Approved: February 15, 2011
Date

MINUTES OF THE HOUSE AGING & LONG-TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 9:02 am. on January 25, 2011, in Room 144-S of the Capitol.

All members were present except:
Representative Scott Schwab- absent

Committee staff present:
Katherine McBride, Office of Revisor of Statutes
Gordon Self, Office of Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Craig Callahan, Kansas Legislative Research Department
Linda Martin, Committee Assistant

Conferees appearing before the Committee:

Shannon Jones, Statewide Independent Living Council of Kansas, Inc.
Debra Zehr, President, Kansas Association of Homes & Services for the Aging (KAHSA)
Sarah Hansen, Executive Director, Kansas Association of Addiction Professionals (KAAP)
Michael Hutfles, Lobbyist, representing: Alphapointe Association for the Blind
CLO
Centene Corporation

Others attending:
See attached list.

Bill Introductions

Representative Vickrey introduced two bills:
The first bill was an introduction of the establishment of an advisory committee for the long-term care Ombudsman.
Representative Vickrey moved, Representative Worley seconded, that the bill be introduced. Motion carried.
The second bill transfers Adult Protection Services from SRS to the Attorney General's Office. Representative Vickrey moved, Representative Kelly seconded, the bill be introduced. Motion carried.

Chairman Bethell then called on the conferees present to give an overview of their agency/organization:

Shannon Jones presented an overview of the Independent Living Council of Kansas which serves persons with disabilities who can and who want to work. The Working Healthy Program allows persons with disabilities to work without losing their Medicaid coverage. (Attachment 1)

Debra Zehr appeared for KAHSA which provides advocacy services, education, information, and other tools to their members. Their members can then provide the services that people need. (Attachment 2)

Sarah Hansen provided an overview of her organization of addiction professionals who treat people with substance abuse problems, especially alcohol abuse. Only 1 in 10 actually receive treatment. (Attachment 3)

Michael Hutfles, Lobbyist, represented three different organizations: Alphapointe Association for the Blind which empowers people with vision loss to maximize their independenc. (Attachment 4),
CLO- Community Living Opportunities for adults and children with special needs which provides full spectrum services for children and adults with special needs in Eastern Kansas (Attachment 5), and
Centene Corporation which is a corporation that operates managed long-term care programs in Arizona and Texas. (Attachment 6)

Minutes of the Aging and Long Term Care Committee at 9:30 a.m. on January 15, 2010, in Room 144-S of the Capitol.
The next meeting is scheduled for January 27, 2011 when Rob Siedlecki, Secretary of SRS will be speaking.

The meeting was adjourned at 9:47 am.

HOUSE AGING AND LONG TERM CARE COMMITTEE

DATE: Jan 25/11

NAME	REPRESENTING
TED HENRY	CS.
Sara Arif	KDOA

PLEASE USE BLACK INK

SILCK

Statewide Independent Living Council of Kansas, Inc.

RESOURCE PAPERS

Shannon Jones

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RESOURCE PAPERS

Table of Contents **Pages**

Introduction

The first Amendment to the Kansas Bill of Rights provides **Equal Rights**.

That means, "All men and women are possessed of equal and inalienable natural rights among which are life, liberty and the pursuit of happiness."

There are long-standing statuary provisions implementing the intent of the Constitution. A part of the statement of the purpose of social welfare in Kansas reads, ".... it is the policy of the state to assist the needy and where necessary the relatives in providing the necessary assistance for dependents."

The Constitution and the above provision of Kansas Law points in the direction of care and services for persons in need. One of these populations includes, persons with disabilities. In 1989 the legislature wrote into law what SRS had been doing for the previous 8 years. The legislature recognized and legally sanctioned the work of Home and Community Based Services. The legislation set the tone on how the state was going to make these important services available across the state.

> "individuals in need of in-home care who are recipients of attendant care services and the parent or guardians of individuals who are minors at least 16 years of age and who are in need of in-home care shall have the right to choose the option to make decisions about, direct the provisions of and control the attendant care services received by such individuals including , but not limited to, selecting , training, managing, paying and dismissing of an attendant." (KSA 39-7,100)

There is a Constitutional mandate for the care of the needy and it is further refined to a specific population (frail elderly persons and persons with disabilities) by the above legislation related to Home and Community Based Services (HCBS). To implement HCBS in the spirit intended; key provisions were included.

The over-arching principle is persons using HCBS should be considered like all other Kansans; persons wanting to live in their own community and home.

Over the last 30 years, SRS working with Centers for Independent Living (CILs), the Statewide Independent Living Council of Kansas (SILCK) and others, has been at the task of transforming the institutional biased service delivery system to one oriented to personal choice and persons wanting to stay in their own home.

The goal of this transformed system is choice and independence on the part of an individual needing services. The system will be comprehensive physical and social services. The system will emphasize consumer control based on needs. The services will be delivered in such a way as to ensure public and consumer accountability. The services provided will be comparable through-out the system. The system will emphasize functional assessments; mental/physical/cognitive.

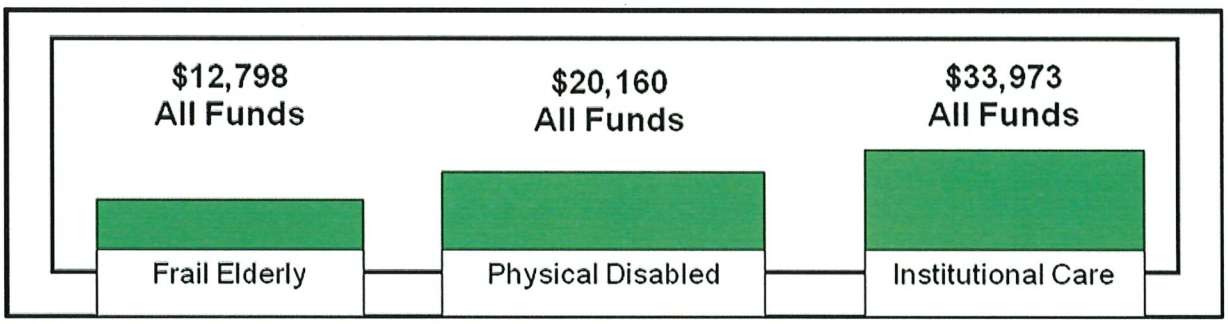
The State of Kansas has a long history of being concerned about neighbors down the road or the street. We are confident our elected public officials of 2011 and beyond will provide guidance and direction and financial support to a program such as HCBS.

The Historical Background of Home and Community Based Services

By the mid-1970's, SRS was paying for approximately 14,000 persons in nursing homes. At that time there was a serious move to look at alternatives which would be beneficial to the consumer and cost effective to SRS. Beginning in the 1980's, Health and Human Services (HHS) started giving waiver options to the states. An option was Home and Community Based Services(HCBS). SRS began with a modest pilot program affecting several hundred persons with physical disabilities and frail elderly persons. The result of that early effort means, in our state where the elderly population continues to grow and there is an ever-increasing need to meet the current needs of persons with disabilities, the nursing home population is going down. The nursing home population of persons being paid for by the State continues in the range of 10,000 persons. At the close of FY 2010 there were 6964 persons with physical disabilities and 5813 elderly persons were receiving HCBS services. These are all persons who have met the **medical** and **financial** qualifications to be in a nursing home and quite likely many, if not all, of these persons would be in nursing homes if it were not for Home and Community Based Services. If these persons had no other alternative than a nursing home, the State would be in clear violation of the provisions of the U.S. Supreme Court Olmstead Decision. One of the main provisions of the Olmstead Decision is that persons needing services should be able to choose and secure that service in the least restrictive environment. Home and Community Based Services provides that opportunity. The nursing home setting does not.

To get an idea of the effectiveness of Home and Community Services consider the following information derived from the end of FY 2010. 10,561 persons in nursing homes at an annual cost of $358.5M. means an annual per person cost of $33,973. For the purpose of illustration, assume the 6964 persons with disabilities and the 5813 frail elderly persons all needed to move into a nursing home, the cost would be 6964 plus 5813 persons = 12,777 persons X $33,973. (the annual cost of a person in a nursing home) = $434.M.

