2) remove overhanging restoration margins and periodontal surgery materials by hand scaling instruments; and

(3) administer local block and infiltration anaesthesia and nitrous oxide. (A) The administration of local anaesthesia shall be performed under the direct supervision of a licensed dentist. (B) Each dental hygienist who administers local anaesthesia shall have completed courses of instruction in local anaesthesia and nitrous oxide which have been approved by the board.

~~(h)~~ *(i)* (1) The courses of instruction required in subsection (g)(3)(B) of K.S.A. 65-1456, and amendments thereto, shall provide a minimum of 12 hours of instruction at a teaching institution accredited by the American dental association.

(2) The courses of instruction shall include courses which provide both didactic and clinical instruction in: (A) Theory of pain control; (B) anatomy; (C) medical history; (D) pharmacology; and (E) emergencies and complications.

(3) Certification in cardiac pulmonary resuscitation shall be required in all cases.

Report of the Long-Term Care Services Task Force to the 2003 Kansas Legislature

CHAIRPERSON: Representative Melvin Neufeld

VICE-CHAIRPERSON: Senator Sandy Praeger

OTHER MEMBERS: Senators Chris Steineger, Susan Wagle, Janis Lee, and Paul Feleciano, Jr.; Representatives Bob Bethell, Garry Boston, Nancy Kirk, and Judy Showalter

NON-LEGISLATIVE MEMBERS: Mark Bailey, Evie Curtis, Janis DeBoer, Martha Hodgesmith, Linda Lubinsky, Patricia Maben, Carol Moore, Bob Smith, Beth Stover, and Ray Vernon

STUDY TOPICS

Year Three Report

December 2002

Task Force on Long-Term Care Services

YEAR THREE REPORT

CONCLUSIONS AND RECOMMENDATIONS

The Task Force reaffirms the six broad goals and the policy directions and strategies adopted in its first year of existence. The Task Force believes progress is being made on providing greater freedom of choice for recipients of long-term care services. Year three stands out as a year where major progress was made on compiling needed demographic and other statistical information for informed decision making regarding long-term care services.

Proposed Legislation: None

BACKGROUND

Long-Term Care Task Force Created

HB 2780 enacted by the 2000 Legislature and codified at KSA 65-6206 created a 20-member Task Force on Long-Term Care Services to study:

> ". . . state and federal laws and rules and regulations which impact on the services provided by the government and the private sector to citizens who are consumers of long-term care services, the financing of these services, both public and private, the effectiveness of partnering activities between state agencies and long-term care providers, and such other matters as relating thereto the Task Force deems appropriate."

The bill later defines long-term care as including a broad spectrum of supports, ranging from skilled nursing services to assistance with activities of daily living or help with instrumental activities of daily living.

Seven members of the Task Force are appointed by the Legislative Coordinating Council (LCC). Three of these appointees must be consumers of long-term care, three providers of long-term care, and one a trustee or board member of a long-term care facility. Of these seven, no more than two members may reside in any one congressional district.

The Chairperson and Vice Chairperson of the Task Force are appointed by the LCC from among the members of the Task Force. The Chairperson is to be a legislative member.

Two members are appointed by the President of the Senate and the Speaker of the House. Of the two appointments, one is to be a member of the Senate Committee on Ways and Means and one a member of the House Committee on Appropriations. The appointees must be from different political parties.

An additional two members are

appointed by the Senate President, and the Minority Leader of the Senate is to appoint two members. In each case, one appointee must be a member of the Senate Committee on Public Health and Welfare and one a member of the Senate Committee on Financial Institutions and Insurance.

Two members are appointed by the Speaker of the House and two members are appointed by the Minority Leader of the House. In each case, one appointee must be a member of the House Committee on Health and Human Services and one a member of the House Committee on Insurance.

The Secretaries of Social and Rehabilitation Services (SRS), Aging, and Health and Environment (KDHE) or their designees make up the remaining members of the Task Force.

The Task Force is required to submit a report and recommendations to the Governor and Legislature on or before the second Monday of January each year through 2005, the year in which the statute creating the Task Force will expire. In developing recommendations, the Task Force is to consider creative, common sense solutions and approaches to problems that do not necessarily require additional expenditures.

Membership of the Long-Term Care Task Force

The current membership of the Task Force appears in the following box.

