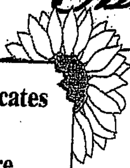
Making Elder Care Better Since 1975



Kansas Advocates for Better Care

Medicaid –Proposed Managed Care and Older Adults needing Long-Term Care

Older adults live in nursing homes for 2.9 years through the end of their lives (on average). They give up nearly everything they have – privacy, daily freedoms, and most of their money—in exchange for care.

Kansas Advocates for Better Care recommends:
--Real outcomes that measure health improvements for older adults.
--Medicaid funding for adult dental health and geriatric mental health.

Older Adults have significant concerns with the Governor's Managed Care Proposal:

A. **Gaps in coverage**/lack of access that seriously and negatively impact elders' health. The need for both has been well documented in hearings.

1. **No coverage for adult oral health** - resulting in infection, confusion, malnutrition, falls, hospitalization, and wrongly prescribed psychotropic drugs/chemical restraints. Public policy does not address elders' dental needs. Most adults lose their dental insurance coverage when they retire from the workforce. Medicare does not cover routine dental care for older adults. Medicaid in Kansas no longer covers oral health care for adults, except for extremely limited, emergency services only. The need for oral health care is illustrated in the 7,800 persons who received dental care and dentures in 2007 after $3.3 million was allocated to fund oral health care under the HCBS/Frail Elderly waiver. The number of dental providers also increased during that time. Funding for dental coverage was cut due to budget constraints, but the very real need remains.

2. **No coverage for mental health** – resulting in overmedication, hospitalization, poor quality of life and poor physical health outcomes. Senior advocates have supported legislation to fund geriatric mental health coverage for more than 5 years. There's been no opposition to the legislation which would fund services through the KDOA at an estimated $1.1 million. If the proposed agency reorganization puts all mental health services under KDOA, then let's address this glaring omission in senior services.

B. **Individual** Outcomes **vs.** Medicaid **Program Outcomes**

1. Much has been said about outcomes. The Administration leads us to b outcomes are measuring health outcomes of recipients, though it outcomes are in the forefront, presuming that better health outc

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result. Prior history with managed care in other states indicates that restricted access to care and care options will be the approach to contain costs that insurance companies will institute.

In fact, the RFP calls for the successful bidders to *"establish a tiered functional eligibility system for the Frail and Elderly* ***that restricts access*** *to the highest cost institutional settings only to those with the highest level of need in order to utilize appropriate alternative home and community based settings."*

2. Raise the minimum direct care nursing standard for nursing home residents. Current Kansas standard is 2 hours of nursing care per resident per day set over 30 years ago. The national recommended standard is 4 hours and 20 minutes per day per resident. Nursing care is a measurable outcome that will benefit elders, improve health outcomes, avoid injury, hospitalization and death. Nurse staffing should be tracked objectively from payroll rather than being self-reported once a year when the nursing homes expect surveyors. SB 184 would implement such a standard.
3. Elders will not have better health outcomes without dental care or mental health care, neither of which is included in the managed care proposal.

C. **Nursing Homes** and the proposed plan

1) **Quality** of providers & quality of **care** for elders
   a. Providers are guaranteed 3 years of business as usual regardless of their care record – 190 of 342 facilities cited with actual harm, or immediate jeopardy last year. Cost is the driving factor not the quality of elder care or health outcomes.
   b. Success is defined by whether or not the insurance company is successful at containing cost, not by measurable health outcomes for elders.
   c. Savings are not invested to better serve elders with critical health needs which are not covered by the existing plan or by investing in home based services.
2) Provider Assessment Funds – ought to require quality improvements in outcomes for residents not simply reimbursements for nursing homes. The current proposal incentivizes person centered care planning and mentoring, but lacks specific targets for improving resident outcomes. Looking to other states, like Florida clearly shows that offering financial incentives won't get us there; to achieve universal improvement requires legislation or state regulation.
3) Secretary Sullivan has referenced Kansas' nursing home utilization rate based on the AARP report - <u>Across the States 2009: Profiles of Long-Term Care</u>. (See report pages attached).

D. Institutional vs. Home Based Care

1) Secretary Sullivan is redefining Assisted Living as Home Based Care. It is not, it is institutional care. While it may be less restrictive than nursing home care it is still institutional care. Assisted Living offers fewer staff and less oversight.
2) Older Adults and others needing long-term care want to stay at home – not live in an assisted living facility – and overall it is less expensive for them to do so.
   Yet this managed care plan proposes:
   a) to move elders from nursing homes into assisted living with increased financial reimbursements to providers RATHER than investing in community based services that would allow persons needing all long-term care services (elders, PD, DD, TBI) to receive care at home.
   b) Although possible, this plan provides no monetary cap on what Assisted Living Facilities (ALFs) can charge residents and their families, unlike in nursing homes. The Secretary is not supportive of caps thereby transferring additional cost burdens to family members in local communities (especially prevalent in Jo. & Sedgwick Co.).
   c) Assisted Living provides fewer staff (in numbers and qualifications), lesser levels of care, has less oversight with fewer regulations (licensed only by state not feds) thereby offering elder consumers fewer protections and depriving them of recourse and remedies available to adults in nursing homes.
   d) Nursing Homes are encouraged to de-license beds and relicense the same beds as ALFs or Homes Plus thereby requiring less payment by the state, with no actual change in institutionalization for elders.

E. Agency reorganization may result in **loss of focus on elders** needing long term care through end of life (2.9 years)

1) KDOA was created in 1975 due to lack of adequate response by SRS in meeting the policy and service needs of elders. (see attached pages)
2) The Governor's 2012 State of the State address, unlike prior administrations, did not mention older adult concerns. Nowhere have they articulated how the agency reorganization will benefit seniors. Nor has the administration outlined a plan for how they will guarantee that senior issues won't get pushed to the back-burner.

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Executive Director

Kansas Advocates for Better Care is a not for profit, volunteer organization dedicated to improving the quality of long-term care in Kansas. KABC has 850 members across the state. KABC offers assistance to consumers of long-term care to find services and placement, provide training to caregivers, and advocate for public policies that assure good long-term care.

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