Long Term Care Cost /per person/ per year-FY2010 *



For FY' 10 the Medicaid Long Term Care Budget

	All Funds	# Served
Nursing Facility	**$358.5M**	**10,561**
HCBS/FE & PD	**$215.2M**	**12,777**

*KHPA
Medical Assistance Report

If the reliance was on nursing home care the total cost would have been $792.5M. That is a difference of **$218.8M**, due to the utilization of HCBS.

Additionally, persons with disabilities in KS are in the job market and employed at twice the national rate. All of these positive results don't happen by chance. There are a number of people across the State working to insure that persons with disabilities and frail elderly persons are having a good and fruitful life. They are living by their choice in a place pleasing to them and being afforded maximum independence. This kind of living arrangement needs to be a part of the 21st century Medicaid equation.

Employment-Working Healthy

Through the dedicated work of the Centers for Independent Living (CILs), a significant change has taken place in terms of the cost of persons with disabilities who are employed and those who remain unemployed. KU conducted a five year study of consumers who were working and were able to maintain their medical card. They found not only were the persons continuing to work but the monthly cost of their medical services substantially decreased.

People with disabilities CAN and WANT to Work!

Through the Medicaid Buy-In or Working Healthy Program, there are over 1,100 people with disabilities currently enrolled. The Working Healthy Program…

- allows people with disabilities to return to or increase their work effort without losing critical Medicaid Coverage.
- encourages people to work, increase their income and accumulate assets in order to reduce long term reliance on public supports.
- some people may be required to pay a monthly Premium for Medicaid coverage.
- premium amounts are based on the household's countable income and are payable monthly.

Medicaid Expenditure Trends

Outpatient per Member per Month Costs

	2004	2005	2006	2007
Non-enrollee Comparison Group*	$1,072	$1,000	$843	$894
All Buy-In Enrollees**	$914	$800	$537	$443
Continuously Enrolled 2004-07***	$481	$437	$380	$260

Data Source: Kansas Medicaid Management Information System (iMMIS); Note: Expenditures were adjusted to 2007 prices using the Consumer Price Index for medical care. * For 2004-2007, n=1200 ** Due to increasing Buy-In enrollment each year, for 2004 n=1025, for 2005 n=1230, for 2006 n=1275, and for 2007 n=1303. *** For 2004-2007, n=254

Working Healthy One Way to Cut Costs

TOPEKA-Researchers at the University of Kansas say one of the surest ways to reduce Medicaid spending on people with disabilities is also one of the most underutilized.

It's called work.

"The problem is most people aren't aware of Working Healthy," said Nicolle Kurth, a researcher at KU's Center for Research on Learning.

Working Healthy is a program that since July 2002 has allowed people with disabilities to hold on to their Medicaid coverage while they work.

"They have to pay a premium," Kurth said, "but the premium is based on a sliding scale and can't be more than 7.5 percent of their income."

In Kansas, around 1,100 disabled people take part in Working Healthy. Almost 40 percent of them are mentally ill; more than 20 percent are physically disabled.

Earlier this year, a KU Center for Research on Learning study found that between 2004 and 2007, Medicaid spending on outpatient services per beneficiary per month went from $816 to $718. For the same period, Medicaid outpatient spending on Working Healthy participants went from $434 to $232.

Outpatient services include visits to the doctor, mental health counseling and most other regular services, excluding pharmacy benefits, that do not require hospitalization.

"Being on Working Healthy reduced Medicaid spending by almost 50 percent," said Shannon Jones, executive director for the Statewide Independent Living Council of Kansas.

"The fact of the matter is that people with disabilities would much rather be out working than staying home, watching their health deteriorate," Jones said. "The reason they don't (work) is they are scared to death of losing their health insurance, which happens to be Medicaid. Working Healthy lets them stay on Medicaid," she said.

Adapted from a NEWS report by Dave Ranney, KHI, October 25, 2010.

The Work of the Centers for Independent Living

An important part of making all of this happen is the staff at the local Centers for Independent Living (CILs). The expenditure for the 12 CILs across the state is approximately $2.7M federal and state funds. For over 30 years, CILs have helped thousands of Kansans with disabilities live on their own, find work, raise families and become active, autonomous members of their communities.

The opportunity for disabled people to become independent is the crux of the CILs mission, allowing persons with disabilities to live by themselves, get married, find a job – anything they want to do – in order to be out on their own and make their own choices and live their own lives.

CILs are run almost solely by persons with disabilities showing those they serve exactly what they are capable of is a great example of the peer approach that sets CIL's apart from other organizations.

CILs give their practical experience on how people with disabilities live their lives, and how they can be independent, make choices, and take control of their life. Too often, people with disabilities when they're growing up, may have people taking care of them, albeit well-intended, what happens is you raise people who can't make their own decisions. CILs help people with disabilities figure out how to make their own decisions and how to take charge of their lives.

The Core Services Provided by All Centers for Independent Living are:

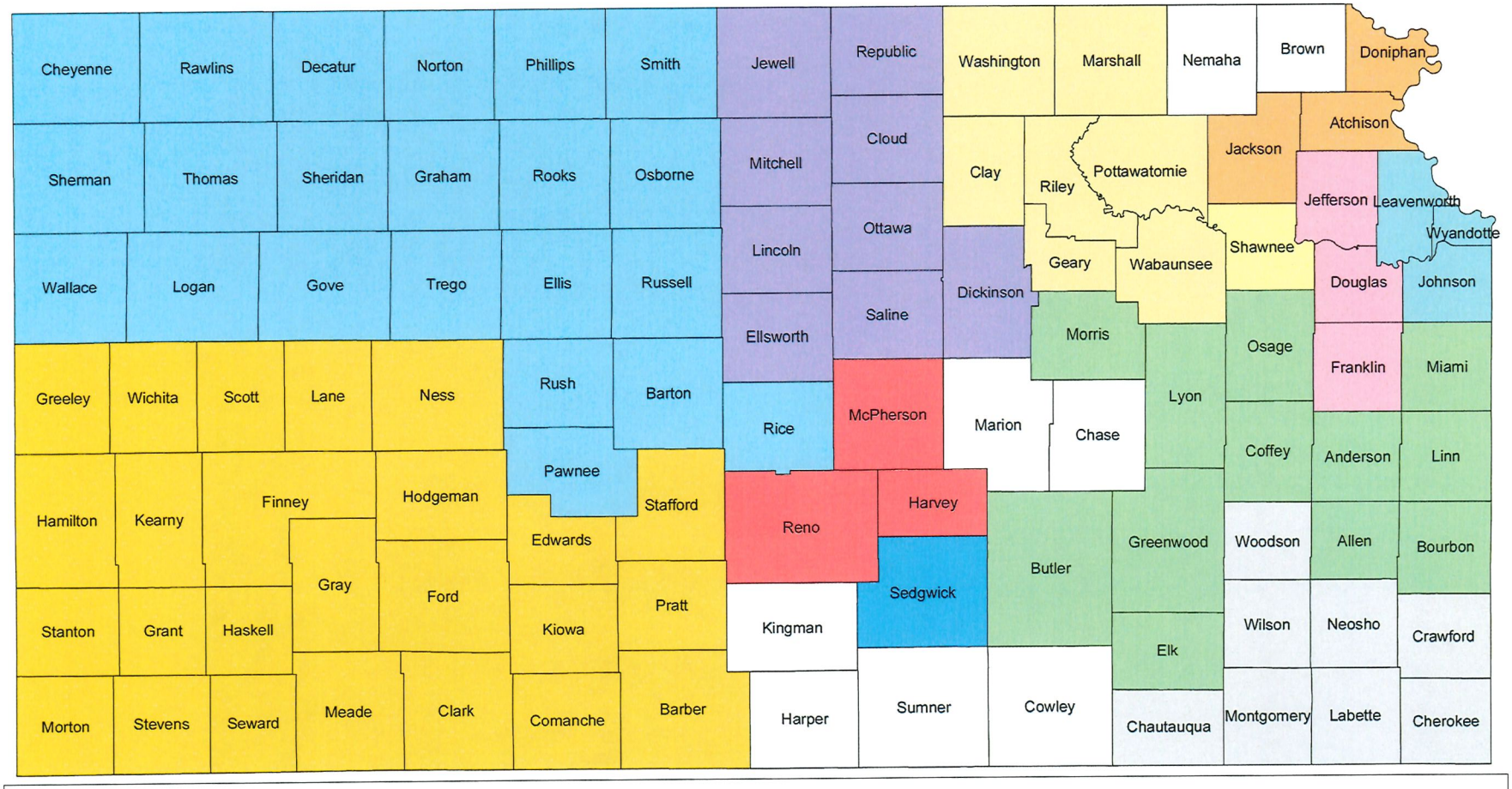
- Individual and Systems Advocacy, assistance with individual human rights issues as well as making system changes on a larger scale for people with disabilities as a whole.
- Information and Referral Services, information on specific disability related topics are referred to the appropriate work area of the CIL or another agency.
- Peer Counseling, an individual with a disability mentors, counsels and /or acts as a role model to another individual with a disability about a variety of issues.
- Independent Living Skills Training, basic life skills training such as cooking, budgeting, transportation skills and social skills.

