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The Honorable Carolyn McGinn, Chairperson
Senate Ways and Means Committee

Reference: ERO 41-The New Department of Aging and Disability Services

Good morning Madame Chair and Members of the Senate Ways and Means Committee. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. We represent over 340,000 members from across the state. Thank you for allowing us to submit our written comments on ERO 41-reorganization of state agencies.

We applaud this committee for holding today's thoughtful hearing on the needs of older Kansans and Kansans with disabilities. We hope that our comments will lead to positive outcomes in this reorganization effort.

AARP Kansas opposes a reorganization effort of this magnitude. Executive Reorganization Order 41 transfers significant new duties to the Department on Aging and renames it the Department for Aging and Disability Services. Although there are always positives and negatives in any reorganization, we will first outline most of the major programmatic changes and then comment on what we believe may need special focus.

Major Programmatic Changes

The following programs will be transferred to Aging and Disability Services from the former Department of Social and Rehabilitation Services:

- Mental health and substance abuse
- Serious emotionally disturbances
- Developmental disability
- Physical disability
- Traumatic brain injury

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W. Lee Hammond, President
Addison Barry Rand, Chief Executive Officer

- Autism
- Technology assistance
- Money Follows the Person Medicaid waivers and programs

The following duties will also be moved to the new Department:

- Licensure and regulation of community mental health centers
- Regulation of community developmental disability organizations
- Licensure of private psychiatric hospitals
- Licensure and regulation of facilities and providers of residential services
- Licensure and regulation of providers of addiction and prevention services
- Medicaid single state authority for substance abuse and mental health
- Responsibility for the operation of five (5) state hospitals and institutions for individuals with developmental disabilities, mental illness and brain injury.
- Any other programs and related grants administered by the disability and behavioral health services system section of the former Department of Social and Rehabilitation Services

In addition to the programs outlined above transferring from the former Department of Social and Rehabilitative Services, the following programs will move from the Department of Health and Environment:

- Licensure of adult care home administrators
- Licensure of dieticians
- Certification of residential care facility operators
- Certification of activity directors
- Certification of social service designees
- Certification of nurse aides
- Certification of medication aides
- Certification of home health aides
- Maintenance of the nurse aide registry

The following responsibilities are also transferred:

- Board of Adult Care Administrators
- Criminal history record check program
- Psychiatric residential treatment facility licensure program
- Criminal history records checks.

Advocacy Considerations

Reorganizations are not inherently good or bad. Each has to be considered on its own merits. If the goal of the state's consolidation of its long-term care (LTC) system is to overcome barriers to consumer access to services and supports, and to ensure the availability of real and viable choices to consumers, that is a good goal. Consolidating the existing fragmented program areas makes it possible for program administrators and consumers to begin thinking about the state's LTC system as one integrated system designed to meet the changing needs of individuals rather than just a collection of separate programs. And if this consolidation is used as the basis for global budgeting, that is even more promising. However, if the primary goal of this reorganization is saving money and reducing staffing and government, AARP Kansas would oppose this effort. Below, in global terms, some potential barriers issues and considerations are outlined.

What are the barriers to achieving consolidation?

Barriers to consolidation can include the difficulty of serving multiple populations with different issues and funding streams, agency turf battles, fear of big government by consumers and policymakers, and some resistance from consumer groups.

- Difficulty of Serving Multiple Populations - Because the needs of individuals may vary considerably, developing common assessment procedures and services can be difficult.

- Agency Turf Battles - State agencies are often difficult to reorganize, particularly when reorganization can mean that some staff will lose their jobs because of the need for fewer administrative personnel or because functions change or are eliminated. One or more units may also lose budget dollars in reorganization. In addition, the cultures of the agencies being merged may be very different.

- Various Programmatic Funding Streams and Eligibility Requirements - Federal rules differ from program to program, specifying or allowing different services. Programs have varying funding streams and different eligibility standards. This situation makes cohesion and coordination difficult.

- Resistance among Some Consumer Groups - Moving various populations into one agency sometimes raises fears in advocacy groups that the interests of the population they support may receive a lower priority.