Legislative Members

Rep. Melvin Neufeld, Chairperson
Sen. Paul Feleciano
Sen. Janis Lee
Sen. Chris Steineger
Sen. Susan Wagle
Sen. Sandy Praeger, Vice Chairperson
Rep. Bob Bethell
Rep. Garry Boston
Rep. Nancy Kirk
Rep. Judy Showalter

Nonlegislative Members

Mark Baily, Via Christi Services
Evie Curtis, Kansas Advocates for Better Care
Linda Lubensky Kansas Home Care Association
Carol Moore, ANP (Gerontology) Mennonite Friendship Manor
Bob Smith, Alzheimer Association
Sister Beth Stover, North Central Flint Hills AAA
Ray Vernon, Wesley Towers
Janis DeBoer (Aging)
Martha Hodgesmith (SRS)
Patricia Maben (KDHE)

Task Force Activities

The Task Force met six days during calendar year 2002. A one-day meeting was held in July where results of the Employee Benefits Research Institute (EBRI) study regarding the income needs of elderly Kansans was presented to the Task Force and the Governor. The study was conducted jointly by EBRI and the Milbank Memorial Fund, an endowed philanthropic foundation. The study is described in a separate section.

A two-day meeting was held at the beginning of September. The first day was devoted to hearing from conferees concerning the increasing costs of liability insurance for long-term care providers.

Conferees who appeared included representatives of the Kansas Department on Aging (KDOA); the Kansas Association

of Homes and Services for the Aging; a representative of a long-term care facility for the elderly; a Kansas insurer for long-term care; and representatives of the Irwin Siegel Agency, a national insurer for community based long-term care services for the disabled.

Conferees expressed concern that nursing home survey results were being used as an underwriting tool by insurance companies to determine insurance rates and as evidence in liability suits against nursing homes. Several conferees pointed out that increasing liability insurance premiums, a national issue, can be attributed in part to the declining stock market and the September 11, 2001 terrorist attacks. One conferee noted the insurance premium for his 169-bed facility will be $63,000. He said rising insurance rates were causing some facilities to go bare—without insurance. One conferee, among other things, suggested that the use of survey results in civil lawsuits should be prohibited, and that standards of care and qualified immunity should be codified.

Task Force members on the second day of the September meeting attended the Kansas Health Policy Forum where a representative of the Urban Institute of Washington, D.C., discussed issues regarding financing long-term care services.

Three meetings were held in early November over a two-day period. The meetings were held in Hays, Hutchinson, and Winfield, and consisted of a series of briefings as well as public forums. The briefings included the public release of the just completed "Kansas ElderCount 2002" report which is described in a separate section, briefings on Task Force activities and goals and briefings by representatives of SRS and KDOA.

More than 30 people representing a variety of groups and agencies which provide services to the elderly and the disabled addressed the Task Force during the course of the public forums in the three cities. Over 150 persons attended the meetings.

A variety of issues and ideas were presented to the Task Force which included the following:

- The importance, value and contribution to society made by the elderly and the disabled who need long-term care services;
- The need to fully fund programs that allow individuals to remain independent and to determine their own destiny;
- The problem which would be created by increasing the PASSAR (level of care) scores to decrease eligibility for services;
- The need for more respite care for family caregivers;
- The need to provide the less costly services in a timely fashion to prevent the need for more expensive entitlements services, *i.e.,* nursing home; and
- The value of socialization, nutritious meals, and senior centers; active lives and independence.

EBRI Study: Income Needs of the Elderly

A ground-breaking study that estimates total projected retirement income and expenses finds that Kansas residents currently between the ages of 38 and 66 will, on average, face expenses that exceed income by at least $10,000 during their retirement years, was presented to the Task Force and the Governor at the Task Force's July

meeting. The study was conducted by the nonpartisan EBRI and the Milbank Memorial Fund. The study found that the projected income deficit in Kansas is more than $20,000 annually for single women; however, the category of married couples fairs the best. By 2031, the aggregate annual deficit for retired Kansans could be in the $700 million range.

See the full report that is available on the EBRI Website at:

www.ebri.org/pdfs/kansas.pdf

As the post-World War II baby boom generation begins to retire, the United States is expected to see a surge in the number of elderly over the next 20 years that will lead to significant cost increases in programs that retired Americans rely on Social Security and Medicare. This demographic problem is already acute in some other industrialized nations, however, the report indicates that the United States still has time to undertake actions before the financial crisis becomes acute.