These basic services are provided to any Kansan who walks through the door of any CIL and without cost. This array is truly one stop shopping. For FY '10, the 12 centers saw over 18,000 persons at an annual cost of $2.1M(AF) which amounts to $117/person/yr.

In FY '10 independent living services were provided to the following disability groups:

- Cognitive 1,083 persons
- Mental/emotional 1,148 persons
- Physical 10,191 persons
- Hearing Impairment 488 persons
- Visual Impairment 490 persons
- Multiple disabilities 2,502 persons
- other 2,156 persons

KANSAS CENTERS FOR INDEPENDENT LIVING



Kansas Centers for Independent Living

- Center for IL for SW KS
- Prairie Independent Living Center
- SE KS Independent Living Center
- Independent Living Resource Center
- Resource Center for Independent Living
- The Whole Person
- Access to Living/Coalition for Independence
- Independence Inc
- Topeka IL Resource Center
- IL Center of NE KS
- Three Rivers
- Independent Connection
- LINK
- Counties served by any CIL on request

Kansas Centers for Independent Living

LINK
2401 E. 13th
Hays, KS 67601
1-800-569-5926

Independent Connection/ OCCK
1710 W. Schilling Rd.
Salina, KS 67401
1-800-526-9731

Three Rivers
PO Box 408,
408 Lincoln Ave.
Wamego, KS 66547
1-800-555-3994

Advocates For Better Living For Everyone, Inc.
P.O. Box 292
521 Commercial, Suite C
Atchison, KS 66002
1-888-845-2879

Topeka Independent Living Resource Center
501 S.W. Jackson, #100
Topeka, KS 66603
1-800-443-2207

Independence Inc.
2001 Haskell
Lawrence, KS 66046
1-888-824-7277

Coalition for Independence
4911 State Ave.
Kansas City, KS 66102
1-866-201-3829

The Whole Person
7301 Mission Road
Prairie Village, KS
1-877-767-8896

Resource Center for Independent Living
P.O. Box 257
1137 Laing
Osage City, KS 66523
1-800-580-7245

Independent Living Resource Center
3033 W. 2nd
Wichita, KS 67203
1-800-479-6861

SKIL Resource Center
1801 Main Street,
PO Box 957
Parsons, KS 67357
1-800 -688-5616

Prairie Independent Living
17 S. Main
Hutchinson, KS 67501
1-888-715-6818

Center for Independent Living for Southwest Kansas
1802 E. Spruce
PO Box 2090
Garden City, K S 67846
1-800-736-9443

Five Good Reasons
Why States Shouldn't Cut
Home- and Community-Based Services in Medicaid

Adapted from Families USA • July 2010

Kansas is facing tough economic times, as we confront budget shortfalls, some are looking to cut Medicaid benefits, including home- and community-based services (HCBS). Home- and community-based services are vital to helping seniors and people with disabilities stay in their communities and out of institutions.[1] If home- and community-based services cuts are on the table please consider the following:

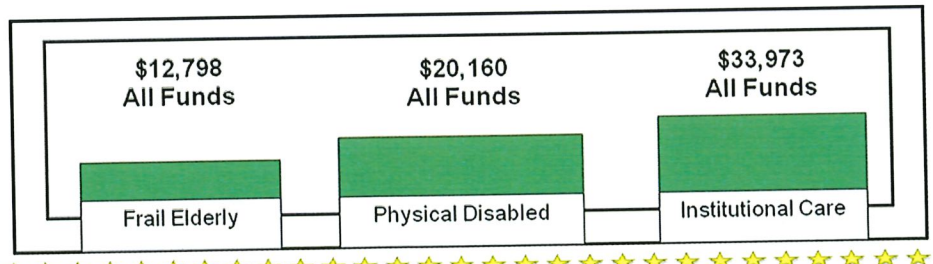
1 Cutting home- and community-based services can cost Kansas more in the long run.

Home- and community-based care costs less than institutional care. On average, home- and community-based care costs one-fifth as much per person per year as nursing home care. In addition, average costs for home- and community-based services are rising at a slower pace than costs for institutional care.

Cutting home- and community-based services can increase the use of more costly institutional care. Higher state spending on home- and community-based services reduces the use of institutional care among childless seniors.

States that spend more on home- and community-based services see a decrease in Medicaid long-term care spending over time. A 2009 study of Medicaid long-term care spending found that, over a 10-year period, states that offered few Medicaid home- and community-based service options experienced an average increase of nearly 9 percent in Medicaid long-term care spending, while states with well-established home- and community-based care programs saw an 8 percent reduction in spending.

Long Term Care Cost /per person/ per year-FY2010 *



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*KHPA
Medical Assistance Report

2 Cutting home and Community-Based services can be bad for Kansas economies.

Cutting home-and community-based services can reduce or eliminate jobs and hurt economic growth. Medicaid brings new money into states in the form of federal matching dollars. These new dollars create jobs and stimulate economic growth. Cuts to home- and community-based services reduce the amount of federal matching dollars that states receive, resulting in lost jobs and reduced business activity.

3 Cutting home- and community-based services increases the burden on informal caregivers, which has implications for U.S. businesses and state economies.

Demands on caregivers already affect their financial stability and health. Over the course of a year, it is estimated that more than 50 million people nationwide provide informal care to those who need long-term services. They are vital sources of support for people needing care and a critical supplement to existing care delivery systems. These informal caregivers—mostly family members and friends of those who require long-term care—often risk their own financial stability and health in performing caregiving functions. The typical family caregiver, who already has a job, loses approximately $110 per day in wages and health benefits due to caregiving responsibilities. More than one-third of caregivers cut back on household spending, one-third limit their work hours, and approximately one-quarter postpone personal medical care.

Cutting home and community-based services increases the burden on caregivers. Medicaid home- and community-based services such as adult day care can provide essential support to caregivers and give them an opportunity for respite. These services can also reduce caregivers' stress and help them to participate more fully in the workforce. Cutting home- and community-based services takes away valuable support for informal caregivers and increases their medical, emotional, and financial stress, which can negatively affect state economies.

The demands of caregiving cost U.S. businesses billions annually. The workplace accommodations that caregivers must make, such as reducing hours or taking unpaid leave, affect businesses as well. Costs to employers include increased absenteeism, workday interruptions, reduced employee hours, reduced productivity, and costs associated with replacing workers who leave the workforce because of caregiving responsibilities. Businesses lose an estimated $33.6 billion annually because of the demands that caregiving places on full-time employees.

The burden on caregivers also has implications for state economies. Demands of caregiving affect caregivers themselves, the businesses they work for, and, in turn, state economies. Economic activity is reduced because caregivers earn and spend less, and their medical costs end up being higher because they postpone their own medical care until their health problems are more advanced and more expensive to treat. Lost business productivity affects business receipts and, ultimately, state revenue.