- Lack of Strong Leadership - Without strong values and leadership within a consolidated structure, an agency can falter in accomplishing its mission.

Potential Positive Outcomes

- Moving licensure and certification of key professionals that work in organizations serving older adults gives this new department more control over the quality of services delivered to all older adults, not just those on Medicaid. This has great potential for improving care and having an impact on the availability of key service professionals throughout the state.

- Moving responsibility for licensure and regulation of facilities for other population groups and the licensing and certification of key occupations does open the possibility of bringing more licensure and regulation of facilities, like nursing homes and adult care homes, into the new department.

Potential Negative Outcomes

- For AARP Kansas, the obvious issue that the aging population is no longer unique and is lumped in with other populations needing long-term care services that may not have similar interests in expanding resources for prevention and early intervention, for example. Seeking common ground with other groups will bring challenges to keep decision makers focused on the unique needs of older adults.

- Reorganizations like this one take time and energy from the management of existing programs. AARP Kansas will work closely with the department leadership and staff and will monitor the agency much more closely to ensure that the existing programs are being properly managed as the new department takes on these large new responsibilities. Regardless of best intentions, huge amounts of hours will be expended putting together the administrative and programmatic structures of the new department.

One central concept behind the consolidation of LTC programs and policies in one agency is that moving to a single agency allows state administrators to focus on the people needing LTC services rather than on separate silos for specific programs and specific funding streams.

We believe that, if this reorganization is approved, the new department should provide a coordinated system of services targeting older Kansans and others who face difficulties in caring for themselves who, without these efforts, cannot live independently within the mainstream of life and are at the greatest risk of institutionalization.

Finally, we ask that, if the state moves forward with this reorganization, you use the most recent "***Kansas: State Long-Term Services and Supports Scorecard***" results as an indicator of where services in Kansas have been and how they can be improved. The ***State Long-Term Services and Supports (LTSS) Scorecard*** is the first of its kind: a multidimensional approach to measure state-level performance of LTSS systems that provide assistance to older people, adults with disabilities, and family caregivers.

Thank you for allowing us this time.

Respectfully,

Ernest Kutzley

Kansas: *State Long-Term Services and Supports Scorecard Results*

This *State Long-Term Services and Supports (LTSS) Scorecard* is the first of its kind: a multidimensional approach to measure state-level performance of LTSS systems that provide assistance to older people, adults with disabilities, and family caregivers. The full report is available at www.longtermscorecard.org

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Kansas ranked:

Overall **9**

- Affordability and access **9**
- Choice of setting and provider **23**

- Quality of life and quality of care **14**

- Support for family caregivers **17**

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Kansas improved its performance to the level of the highest-performing state:

- 9,189 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 1,886 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes.
- 3,357 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- 1,905 unnecessary hospitalizations of people in nursing homes would be avoided.

State Long-Term Services and Supports Scorecard Results - KANSAS

2011 Scorecard					
Dimension and Indicator	State Rate	Rank	All States Median Rate	Top 5 States Average Rate	Best State Rate
AFFORDABILITY AND ACCESS		9			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	177%	4	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	87%	18	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	73	8	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government	46.9%	41	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250%	43.1	14	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale	7.1	30	7.7	10.5	11.0
CHOICE OF SETTING AND PROVIDER		23			
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical	40.1%	17	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	55.6%	18	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	11.1	21	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	2.75	22	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age	54	10	34	88	108
Assisted living and residential care units per 1,000 population age	23	36	29	64	80
Percent of nursing home residents with low care needs (2007)	18.6%	45	11.9%	5.4%	1.3%
QUALITY OF LIFE AND QUALITY OF CARE		14			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	73.8%	7	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	88.3%	7	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability	23.3%	33	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores	9.5%	13	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	0.9%	1	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	63.2%	38	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	21.6%	35	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	91%	19	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	28.0%	22	29.0%	23.2%	21.8%
SUPPORT FOR FAMILY CAREGIVERS		17			
Percent of caregivers usually or always getting needed support	81.1%	7	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-10)	2.20	38	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	6	26	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

Refer to Appendix B2 in *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for indicator descriptions, data sources, and other notes about methodology. The full report is available at www.longtermscorecard.org