For government, this could allow smaller changes now instead of bigger, more painful changes later. For business, early action increases the likelihood of future retirees having income and assets to spend in a consumer-driven economy. While the nation must face these issues as a whole, they also will present challenges for states and localities, and for public- and private-sector decision makers. Yet, analysis of future economic well-being of the retired population at the state level has been very limited due to the unavailability of the necessary data and models to perform the analysis.

EBRI and the Milbank Memorial Fund, initially working with the Oregon Governor's office, set out to see if this situation could be addressed for Oregon. The results released in 2001 made it clear that major decisions lie ahead if the state's population is to have adequate resources in retirement. Kansas was chosen as the second state to be assessed, and additional capabilities were added to the model for the Kansas assessment. Additional states will be analyzed in the future.

One of the key variables in the Kansas study affecting estimates for individuals is how house equity is allocated. The homes Americans own are often their most valuable financial asset. The elderly's housing equity was included in their retirement income sources and total expenditures were divided into expenses they all face each year (food, housing, and certain health expenditures), and those that only some elderly will experience in any given year (home-based health care and nursing facility care).

Results of the study are presented for three different assumptions on housing equity and Social Security benefit payments in the future. Housing equity is either assumed to be not liquidated, annuitized at normal retirement age (turned into a regular stream of income), or liquidated as needed. The Social Security benefits for retirees will be at current-law benefit levels, reduced benefits that could be fully funded from the current tax rate, or a combination of tax increases and increases in the normal retirement age (results also are given under different Social Security reform proposals).

Among the major findings of the EBRI/Milbank study:

- Assuming today's Social Security benefits, a single female Kansan in the 1936-1940 birth cohort would ultimately be expected to accumulate an average present-value deficit of $32,484 from age 65 until death, after paying for health and long-term care, food, and housing costs, if Medicaid pays in the future for custodial long-term care for the indigent what it pays for now (assuming the various thresholds are adjusted for inflation). Single males and both members of a married family would ultimately be expected to accumulate on average a present value deficit of slightly more than $19,000. If these same Kansans are assumed to annuitize their net housing equity at age 65 (perhaps by taking out a reverse mortgage that provides monthly income), the present-value of the aggregate deficits decrease to an ultimate value of $30,897 for single females and slightly more than $18,000 for single males and family members. However, if housing equity is assumed to be liquidated as needed, the present value of the ultimate deficits drops even further: $28,620 for single females, $14,198 for single males, and $10,212 for family members.

- Nominal annual deficits are simulated for all Kansas residents age 65 and over after Medicaid reimbursements, assuming status quo as well as current-law Social Security benefits, where current retirees are similar to the oldest cohort of workers. The results varied by housing equity scenario: the annual deficit for 2003 was estimated to be $168 million if housing equity is liquidated as needed to meet potential deficits, $263 million if all housing equity is annuitized at age 65, and $291 million if housing equity is never liquidated. By the year 2031, the corresponding values are estimated to have increased to be $478 million if housing equity is liquidated as needed to meet potential deficits, $659 million if all housing equity is annuitized at age 65, and $693 million if housing equity is never liquidated.

Although the actual values of the ultimate deficits are a function of the birth cohort, gender, family status, and choice of assumptions for Social Security and liquidation of housing equity, certain themes remain fairly constant across the scenarios:

- Single females can be expected to have a substantially larger ultimate deficit than either their single male or married counterparts—in some instances, nearly twice as much.

- Assuming that housing equity is annuitized at age 65 reduces the ultimate deficits, but not nearly as much as assuming that housing equity is liquidated when first needed to prevent a deficit.

Deficits are lowest under the current Social Security law assumptions. They increase somewhat under different Social Security reform proposals.

Kansas ElderCount 2002

The results of the Kansas ElderCount project was presented to the Task Force at its November meeting in Hays, part of a three-city public forum effort of the Task Force.

The mission of Kansas ElderCount is to collect and disseminate data describing the well-being of older adults for the

enhancement of public policy, program planning, and general understanding.