4 Cutting home- and community-based services runs counter to consumer preferences.

Most consumers who need long-term care prefer to remain in their homes or in the community. About 80 percent of people needing long-term services would prefer community-based care over institutional care.

Kansas can both serve their residents better and save money by shifting their service focus to home- and community-based care. Kansas has actively shifted their long-term care delivery from institutional to home- and community-based care have not only given their residents better choices, they have also been able to serve more people at lower overall cost.

5 Cutting home- and community-based services may violate the Supreme Court's *Olmstead* decision.

Kansas must have a plan for placing individuals with disabilities in the least restrictive care setting. In the 1999 case *Olmstead v. L.C.*, the Supreme Court held that unjustified institutionalization of people with disabilities who were able to function in the community constituted a form of discrimination that violates the Americans with Disabilities Act (ADA). To comply with *Olmstead,* states must have a working plan for placing individuals in the least restrictive setting that is appropriate to their needs.

Recent court cases challenge state cuts to home- and community-based services that violate *Olmstead.* The Obama Administration is taking action to enforce *Olmstead.* As part of its enforcement activities, the Department of Justice has recently filed briefs in several cases arguing that state reductions in home- and community-based services or failure to provide sufficient home- and community-based services violate *Olmstead* and the Americans with Disabilities Act because they place individuals at risk of institutionalization.[4]

Patients and their advocates can challenge state home- and community-based services cuts based on *Olmstead.* Final decisions have not yet been reached in the cases noted above. However, when cuts in home- and community-based services limit services to the point that individuals are placed at risk of institutionalization, patients and their representatives can argue that the cuts may constitute an *Olmstead* violation and could consider a court challenge.

Conclusion

State cuts to home- and community-based services in Medicaid can be shortsighted. While they might produce some short-term cost savings, those savings can result in higher costs to states in the long term, including increased use of higher-cost institutional care, lost caregiver wages and the associated negative economic effects, and lost Medicaid matching funds. In addition to being a bad idea from an economic perspective, cuts are contrary to the wishes of the majority of constituents who need these services, and, in addition, they may violate the Supreme Court's *Olmstead* decision.

There are better options for states. Among them is the option to expand home- and community-based services through new opportunities that are available in health reform. These include improvements to the Medicaid state plan option for home- and community-based services (section 1915(i) of the Social Security Act) as well as two new programs that will start in October 2011.[5] The new programs, the Community First Choice Option and the State Balancing Incentives Payments Program, include added federal matching dollars to help states expand home- and community-based services. (For more information on these programs, see Families USA's publication, Helping People with Long-Term Care Needs: Improving Access to Home- and Community-Based Services in Medicaid, available online at http://www.familiesusa.org/assets/pdfs/health-reform/help-with-long-term-health-needs.pdf.)

Rather than cutting home- and community-based care programs, states should maintain their current programs and explore health reform's new options to expand home- and community-based care. This could save money in the long term, provide economic benefits, and better serve state residents.

Future Opportunities for Kansas

Rather than cutting home- and community-based care programs, states should maintain their current programs and explore health reform's new options to expand home- and community-based care. This could save money in the long term, provide economic benefits, and better serve state residents.

Among them is the option to expand home- and community-based services through new opportunities that are available in health reform. These include improvements to the Medicaid state plan option for Home and Community-Based Services (section 1915(i) of the Social Security Act) as well as two new programs that will start in October 2011.5 The new programs, the Community First Choice Option and the State Balancing Incentives Payments Program, include added federal matching dollars to help states expand home- and community-based services.

Community First Choice Option (CFC)

The Community First Choice (CFC) Option will provide individuals with disabilities who are eligible for nursing homes and other institutional settings with options to receive community-based services. CFC will support the Olmstead decision by giving people the choice to leave facilities and institutions for their own homes and communities with appropriate, cost effective services and supports. It will also help address state waiting lists for services by providing access to a community-based benefit within Medicaid. The option will not allow caps on the number of individuals served, nor allow waiting lists for these services. **A significant enhanced Federal Medical Assistance Percentages (FMAP) will be provided, depending on cost, to encourage states to select this option.**

Summary of Core Provisions:

- Amend Medicaid to allow state Medicaid plan coverage of community-based attendant services and supports for certain Medicaid-eligible individuals.

- Services must be provided in a home or community setting based on a written plan.

- Services must be made available statewide and must be provided in the most integrated setting appropriate for the individual.

- Services must be provided regardless of age, disability, or type of services needed.

- States will establish and maintain a comprehensive, continuous quality assurance system, including development of requirements for service delivery models; quality assurance to maximize consumer independence and consumer control; and external monitoring; along with other critical state and federal responsibilities/requirements included in S. 683/H.R. 1670.

- Service delivery models must include consumer directed, agency-based, and other models, along with requirements to comply with all federal and state labor laws.

- CFC services will not affect the states' ability to provide such services under other Medicaid provisions.

These incentives include an increased federal Medicaid matching rate for new home and community based attendant care services.

KAHSA
creating the future of aging services

To: Rep. Bob Bethell, Chair, and Members, House Aging and Long-Term Care Committee

From: Debra H. Zehr, President/CEO

Date: January 19, 2011

A Snapshot of the Kansas Association of Homes and Services for the Aging (KAHSA)

Thank you for this opportunity to speak with you today.

KAHSA represents 160 not-for-profit aging service organizations throughout the state. Our members include nursing homes, retirement communities, assisted living residences, low income housing, PACE, community-based service providers and hospital long-term care units. Together our members serve over 20,000 senior Kansans and employ about 20,000 people.

KAHSA provides advocacy services, education and shared learning, information, and other tools and resources for members to assist them to provide the services people need, when they need them, in a place they call home, and quality people can trust. In addition, we are a knowledge resource for aging Kansans and those who care for and about them.

KAHSA's six strategic priorities include:

1. Create the next generation of aging services
2. Improve aging services financial sustainability
3. Grow leaders in aging services
4. Grow and improve our workforce
5. Advance regulatory reform and improve compliance
6. Promote and protect the not-for-profit difference

Our two primary legislative priorities this year include:

1. Sustain funding for long term supports and services for frail older Kansans
2. Comprehensive Workers Compensation reform

KAHSA and its members have a wealth of knowledge and experience on aging issues and services. As you deliberate on the many important issues you will face this Session, we invite you to call on us as a trusted resource for information to assist you in responding to constituent concerns and in policy-making.

785.233.7443
kahsainfo@kahsa.org

ATTACHMENT
HOUSE AGING & LTC
DATE: 1/25/11
ATTACHMENT #2

Services to our Membership

1. Advocacy
2. Educational Programming
3. Tools to help members succeed
4. Communications and Info.
5. Group Purchasing and Shared Services options.
6. Worker's Compensation Pool

Debra Harmon Zehr
President/CEO

Kevin McFarland
President of KING

Brad Frederick
Vice President/CFO

Dana Weaver
Vice President
Programs and Services

Joe Ewert
Director of Govt Affairs

Melissa Sica
Director of Membership

Denise Howell
Director of Education

Diana Stettnisch
Registrar and Education Coordinator

Tina Andres
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Jarene Fluker, Secretary
Presbyterian Manors of
Mid-America, Wichita

Jerry Carley
Via Christi Villages, Wichita

Kristi Kuck
Phillips County Retirement Center,
Phillipsburg

Willie Novotny
Meadowlark Hills, Manhattan

Kevin Reimer
Pleasant View Home, Inman

Tom Williams
Asbury Park, Newton

www.kahsa.org

Kansas Association of Homes and Services for the Aging

KAHSA

creating the future of aging services

Who is KAHSA?

The Kansas Association of Homes and Services for the Aging is a 501 (c) (6) trade association whose 160 members are not-for-profit, mission-driven organizations that exist solely to serve the unmet needs of elders. They serve over 20,000 people throughout the state every day.

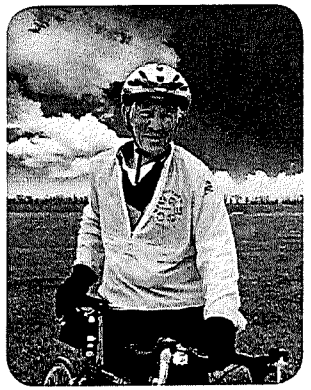
KAHSA members provide a wide spectrum of services including senior housing, assisted living, nursing home care, hospital-based long term care, continuing care retirement communities, adult day services, home health and a variety of community services.

KAHSA is also committed to educating the greater community on the positive aspects of aging and new models of care and supportive services.

Our Mission

To assist our members to provide services and supports to aging Kansans in the place they call home.

Learn more at www.kahsa.org



Our Vision

KAHSA will be the recognized leader and knowledge resource for aging Kansans.

Our Core Values

Quality, Choice, Relationship and Outstanding Value. The focus of the Association going forward is to empower and equip our members to transform into what older Kansans want:

Relationship - To contribute to and have meaningful relationships with individuals, their communities, and society at large.

Choice - To decide their own pattern of daily living and to have access to a spectrum of services to meet their changing needs and preferences.

Quality - To achieve and maintain their desired quality of life, aided by caring, competent persons and excellent services.

Outstanding Value - To have access to reasonably priced, efficient services.

WORKERS COMPENSATION

We ask the 2011 Legislature to Support Comprehensive Workers Compensation Reform.

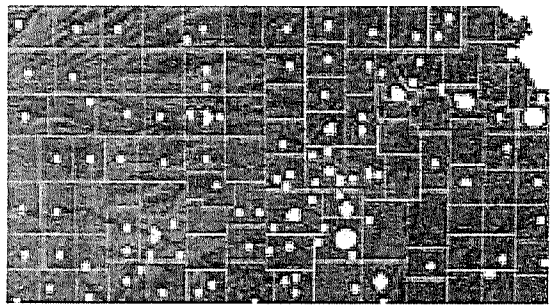
The Kansas Legislature has not made comprehensive changes to workers' compensation law since the mid-1990s. Since that time, various factors have combined to strain the worker's compensation system, greatly increasing costs for employers.

Kansas needs comprehensive worker's compensation reform to bring balance and fairness back to the system. Without reform, the escalating costs of the Kansas system will threaten the state's ability to retain and attract jobs.

KAHSA's Mission

To assist our members to provide services and supports to aging Kansans in the place they call home.

KAHSA Members Across Kansas



Larger dots represent an area with 10 or more members

What services do KAHSA members provide?

- 71% provide nursing home care
- 41% provide assisted living services
- 47 % provide housing for the elderly
- 11% provide government subsidized housing for the elderly
- Three-quarters of KAHSA members provide one or more community-based services such as home-delivered meals, adult day services or transportation

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Kansas Association of Homes and Services for the Aging
217 SE 8th Avenue
Topeka, KS 66603-3906
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www.kahsa.org

2011
Legislative Priorities

Fund Long Term Supportive Services for Frail Older Kansans

Support Comprehensive Workers Compensation Reform

KAHSA
creating the future of aging services

Kansas Association of Homes and Services for the Aging

2-4

2011 KAHSA's Legislative Priorities

The Right Public Policy for the Right Reasons

Kansas Association of Homes and Services for the Aging (KAHSA) represents not-for-profit aging service provider organizations throughout Kansas. Our 160 members exist solely to serve the unmet needs of elders. They spring from a diverse heritage of religious, fraternal and civic organizations, and local units of government. All share a common benevolent purpose and are committed to a ministry of service, care, and community benefit. KAHSA members serve nearly 20,000 Kansas seniors in nursing homes, retirement communities, hospital long-term care units, assisted living residences, senior housing and through community-based services.

Medicaid Funding

Kansans want the right long-term care services and supports, at the right time, in the place they call home. Medicaid is the state and federally funded program that pays for health care for impoverished Kansans. 56% of nursing home residents or 10,000 frail Kansans depend on the Medicaid program to pay for their long term care. An additional 5,000 Kansans receive services at home through the Home and Community Based Services for the Frail Elderly waiver program (HCBS/FE), and 300 individuals participate in the two PACE programs operating in Kansas.

Nursing Homes

We ask the 2011 Legislature to maintain Medicaid funding according to methodology currently set in state law and regulation.

Medicaid reimbursement to nursing homes is calculated through a strict cost-based system. In 2009 the state froze Medicaid reimbursement to nursing homes based on the average costs incurred between 2005 and 2007. Additionally, Medicaid reimbursement for all providers was cut 10% from January 1, 2010 through June 30, 2010, further exacerbating the shortfall between Medicaid reimbursement and the actual costs incurred in caring for the individuals receiving Medicaid benefits.

While the 10% cut was reversed beginning July 1, 2010, many homes across the state struggle to provide care needed by our frailest Kansans with the resources available through Medicaid. Proper funding is crucial to nursing homes' ability to recruit and train workers capable of delivering quality care to our state's aging population.

Home and Community Based Services/ Frail Elderly (HCBS/FE)

We ask the 2011 Legislature to fund the Medicaid HCBS/FE program to reactivate the services suspended in SFY 2010.

The HCBS/FE waiver is a Medicaid-funded program that delivers specific services to frail elders in their home as an alternative to entrance into a nursing home. In addition to cutting reimbursement for Home and Community Based Service providers 10% in SFY 2010, the HCBS/FE program was forced to suspend 4 of 10 the services provided under this program. Currently, these 4 services are available to frail elders in crisis situations only.

The HCBS/FE program provides key services that support seniors' wishes to remain in their own home as long as possible, and provides the state with a tool to reduce Medicaid cost growth in the long term. In many cases, HCBS/FE services delay the use of more costly services. Adequately funding the HCBS/FE program is an important investment in the overall health of Kansas.

PACE

We ask the 2011 Legislature to support current and future PACE sites in Kansas.

The Program for All Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to elderly individuals through a unique capitated rate structure. PACE providers receive monthly Medicare and Medicaid payments for each eligible enrollee and assume full financial risk for participants' care without limits on amount, duration, or scope of services. Kansas currently has two PACE providers, which are members of KAHSA.

more...

Since 1974
KAAP
Kansas Association of Addiction Professionals

Kansas Association of Addiction Professionals

107 SW 6th Ave, Ste. 200
Topeka, KS 66603
785-235-2400

January 25, 2011

House Committee on Aging and Long Term Care

Substance Abuse Among Older Adults

Sarah M. Hansen, Executive Director
Kansas Association of Addiction Professionals

For Additional Information Contact: Stuart Little, Association Lobbyist, Little Government Relations, LLC, 800 SW Jackson St, Ste 914, Topeka KS 66612, (785) 845-7265 or Sarah Hansen, Association Executive Director, (785) 235-2400.

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January 25, 2011

House Committee on Aging and Long Term Care

Substance Abuse Among Older Adults

Chairman Bethell and committee members:

I would like to thank you for the opportunity to discuss addiction treatment in Kansas and specifically substance abuse among older adults. We are appreciative of your interest in services and more appreciative of your interest in assuring those in need have access to care and treatment.

About the Association. The Kansas Association of Addiction Professionals (KAAP) is the largest professional addiction association in the state. KAAP's members include addiction and prevention focused professionals and others interested in the KAAP mission. The association boasts nearly 500 individual and organizational/program members from across the state of Kansas. Our organizational members vary from small private practice agencies to large statewide agencies. KAAP is a member of and closely works with the National Association for Addiction Professionals (NAADAC). Through our affiliation with NAADAC, KAAP's network of addiction and prevention professionals reach across the state and the country.

State of Services in Kansas. In talking about services to Kansans, it is beneficial to discuss the state infrastructure. Many Kansans receive services through either Federal Block Grant (which also includes a modest amount of state fee funds) funding or through Medicaid. Our providers serve about 14,000 individuals per year in the block grant system and 6,000 individuals per year in the Medicaid system, respectively. In FY 2010 alone, substance abuse treatment providers billed $1.5 million over existing capacity within block grant. This only accentuates the need which exists and the lack of adequate funding to meet the need. It is also important to note that Medicare does not provide a substance use disorder treatment benefit.