The need for county data describing older adults became clear at a spring 2000 meeting of the Kansas Task Force on Long-Term Care Services, moderated by Monsignor Charles Fahey of the Milbank Memorial Fund. During the meeting, a wall chart (*Aging in Kansas*) produced by the Center on Aging at the University of Kansas Medical Center was circulated. The wall chart contained social and demographic data from the 1990 census, at the county level. Task Force members from the Kansas House of Representatives and Senate began looking up their counties on the wall chart and comparing the data among counties. The data stimulated discussion and questions about the status of older adults. The Task Force chairperson and co-chairperson decided that the legislature, program planners, and the public needed an older adult version of Kids Count.

In the fall of 2000, The Kansas Health Foundation, a Wichita-based philanthropic organization dedicated to improving the health of all Kansans, awarded funding to the Center on Aging at KU Medical Center to spearhead the development of Kansas ElderCount. A statewide 32-member Advisory Committee was convened to help identify, prioritize, and secure data. This chart book and the accompanying wall chart can be found at:
http://www2.kumc.edu/coa/eldercount.

Other project partners besides the Task Force, the KU Center on Aging and the Kansas Health Foundation are KDOA and the Milbank Memorial Fund, the latter of which provided money to publish the study.

The intended audience for Kansas ElderCount are:

- Program planners and community advocates seeking county-level data that will facilitate their ability to plan and deliver services on behalf of older adults.

- Educators wanting to share information about older adults and the communities in which they live, with students of all ages.

- Members of the Kansas State Legislature. State Senators and Representatives making important policy decisions, in particular, concerning the provision of long-term care services, as members of the Baby Boom generation (born 1946-1964) age into older adulthood. It is essential that current and high quality data are available to help legislators make informed policy decisions.

There are three ElderCount products: the chart book, a wall chart, and a Website. Data in ElderCount are grouped into five categories: population, economics, health, community living, and nursing homes. There are 36 indicators (variables) in the chart book reported for the 105 counties, 11 Area Agencies on Aging, and the State of Kansas.

In the wall chart, data are reported for counties and the state. The purpose of the wall chart is to facilitate comparison among counties (the data are presented in columns). There is overlap between the variables in the chart book and the wall chart (although not all chart book variables are on the wall chart). The wall chart also includes variables that are not in the chart book.

The Website contains the entire chart book and the wall chart for people to read on-line or download.

Basic demographic data describing the age structure, sex distribution, and racial makeup of the State of Kansas is a backdrop to putting ElderCount information into perspective. With 2,688,418 people, the state of Kansas constitutes about 1 percent of the United States population. The population is dispersed among 105 counties. One-third of all Kansans live in two counties, Johnson and Sedgwick, each with 17 percent of the state's population. Wyandotte and Shawnee each contain 6 percent of Kansans. On the other hand, 68 counties have less than one-half of 1 percent of the Kansas population.

The majority (64) of Kansas counties contain fewer than 2,000 older adults and 34 counties have 1,000 fewer people age 65 or older. In fact, only five counties have more than 10,000 people age 65 or older:

1.	Sedgwick	51,574
2.	Johnson	45,069
3.	Shawnee	23,341
4.	Wyandotte	18,520
5.	Reno	10,618

Many rural counties have been experiencing a steady decline in total population for decades. The challenges of maintaining independence and autonomy in older adulthood vary by geographic locale. Older adults in rural areas and their families face a unique set of challenges when it comes to accessing health care and receiving community-based long-term care services.

The following population data are reported in the ElderCount chart book:

- Population, 65+
- Race: nonwhite, 65+
- Hispanic, 65+
- Men and Women, 85+
- Registered to vote, 65+

The ElderCount chart book includes the following economic indicators:

- Labor force participation;
- Medium household income;
- Persons living in poverty;
- Medicaid enrollment;
- Total social security payments to persons age 65+; and
- Percentage of the area's total personal income from social security benefits to persons 65+.

The ElderCount book indicates the following health data:

- Mammography—annual rates;
- Hospitalization for cardiovascular care;
- Hospitalization for hip fracture; and
- Number of people 18+ per primary care physician.

The ElderCount book includes the following community living data:

- Percentage of 65+ living alone;
- Indicators of disability;
- In-home public long-term care services;
- Medicaid services for frail elderly;
- Medicaid average individual monthly payment; and
- Assisted living beds.

In regard to nursing homes, the ElderCount book contains the following:

- Beds (licensed) and occupancy rate;
- Residents, 65+;

- Residents (men and women reported separately), 75+;
- Residents, 65+ (total during 2000);
- Medicaid, 65+ (total during 2000); and
- Medicaid average monthly payment.