Benefits of Addiction Treatment. It is estimated that about 23 million Americans suffer from alcohol and drug addiction. Nationally, only 1 in 10 of these 23 million actually get treatment. Addiction can be defined, by US Center for Disease Control, as a chronic disorder as it is prolonged (more than 3 months), will not resolve spontaneously and is rarely cured completely. Thomas McLellan states that "Hypertension, diabetes and asthma are also chronic diseases, requiring continuing care throughout a patient's life. Treatments for these illnesses are effective but heavily dependent on adherence to the medical regimen for that effectiveness."

In 2008 the annual national cost to be about $243.8 billion. Drug abuse was estimated to cost the nation $160.7 billion in 2000 (Office of National Drug Control Policy, 2001). Updating that cost to 2008 dollars

means that the estimated cost of drug abuse in 2008 was $200.9 billion, for a combined cost of alcohol and drug abuse of $444.7 billion. For individuals with alcohol and drug abuse, the annual cost per person can easily exceed $40,000. Only 5% of the cost of alcohol abuse and 9% of drug abuse cost is attributable to health or mental health care.

A study conducted in the state of Oregon produced substantial results and indicators of cost and societal savings simply by offering substance abuse treatment.

- Persons who completed outpatient substance abuse treatment were arrested at a rate 45% lower than the matched group during the three-year period subsequent to treatment.
- Treatment completion was associated with substantially fewer incarcerations in the state prison system and with fewer days of incarceration. For example, residential treatment completers were incarcerated at a rate of 70% lower than the matched group.
- The use of food stamps was reduced significantly for clients who completed treatment compared with those who were non-completers. Completers had only one-third the use of food stamps experienced by the early-leaver comparison group.
- For clients who completed treatment, open child welfare cases decreased by 50% subsequent to treatment.
- Medical expenses were substantially lower for those who completed treatment compared with the control group. For example, early-leavers showed a dramatic increase in the use of hospital emergency rooms during the period following treatment compared with the treatment group.
- In looking across an eight year span, Oregon concluded that every tax dollar spent on treatment produced $5.60 in avoided costs to the taxpayer.

By examining national data and data from other states, we can conclude that the price of treatment is small in comparison to the dollars which are saved in avoidance of medical cost, incarceration cost and other societal costs.

Substance Abuse Among Older Adults. According to the *Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol on Substance Abuse Among Older Adults*, until recently, alcohol and prescription drug misuse was not discussed in either the substance abuse or the gerontological literature. According to SAMHSA, about 17 percent of older adults misuse substances. Health care providers tend to overlook substance abuse and misuse among older people, mistaking the symptoms for those of dementia, depression, or other problems common to older adults. In general, older adults are more likely to hide their substance abuse and less likely to seek professional help. Many relatives of older individuals with substance use disorders are ashamed of the problem and choose not to address it. The result is thousands of older adults who need treatment and do not receive it.

According to SAMHSA, people 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects.

Perhaps surprisingly, alcohol abuse and misuse is the major substance abuse problem among older adults. "In the United States, it is estimated that 2.5 million older adults have problems related to alcohol, and 21 percent of hospitalized adults over age 40 . . . have a diagnosis of alcoholism with related hospital costs as high as $60 billion per year." Nationally, rates for alcohol-related hospitalizations among older

patients are similar to those for heart attacks.

Adults over the age of 65 are more likely to be affected by at least one chronic illness, many of which can make them more vulnerable to the negative effects of alcohol consumption (Bucholz et al., 1995).

Three age-related changes significantly affect the way an older person responds to alcohol:

- Decrease in body water
- Increased sensitivity and decreased tolerance to alcohol
- Decrease in the metabolism of alcohol in the gastrointestinal tract.

As lean body mass decreases with age, total body water also decreases while fat increases. Because alcohol is water-soluble, this change in body water means that, for a given dose of alcohol, the concentration of alcohol in the blood system is greater in an older person than in a younger person. The same amount of alcohol that previously had little effect on the individual can now cause intoxication. This often results in decreased tolerance to alcohol as people age.

Studies indicate that older men are much more likely than older women to have alcohol-related problems. Since the issue was first studied, most adults with alcohol problems in old age have been found to have a long history of problem drinking, and most of them have been men. A number of differences between older male and female alcohol abusers have been reported. Women are more likely to be widowed or divorced, to have had a problem drinking spouse, and to have experienced depression. Women also report more negative effects of alcohol than men, greater use of prescribed medication, and more drinking with their spouses.

According to the National Institute on Alcohol Abuse and Alcoholism, alcohol abuse is more prevalent among older adults who have been separated or divorced and among men who have been widowed. Some researchers have hypothesized that a multitude of disorders may be triggered in older men when their spouse dies - depression, development of alcohol problems, and suicide. The highest rate of completed suicide among all population groups is in older white men who become excessively depressed and drink heavily following the death of their spouses.

As individuals age, they not only lose their spouse but also other family members and friends to death and separation. Retirement may mean loss of income as well as job-related social support systems and the structure and self-esteem that work provides. Other losses include decreased mobility, impaired sensory capabilities, and declining health.

High rates of alcoholism are consistently reported in medical settings, indicating the need for screening and assessment of patients seen for problems other than substance abuse. Among community-dwelling older adults, investigators have found a prevalence of alcoholism between 2 and 15 percent and between 18 and 44 percent among general medical and psychiatric inpatients.

According to the Kansas Department of Social and Rehabilitation Services, the majority of those admitting for formal treatment over the age of 65 years, are admitting for alcohol misuse or dependence although, the total presenting for treatment is low.

Table 1.1 Kansas Treatment Admissions for clients over 65 years of age by Primary Problem, FY 2010.

Primary Problem	Total	Percent
Alcohol	50	81.97%
Cocaine/crack	2	3.28%
Heroin	1	1.64%
Inhalants	1	1.64%
Marijuana	2	3.28%
Methamphetamine	2	3.28%
Other drug combinations	1	1.64%
Other opiates	1	1.64%
Other Sedatives	1	1.64%
Grand Total	61	100%

Treatment Approaches. The Substance Abuse and Mental Health Services Administration recommends a few best practices in the treatment of the older alcohol abuser:

- Age-specific group treatment that is supportive and nonconfrontational and aims to build or rebuild the patient's self-esteem
- A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
- A focus on rebuilding the client's social support network
- A pace and content of treatment appropriate for the older person
- Staff members who are interested and experienced in working with older adults
- Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Furthermore, SAMHSA recommends the following general approaches for effective treatment of older adult substance abusers:

- Cognitive-behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community-linked services and outreach.

Improvements in Kansas. As is clear from national and state data, our state is challenged to conduct proper education, screening, assessment and treatment for older Kansans. By educating the public, families, healthcare and others, we can begin to offer help for the thousands in need of care and treatment.

Thank you for your time and interest. I would be pleased to respond to questions at the appropriate time.

ALPHAPOINTE®
Association for the Blind

FACT SHEET

Mission Statement: **The mission of Alphapointe Association for the Blind is to empower people with vision loss to maximize their independence.**

History: In 1911, Kansas City Association for the Blind was founded to provide employment for blind individuals in Kansas City. Renamed Alphapointe in 1993, the agency served over 4000 visually impaired individuals in 2009 with employment opportunities, educational, and rehabilitation services.

Employment: Employment of blind individuals is the major focus of Alphapointe. Graduates of **Comprehensive Rehabilitation Services** seek employment in the community, at the Life Skills Campus, the Base Service Centers at Little Rock, Arkansas, and Ft. Leonard Wood, Missouri, and a switchboard operation within the region. All education and training at Alphapointe centers on promoting self sufficiency through work, life, and social skills training for visually impaired individuals.

Comprehensive Rehabilitation Services: All individualized rehabilitation services are administered by professionally certified and licensed staff. Services include:

*Adjustment to blindness and counseling needs
*Independence in orientation, mobility and daily living skills
*Academic, written and vocational skills
*Computer aptitudes and interests

Educational services involve Diabetes management, School to Work and College Prep, and Seniors Low Vision Services.