YEAR THREE
CONCLUSIONS AND RECOMMENDATIONS

The Task Force believes that progress is being made in regard to implementing the goals established by this Task Force in Year One; in regard to making Kansas more aware of long-term care needs of their fellow citizens, and in regard to bringing about a climate for needed change at the local, state, and federal levels.

The Task Force however, believes that much more must be done both in the short term and in the long term to bring about needed changes. The following are the specific recommendations of the Task Force as it concludes its third year of existence:

- The Task Force believes that there is a general perception that the makeup of the Task Force itself and its focus is primarily on the long-term care needs of elderly Kansans. The Task Force believes its makeup should be expanded to include one or more additional members that represent the interests of younger recipients of long-term care services, *i.e.* those persons other than the frail elderly. The Task Force asks the appropriate standing committee of the Kansas Legislature to introduce such a bill and that it receive favorable consideration by the 2003 Legislature.

- The Task Force on Long-Term Care is concerned about the federal forms and their use in the survey process (inspections) of Kansas nursing homes. The form (HCFA 2567) is a U.S. Department of Health and Human Services form that state surveyors (inspectors) use to record the results of their surveys or inspections. The federal regulations require that the statement of deficiencies is to be written in terminology specific enough to allow a reasonably knowledgeable person to understand the regulatory requirements that are or are not met. In the event there are no deficiencies cited, a statement to that effect is to be included on the HCFA 2567. If deficient practices are identified, the form (first column) contains a prefix tag (F Tag). The second column on the form is used to record a summary of the evidence of noncompliance and supporting observations. The documentation must be written in language specific enough to identify the scope and severity of the noncompliance. Surveyors are required to follow principles of documentation as set forth in the federal Health and Human Services manual. This federal manual was developed to ensure that the deficient practice statements would be strong evidence to use in administrative appeal hearings and court hearings.

The Task Force notes that representatives of the Milbank Fund have initiated a discussion with the U.S. Department of Health and Human Services about the nursing home inspections form and the inspection process to encourage a more collaborative model of inspection. In addition, several states have entered into similar

discussions with the federal agency regarding this issue.

The Task Force believes the survey process and the HCFA 2567 form are a major factor driving the increased liability insurance costs for nursing homes.

The Task Force agreed that Senator Praeger, the Chairperson, should write a letter to the group of states discussing the survey process with the federal agency and offer the support and encouragement of the Task Force. Further, the Task Force authorized Senator Praeger to send a letter listing the Task Force concerns about the nursing home survey process and the use of HCFA 2567 to the Secretary of the U.S. Department of Health and Human Services.

The Task Force considered recommending legislation that would prevent the use of the survey form HCFA 2567 as evidence in civil liability suits against nursing homes. At least one state, Ohio, has enacted legislation prohibiting the use of survey results in civil lawsuits against nursing homes. The Task Force, after deliberation, rejected this idea.

- The Task Force recommends that legislation be introduced to amend KSA 39-709(g)(2)(B) dealing with recovery from estates of persons who had been receiving Medicaid benefits to shield from recovery the amount paid for long-term care by long-term care insurance purchased by the Medicaid recipient.

The Task Force makes the above recommendation with the recognition that such legislation may not be permitted under federal law at this time. The Task Force has requested KDOA and SRS to review the federal law on this issue to determine if this request for legislation should be pursued.

- The Task Force recommends that a program be initiated where durable medical equipment which has been provided to Medicaid clients by the State of Kansas be recouped at the time the equipment is no longer needed or at the death of the client. The Task Force suggests further that any such equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles. The equipment could then be redistributed to other persons needing it by SRS. The Task Force asks that this recommendation be reviewed by the appropriate standing committee and that legislation be introduced if needed to implement this recommendation.

- The Task Force recommends that a loophole within the Medicaid recipient estate recovery law be closed regarding burial plots. Last year the Legislature closed a loophole regarding prearranged services with the passage of SB 513. The Task Force believes some savings also could be achieved by legislation which would prevent surviving relatives of deceased Medicaid recipients from opting for cremation or a less expensive burial plot and retaining the money saved by such action. The Task Force recommends the appropriate standing committee introduce this legislation for consideration by the 2003 Legislature.

- The Task Force recommends the appropriate standing committees review the top three data gaps that

were identified in the *Kansas ElderCount 2002* study and consider the introduction of legislation, if needed, to fill these data gaps. These include:

- **Abuse, Neglect, and Exploitation.** Currently, there are no county-level data available that describe the number of older adults who experience abuse, neglect, or exploitation. Without such data, it is not possible to target areas of the state for improvement.

  Recommendation #1: SRS and the Kansas Department of Health and Environment (KDHE) should continue to work together in developing data collection systems that can report data on incidences of abuse, neglect, and exploitation in licensed health care settings and in the community. The data system should provide for the reporting of data at the county level.

- **Population Projections.** The State of Kansas needs an official set of population projections of the older adult population in order to plan appropriate services and set public policy.

  Recommendation #2: The Division of the Budget (DOB) should produce and disseminate county population projects for older adult men and women ages 65-70 and 80+. It also is recommended highly that the DOB produce and disseminate population projections for the 85-89 and 90+ age groups at the Area Agency on Aging level. The projections should be developed through the year 2040, and should be updated and disseminated every five years.

- **Difference between the Number of People Receiving Services and the Number Needing Services.** The need for nursing home care often can be prevented or postponed if older adults receive appropriate services in the community. The services can be provided by family members or friends (informal), or by community-based organizations (formal). (ElderCount reports the number of frail and low-income older adults receiving home and community-based care.) County data were not available, however, on the number of older adults in each county who wanted to receive services but did not, because they could not afford services, were on a waiting list for services, or services did not exist in their area. Such data are important for program planning.

  Recommendation #3: KDOA should collect and distribute county data describing the number of people who are eligible to receive HCBS/FE services but are not able to, and why.

- Additionally, the Task Force wants to remind the Legislature and the Executive Branch that the state should be aware that it is the major purchaser of long-term care services from providers in this state. The state by its purchasing decision can and does affect both the types of care and the quality of care that long-term care recipients will receive whether in the community or in a facility. Those decisions also can have a decided

impact on the availability of services. Inadequate reimbursement not only affects the providers fiscal viability but also their ability to recruit and retain necessary staff.

The Task Force believes that there are a number of excellent long-term care services and facilities around the state. There are cultural changes being incorporated in the way these facilities operate, not only for the elderly but also for the disabled. Residents and recipients of care are given more freedom to choose how to spend their time, how to organize their daily activities, what and when they eat, and a number of other choices. The Task Force believes these changes should be encouraged and that contracts between the state as purchaser of long-term care services should reflect these freedom of choice options for persons needing long-term care services.

- The Task Force is aware of the *sometimes* major increases in liability insurance costs that long-term care facilities are being required to pay. The Task Force urges the 2003 Legislature to work closely with the Kansas Insurance Commissioner to arrive at legislative solutions, if needed, to provide relief from these increasingly burdensome costs.

- The Task Force wants the 2003 Legislature to be aware of the overwhelming majority of persons who testified before the Task Force this past year who expressed their preference for in-home and community-based services regardless of the age of the persons—in other words it was the same message from the disabled community as well as the elderly community. On the other hand, there was a consensus of concern about the potential program cuts and the impact of these cuts on people of Kansas who have very real needs that will occur if budgets of SRS and the KDOA are further cut.

Finally, the Task Force wants to commend the local committees who have joined together to provide creative ways of meeting the needs of the elderly and the disabled in spite of money shortages. The Task Force urges the 2003 Legislature to look for ways to meet the needs for more community-based and in-home services. This may entail looking at the possibility of closing one more of the state's remaining institutions providing care for the developmentally disabled. The Task Force recognizes that it is very expensive to operate parallel community based options with state institutions.

Year One Goals Reaffirmed

The Task Force reiterates the following definition of long-term care and its conclusions formulated as six broad goals and the policy directions, strategies, and immediate actions attached to each goal of the Task Force developed in Year One.

> Long-term care is defined as providing assistance to meet needs of persons who are limited in their ability to function independently over an extended period of time.
>
> Assistance includes the informal network of families, friends, and community services as well as formal services such as social service agencies, home health agencies, supportive day care, assisted and residential living, and nursing homes. Professional care coordination is a critical

component of the long-term care system.

The Task Force, by consensus, arrived at six goals to be achieved by the end of 2005. The Task Force also determined an overall policy direction to be attributed to each of the goals. From each goal and policy direction several strategies were adopted to achieve the goal and one or more steps for immediate action to move toward achieving the goal were selected. The following is a listing of each of the six goals and the policy directives, strategies, and immediate action steps that attach to it. Steps that have been taken to date to achieve the goals, policy directions, and strategies are then described.