Manufacturing: Alphapointe produces fifteen types of Skilcraft® pens for the United States Government. Blind and low vision employees at Alphapointe manufactured over twelve million pens in 2009. Additionally, Alphapointe is a major supplier to the Veteran's Administration and the Department of Defense, annually producing over 50 million pharmaceutical, prescription and specimen bottles. Alphapointe operates an online supply store at alphapointeonline.com which features 40,000 office supplies, janitorial and sanitation products and furniture.

For more information or a tour call 816-421-5848.

HOUSE AGING & LTC
DATE: 1/25/11
ATTACHMENT 4

CLO

Services for Adults and Children with Special Needs

Making a Mean

HOUSE AGING & LTC
DATE: 1/25/11
ATTACHMENT # 5

Community Living Services

Family Teaching Model

CLO designed the Family Teaching Model to produce 11 key, positive outcomes for each individual who receives services. CLO has long considered these outcomes to be the foundation of *all* of our programs and services.

In family teaching homes, four or fewer people with developmental disabilities live on one side of a duplex or attached-home arrangement. Their living space includes various accessibility and safety features. A married couple, called a family-teaching couple, occupies the adjoining living space with their own immediate family members. The living spaces are connected via a common door or hallway for easy, quick access.

The family teachers provide most of the care and arrange for additional support services for the people they serve, ensuring that each individual's needs are met. Family teachers are also trained and encouraged to build positive and lasting relationships with those individuals and families or guardians.

Extended Family Teaching Model

The Extended Family Teaching Model is like adult foster care in some respects, only better. A specially-trained person or couple opens their own home and extends their family life to someone in need – in this case, one or two individuals with developmental disabilities. CLO's extended family-teaching arrangements are intended to be long-term and often evolve from pre-existing positive relationships. An individualized service contract is developed between the extended family teachers and the individuals they serve (and their families/guardians), specifying desired outcomes that address needs and lifestyle preferences.

Day Services, Wellness Services

Day Services

CLO's Day Services program focuses on teaching adults with disabilities ways to live, work and participate more fully in their communities. Recreational activities provide opportunities for individuals to express themselves through hobbies, sports and other interests. Opportunities for work and even outside employment help individuals develop pride and self-worth. Excursions in the community help individuals stay connected with friends and the world around them. All of these activities set occasions to teach appropriate socialization and other life skills.

Wellness Services

CLO meets the often significant health-care needs of the individuals we serve through on-site Wellness Clinics. CLO's nursing staff, along with visiting nurse practitioners and physicians, conduct wellness assessments and provide preventive health care with a focus on catching health concerns early and closely monitoring each individual's health needs. CLO's Wellness Clinics provide a familiar, comfortable setting for exams and certain health-care procedures. CLO also provides on-site occupational and physical therapy.

Children's Services

Early Childhood Autism Program

CLO's Early Childhood Autism Program (ECAP®) has specially-trained consultants to conduct assessments and then develop individualized teaching and behavior support programs for children with autism spectrum disorders. Parents benefit, too, learning educational and therapeutic terminology, teaching strategies to use at home, and communication and negotiation skills.

ECAP's Early Intensive Behavioral Intervention program offers intensive, one-on-one intervention, helping children reach developmental milestones.

Positive Behavior Supports

The Positive Behavior Supports program helps families in the community who are struggling with a child's challenging behaviors. A qualified consultant analyzes problem behavior in context to discover possible causes and develops a multi-component, positive intervention to reduce the behavior and teach new skills, thus enhancing the overall quality of life for whole family.

Child Placement

CLO is licensed as a Child Placement Agency to help children with disabilities (infants to age 18) who need more care than some biological families can provide. CLO's full array of supports, lifespan services, and clinical staff are available at any time to meet the child's needs.

Targeted Case Management

CLO's targeted case managers serve as the facilitators of individuals' support teams, enabling and ensuring that each individual obtains and benefits from the variety of services and supports available from CLO, as well as those offered by other community providers and government resources.

CLO's well-qualified and dedicated case managers are committed to achieving high quality outcomes for individuals who have developmental disabilities and their families by:

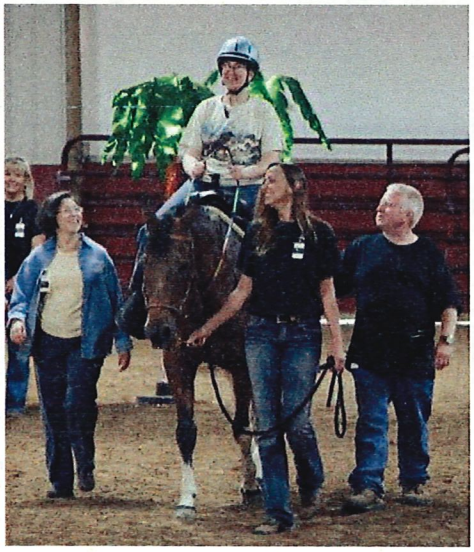
- Assessing needs and lifestyle preferences.
- Providing transition planning to promote success in new environments.
- Facilitating the person-centered support planning process, (called a Quality of Life Plan (QLP) at CLO).
- Pursuing resources, funding, services and supports to meet the needs, interests, goals and preferences of the individual.
- Evaluating the quality of services provided and acting to achieve desired outcomes.
- Serving as a liaison with families and guardians, ensuring effective communication.

Midnight Farm

Midnight Farm, located seven miles south of Eudora, Kansas on 40 acres of scenic farmland, offers opportunities for people with special needs to live, work, relax, and pursue recreational activities in the natural beauty of the Douglas County countryside.

Activities revolve around Midnight Farm's 22,000-square-foot multi-purpose facility that is fully accessible for people with disabilities. It includes a rustic meeting lodge with a cozy stone fireplace and a fully equipped kitchen, a guest bunkhouse, an indoor equestrian arena (home of a NARHA-certified therapeutic horseback riding program), and a general purpose barn. Spilling out from the barn in every direction are paddocks and petting areas for gentle farm animals, walking and riding trails, picnic spots, a fire pit and outdoor theater, flower gardens and specialty crop growing areas.

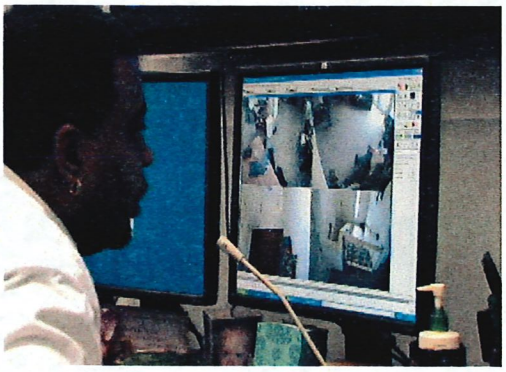
CLO offers a variety of day services at Midnight Farm, including camps and field trips, for people with special needs. Community groups and the public at large are welcome to volunteer, enjoy the farm's amenities, buy products, and more.



HomeLink

CLO developed HomeLink to use the latest in technology to bring "on-demand" support directly into the homes of people with disabilities. An integrated system of video cameras and other monitoring devices gives specially trained personnel remote access to the home, be it on the other side of town, in another state, or across the country. HomeLink makes it possible to:

- Determine when an individual in a home setting needs help and immediately dispatch a support staffer.
- Remotely supervise awake-at-night staff to make sure they're on task, and that the individuals they serve are safe and getting proper care.
- Let a health-care provider make multiple "house calls" to consult with home-based staff, check on a patient, or remotely collect data like temperature, weight, blood pressure, oxygen levels, and more.
- Monitor individuals with seizure disorders and respond at the first observable signs of a seizure.
- Allow a certified behavior analyst to observe and evaluate behavioral concerns in their natural settings.



CLO's Mission: Make a Meaningful Difference for People with Developmental Disabilities

Community Living Opportunities (CLO), Inc. is a not-for-profit organization formed in 1977 in Johnson County, Kansas by a group of parents who wanted people with developmental disabilities, no matter how severe, to live fulfilling lives in the community. CLO was among the pioneers of community-based developmental disability services for people with more challenging needs and soon become a leader in developing and implementing unique and effective service models. From the start, CLO's advisors and consultants included key faculty and graduate students from the Department of Applied Behavioral Science at the University of Kansas, who have been instrumental in creating CLO's Qualify of Life planning process, Family Teaching Model, Extended Family Teaching Model, Early Childhood Autism Program (ECAP®), and more.