I. Goal No. 1. Establish a long-term care system which is understood and supported by Kansans; which recognizes the dignity and uniqueness of persons needing long-term care which promotes the need for healthy lifestyles; and which enables informed consumers to understand the possible outcomes of their choices.

Policy Direction. All Kansans should have a right to access accurate, timely, and understandable information regarding the Kansas Long-Term Care System.

Strategies and Immediate Action

- Develop an interactive Internet website to permit access to information regarding long-term care services available in Kansas; develop and disseminate brochures and related publications informing Kansans of long-term care services available; and develop and promote public service announcements regarding the Kansas Long-Term Care System.

- Investigate the feasibility of establishing a 2-1-1 telephone system for Kansas by implementing a pilot project in two areas, one urban and one rural, with live operators to disseminate long-term care information in non-crisis situations.

- Direct SRS to develop comparable data to the ElderCount book to include persons with physical and mental disabilities.

- The University of Kansas Medical Center's Center on Aging in conjunction with the KDOA should continue to update the demographic profile of the future Kansas aging population and begin to develop models to project future long-term care costs to serve these populations. SRS should cooperate with the above entities and develop similar future demographic profiles of the disabled populations and models to project future long-term care costs to serve these groups also. Every effort should be made to integrate these efforts with the ElderCount project that is currently in progress.

Progress to Date. KDOA and SRS have both made numerous improvements to their websites.

- KDOA is tracking the 2-1-1 activity. According to the Alliance of Information and Referral Systems (AIRS) magazine for August 2002, over 10 percent of the United States population can now access information through 2-1-1. They are striving for 50 percent by 2005. AIRS is working with the United Way of

America, who has enlisted the support of a marketing firm that has developed a new logo and is in the process of developing a marketing kit and awareness campaign. In Kansas, the 2-1-1 activity has been on hold for over a year while tariff rates are being set. The Kansas Corporation Commission (KCC) is involved in the rate setting procedure.

- The ElderCount project is completed, as noted in this report (Year 3). Updating the ElderCount information and developing comparable data to include persons with physical and mental disabilities remains a strategy of the Task Force.

- KDOA and SRS will review the federal law with regard to federal estate recovery legislation and determine if the request to amend KSA 39-709(g)(2)(B) can be pursued.

II. Goal No. 2. Provide an accessible, integrated, and comprehensive range of service options to meet consumer needs.

Policy Direction. An on-going process should be initiated that assesses the long-term care needs of Kansans and matches them with quality services whether publicly or privately funded.

Strategies and Immediate Action

- The Insurance Commissioner should be requested to examine the feasibility of an alliance between the State of Kansas and private insurers to offer long-term care insurance policies that are comprehensive and affordable to a broad range of individuals and report to the appropriate 2001 House and Senate standing committees.

Progress to Date. The Kansas Insurance Department submitted a report on the feasibility of an alliance between the State of Kansas and private insurers to offer long-term care policies. The report provides background on the issue, describes the State of Kansas long-term care insurance program for state employees, describes federal efforts to establish long-term care insurance for federal employees, describes certain problems and limitations in bringing about the proposed alliance, describes actions taken by the Kansas Insurance Department in this area, and discusses certain proposed incentives including state income tax incentives. The report concludes that there is no magic solution to creating one effective alliance between government and the insurance industry to provide long-term care insurance that is comprehensive and affordable to a broad range of individuals.

The Task Force was informed by SRS that long-term care insurance premiums are allowable against a person's spenddown for medical purposes just like health insurance premiums. It was noted that the state could create a program to pay for long-term care insurance coverage. The state would need to address the possibility that individuals who would likely be covered by such a program might be persons who expect to need services in the near future and the expense of a program could be considerable. Developing a program would have a number of challenges. It would be necessary to take into account the type of coverage offered as most long-term care insurance policies do not cover 100 percent of costs, have a number of limitations, and may be even more restrictive based on the age and medical condition of the potential insured person.

Medicaid provides full coverage and likely would still be needed as a supplement for things like drugs.

III. Goal No. 3. Provide high quality long-term care.

Policy Direction. The management, funding, and regulatory functions of the Kansas long-term care system should be accountable for the achievement of desired, specified, and measurable outcomes.

Strategies and Immediate Actions

- A user friendly, understandable system should be created to identify quality outcomes, customer satisfaction, and provide effective dispute resolution or grievance procedures for licensed facilities and agencies providing long-term care. KDOA is to be the lead agency in convening a group to include SRS, KDHE, the provider organizations, and advocacy groups.

- The survey process should be altered to insure the focus is on quality of care and consistency of the surveys (inspections) of long-term care facilities and agencies. The Task Force requests that a person from the Washington State Quality Assurance Nurse Program be brought to Kansas to present information to a joint meeting of the House and Senate Public Health and Welfare committees and the Task Force on Long-Term Care Services at the beginning of the 2001 Legislature.

- A study should be conducted by KDOA with the assistance of SRS, KDHE, and other appropriate parties including the Kansas Insurance Commissioner to determine the implication of survey results on liability insurance rate increases and nonrenewal of policies for long-term care facilities and agencies. The findings should be to the appropriate standing committees of the 2001 Legislature.

- The KDOA, as the lead agency, with SRS and KDHE, provider organizations, and advocacy groups, is requested to develop a proposal for a more formal system of continued coordination and monitoring of the long-term care services delivery system continually reassesses the service needs of Kansans, evaluates the quality of services provided, and insures needed changes are made in a timely fashion. The proposal for the system should be presented to the Task Force.

Progress to Date. The Task Force notes that a report is being prepared by the KDOA and the Kansas Insurance Department regarding the impact of survey (inspection) results on nursing home liability insurance premiums. See Goal 3, Strategy 3 above.

IV. Goal 4. Provide effective, efficient, and affordable services.

Policy Direction. The Kansas long-term care system should provide the appropriate level of service emphasizing personal responsibility, prevention, and home and community-based care which supports the informal network of family, friends, and neighbors, and clearly establishes the locus of funding responsibilities.

Strategies and Immediate Action

- An analysis of the current licensed Home Plus system should be made to determine its cost effectiveness.

- A format shall be developed to independently assess the role, function, and effectiveness of point of entry state contractors and providers of long-term care services and the appropriateness of their placements.

- A system should be established to monitor cost effectiveness of long-term care services.

Progress to Date. Legislation was enacted in 2002 to increase the number of individuals allowed in a home plan facility from five to eight and allows an adult care home to convert a portion of one wing to a home plan facility as long as separate licensure is maintained.

V. Goal No. 5. Support an adequate and effective work force.

Policy Direction. Incentives should be initiated that will assure adequate compensation, training, and career development to direct care workers in the Kansas Long-Term Care System.

Strategies and Immediate Actions

- The Task Force will examine the current reimbursement system at the beginning of the 2001 Legislative Session and make recommendations to the 2001 Legislature regarding modifications of the reimbursements for direct care workers in the long-term care delivery system.

- The Kansas Department of Human Resources (KDHR) should make an assessment of the successful training and retention programs that are available for long-term direct care workers in Kansas and nationally. In implementing this request of the Task Force, KDHR should make use of information obtained, under SCR 1606, passed by the 2000 Legislature. SCR 1606 requests the Governor to ask the various secretaries of Executive Branch agencies to examine the industrial training and retraining law and to identify funds available for training and retraining or continuing education of long-term care staff and report this information to the 2001 Legislature.

VI. Goal No. 6. Provide coordination and communication between the federal agencies, state agencies, and local agencies, and between the public and private sectors.

Policy Direction. Long-term care programs and policies should be developed through a broad-based, consensus building process involving all the key stake holders at all levels of government, the public and private sectors, as well as consumers and family members.

Strategies and Immediate Action

- Secure funding to hire a professional public relations firm to inform Kansans about long-term care needs and solutions.

- The Task Force should host a series of town meetings on the Kansas Long-Term Care System in the 2001 Interim. The town meetings will serve as a means to gather as well as to disseminate information about the need to further develop the Kansas Long-Term Care System.

Progress to Date. In regard to Goal No. 6, Strategy No. 2 calling for a series of town meetings on long-term care issues during the 2001 Interim, the Task Force did not undertake this strategy due to the cost of holding these meetings and the Task Force's recognition of tight fiscal constraints of the state.

The Task Force did undertake a series of three meetings in November 2002 in Hays, Hutchinson, and Winfield. See page 3 for more discussion of these meetings.