CLO's services have always been based on dignity and respect, with a family-style atmosphere in the home setting, opportunities for choice, an emphasis on teaching, positive reinforcement, and as much independence as possible. CLO believes in active family involvement. In fact, family members or guardians of the people we serve make up the majority of our board of directors.

CLO provides a full spectrum of lifespan services for more than 400 children and adults with special needs, primarily in eastern Kansas. Among our services are community living, day services, behavioral consultation, targeted case management, children's services, and health-care supports. CLO also embraces the value of best practices and sharing ideas. Nonprofit organizations patterned after CLO provide services in south-central Kansas, Tennessee, and California.

The title of this original watercolor, ***Life is a Very Steep Hill***, exemplifies the life of its subject, my son, Jim Duncan. Jim was born in 1959, when services for Kansans with mental retardation and other developmental disabilities were still in the dark ages. CLO was one of the very earliest community residential care providers to emphasize quality of life for its clients. At CLO, Jim found a group of dedicated people who worked him through an eight-person group home, to a three-person apartment, to a Family-Teaching Model home, to an Extended Family-Teaching Model arrangement where, finally, he was living in his own apartment. Every step up the very steep hill of life advanced him on the road to a good life.

Ellen Duncan, artist

CLO

Visit us on the web:

www.clokansas.org

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In Southeast Kansas:
11627 W. Madison Street
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Iola Kansas 66749-0748
Phone: 620-365-7119
Fax: 800-232-7051

CENTENE® Corporation

people
commitment
results

Health Plans

While Centene is a national company with corporate offices in St. Louis, Missouri, its local approach to managing health plans enables it to provide accessible, high quality, culturally sensitive healthcare services to its members.

Additionally, this local approach allows Medicaid recipients, providers and state regulators direct access to the local health plan where its officers and staff are available and accountable.

Centene combines its local approach with centralized finance, information systems, claims processing and medical management support functions.

Arizona
Bridgeway Health Solutions

Florida
Sunshine State Health Plan

Georgia
Peach State Health Plan

Indiana
Managed Health Services

Massachusetts
CeltiCare Health Plan

Mississippi
Magnolia Health Plan

Ohio
Buckeye Community Health Plan

South Carolina
Absolute Total Care

Texas
Superior HealthPlan

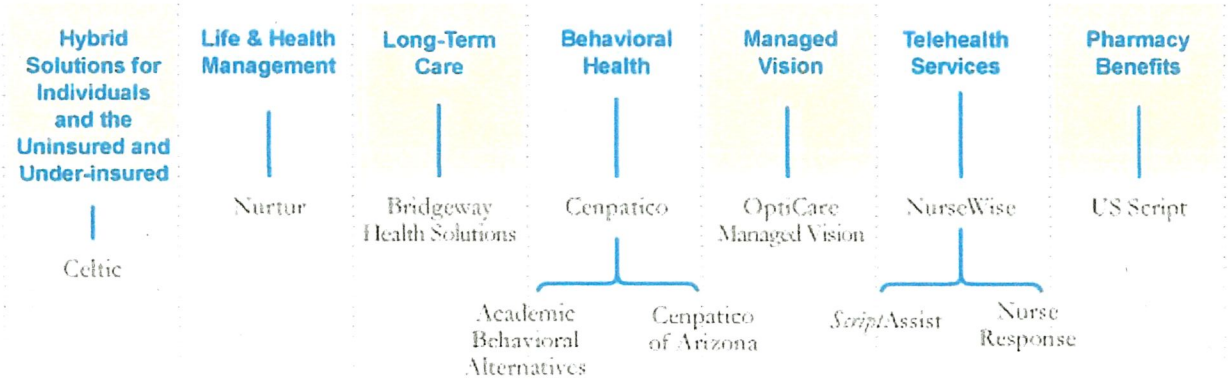
Wisconsin
Managed Health Services

CENTENE Corporation

people
commitment
results

Specialty Companies

Centene strives to provide specialized health solutions to the complex problems faced by state governments and patients. We offer a unique suite of programs and services which, alone or combined, deliver improved outcomes, reliable data, and cost-effective coordinated care.



CENTENE® Corporation

7700 Forsyth Boulevard St. Louis, MO 63105 • 314-725-4477 • Fax 314-725-2065

Long Term Care Solutions

Centene Corporation possesses over 25 years of experience in full-risk Medicaid managed care programs. Centene is a fiscally sound organization, with over $4.3 billion in annual revenue, whose financial reports are publicly available on www.centene.com. Centene currently serves 1.2 million TANF, SCHIP, ABD, Long Term Care and Foster Care members in full-risk managed care programs in nine states: Arizona, Florida, Georgia, Indiana, Ohio, Mississippi, South Carolina, Texas and Wisconsin. In addition to operating locally-based health plans in the states we serve, Centene offers a full range of healthcare solutions for the rising number of uninsured Americans. We also contract with healthcare organizations to provide specialty services such as behavioral health, life and health management, managed vision, telehealth, pharmacy benefits management and medication adherence.

Centene currently operates managed long term care programs in Arizona and Texas. In Arizona, long term care services have been managed on a full-risk basis since 1988. In October 2006, Bridgeway Health Solutions, a Centene subsidiary, began serving Arizona's long term care population. The program has decreased nursing facility placement from 63% to 38% and has 93% customer satisfaction. In Texas, long term care services have been managed on a full-risk basis since 1998. In 2007, Superior HealthPlan, a Centene subsidiary, began serving over 11,800 of Texas' long term care population and currently serves over 34,800 enrollees. The program has generated 8% cost savings, 25% diversion from nursing facilities into home and community based settings and has a 90% customer satisfaction rating.

The state of Kansas could benefit from the improved health outcomes, quality of care and savings that would be achieved through a full-risk long term care program. The proposed program would include individuals who require a nursing facility level of care. Those who are appropriately served in a nursing facility will receive medical management to ensure the proper level of care is being provided. Those individuals who have the desire and ability to be in a home and community based setting will receive the services and support they need to do so.

Long Term Care Program Objectives

- Promote choice for consumers by providing the option of community living as an alternate to nursing home placement.
- Enable the transition of people in nursing homes back into the community.
- Ensure that triggers to institutionalization are eliminated.
- Address barriers to care that serve to reduce emergency room and inpatient costs.
- Create a financially sustainable approach to rebalancing long term care costs from "Nursing Facility" to "Home and Community Based Alternatives".

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Features of Managed Care

- Budget certainty with savings beginning at the inception of the program
- Competitive procurement
- Integrated care across the spectrum of services
- 24/7 access to Care Coordination
- Flexibility to quickly deliver appropriate services
- Sophisticated Information Technology Systems and Tools
- Accountability for Quality of Care, Timely Reimbursement Processes, and Consumer Inclusions through contractual requirements

Arizona Long Term Care System (ALTCS)

Eligibility

- All recipients determined financially and functionally eligible for Medicaid Nursing Home placement.
- Determination is made by independent state agency personnel.

Benefit Package

- All acute medical, institutional, behavioral health, home and community based services including Medicare related copays and deductibles.

Managed Care Responsibilities

- All consumers receive a Case Manager who must make contact and arrange services within 5 days of enrollment.
- Consumers have 24/7 access to assistance.
- Establishment of locally based Consumer, Provider, and Advocate Councils that monitor performance and processes.
- Quality and performance measures are established in contract and subject to sanctions.

Provider Networks

- Access standards are established and enforced by contract.
- 30 day clean claim requirements.
- Minimum rate levels for HCBS and Nursing Home providers are included in the Managed Care Capitation with rate changes established by State Agency.

Managed Care Capitation

- Target mix of home-based and institutional placements establishes base rate.
- Rates are promulgated each year based on consumer mix, Managed Care Entity financials and encounter data.