Approved: March 9, 2010
Date

MINUTES OF THE HOUSE AGING AND LONG TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 3:30 p.m. on March 2, 2010, in Room 784 of the Docking State Office Building.

All members were present.

Committee staff present:
Doug Taylor, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judith Holliday, Committee Assistant

Conferees appearing before the Committee:
Nick Wood, Advocate, Disability Rights Center
Tom Bell, President, Kansas Hospital Association
Debra Zehr, President, Kansas Association of Homes and Services for the Aging
Representative Cindy Neighbor
Terry Humphrey, on behalf of Kansas Chapter, National Association of Social Workers

Written Testimony submitted by:
Tom Laing, Executive Director, InterHab
Mike Oxford, Executive Director, Topeka Independent Resource Center
Andrew Allison, Acting Executive Director, Kansas Health Policy Authority
Joe Tilghman, Board Chairman, Kansas Health Policy Authority
Mitzi McFatrich, Kansas Advocates for Better Care
Derrick Sontag, Advocate, Americans for Prosperity
Ed Strahm, Administrator, Apostolic Christian Home, Sabetha

Others attending:
See attached list.

Chairman Bethell asked for approval of the minutes of the February 25 committee meeting. Representative Williams made a motion to approve the minutes, seconded by Representative O'Brien. The motion carried.

Chairman Bethell continued the briefing on **HB 2673 - Assessment of quality assurance fee on skilled nursing care facilities to improve the quality of care**.

3/2

Nick Wood, Advocate, Disability Rights Center of Kansas (DRC), testified as a proponent of **HB 2673**. (Attachment 1) Disability Rights Center of Kansas is a private, nonprofit corporation independent of state government with the sole interest of protection of the legal rights of Kansans with disabilities.

HB 2673 would help maximize financial resources and DRC supports the bill and further advocates that 20% of all revenue generated also be allocated to the state's Home and Community Based Services (HCBS) waiver programs. Kansans with disabilities are forced to wait for services and supports.

If services are not provided in the community, this forces people to be served in more expensive institutional settings at four times the cost of HCBS. Wait lists are bad for people with disabilities, bad for taxpayers, and bad for Kansas.

Tom Bell, President, Kansas Hospital Association, testified as a proponent of **HB 2673**. (Attachment 2) Mr. Bell addressed the options available regarding the hospital provider assessment program. They could do nothing and watch Medicaid rates erode as a percentage of what it costs to deliver the care. Or, they could be proactive and establish a program to assess hospitals a certain amount for the purpose of generating additional federal matching funds to be used to increase Medicaid reimbursement rates for hospitals and physicians. This program is a true partnership between hospitals and the state, and has been successful so far. In order to ensure that resources of hospitals and communities they serve would be used to improve the health care system, several key provisions need to be included:

- The assessment rate and base needs to be specific in the statute;

- The program must be a formal agreement between the state and any providers assessed;
- To the extend permitted by federal regulation, assessed funds need to be returned to the providers in the most expeditious manner possible;
- The assessment and increased hospital payments must terminate if either is not eligible for federal matching funds;
- The increased provider payments financed by the hospital assessment must be required by the statute and an efficient and equitable mechanism to determine the specifics must be included;
- There must be a requirement for independent auditing of the program;
- There must be "maintenance of effort" by the state to prevent diversion of new funds for other purposes or to supplant existing state funds.
- Many provisions are addressed in **HB 2673**, but there are many unknowns, so it is difficult to oppose or support a provider tax program absent the assessment rate being known. These programs do not work well without virtual unanimity of those being assessed, and providers should determine how this program would impact their industry and their individual facility. Thus far, **HB 2673** does not allow this.

The Committee had a number of questions for Mr. Bell regarding his program.

Chairman Bethell asked Bill McDaniel, Commissioner, Kansas Department on Aging, to provide a breakdown of the losers and winners with this proposed bill and see that the Committee gets copies.

Debra Zehr, President, Kansas Association of Homes and Services for the Aging (KAHSA), testified in opposition to **HB 2673**. (Attachment 3) Ms. Zehr acknowledged that the state is facing serious budget problems, especially in the area of adequately funding Medicaid. However, KAHSA does not agree that **HB 2673** is the only way to restore funding, and that now is not the time to take the easy way out.

Ms. Zehr stated that **HB 2673** is bad public policy because:

- Caring for the poorest citizens is a societal obligation historically funded through broad-based taxes; **HB 2673** departs from that social contract.
- There will be losers, nursing homes that pay more in tax than they get back.
- In Kansas, almost 40% of nursing home residents pay their own bill. **HB 2673** will force those who pay their own way to absorb additional costs, putting them at risk for premature reliance on Medicaid.
- Provisions to the bill will change in coming years, increasing taxes and/or using the money for other things. Even in Kansas where there is a hospital provider tax, hospitals were not spared the recent 10% Medicaid cut.

Ms. Zehr urged the Committee to insist on accurate numbers so they could understand the impact and make an informed decision.

In response to questions regarding the criteria for exemption, Ms. Zehr stated that two-thirds of Kansas hospitals are exempt critical access hospitals that do not take Medicaid; low-Medicaid/high Medicare hospitals that are in rural areas are exempt. Not-for-profits take care of a lot of Medicaid recipients, compared to other states. In Kansas, it is about a 50/50 ratio.

Proponent written testimony on **HB 2673** submitted by:
Mike Oxford, Exec. Dir., Topeka Independent Resource Center (Attachment 4)
Tom Laing, Executive Director, InterHab (Attachment 5)

Neutral written testimony on **HB 2673** was submitted by:
Andrew Allison, Acting Executive Director, Kansas Health Policy Authority (Attachment 6)

Opponent written testimony on **HB 2673** submitted by:
Joe Tilghman, Board Chairman, Kansas Health Policy Authority (Attachment 7)
Mitzi McFatrich, Kansas Advocates for Better Care (Attachment 8)
Derrick Sontag, Americans for Prosperity (Attachment 9)
Ed Strahm, Administrator, Apostolic Christian Home, Sabetha (Attachment 10)

Minutes of the House Aging and Long Term Care Committee at 3:30 p.m. on March 2, 2010, in Room 784 of the Docking State Office Building.

Chairman Bethell closed the briefing on **HB 2673.**

Briefing on SB 31- Concerning social workers, social worker safety training

Chairman Bethell opened the briefing on **SB 31 - Concerning social workers, social worker safety training.** He explained that **SB 31** is not an active bill, and he hoped to get the language for social worker safety training inserted either into the "shell" of **SB 31** or possibly into another bill.

Representative Cindy Neighbor testified as a proponent of **SB 31**. (Attachment 11) Representative Neighbor testified that this bill addresses an issue very close to her. She related the tragic story of a young social worker who was murdered while evaluating a young client in his home. She stated that **SB 31** does not cost the state general fund one dollar, but requires that six continuing education units of the 40 required every two years be for safety training. She told the Committee there is a solution to helping make the social worker workplace safer.

Questions from Committee members addressed the ages of clients served by social workers, and at what stage of the social worker curriculum would safety training be offered.

Terry Humphrey, on behalf of the Kansas Chapter, National Association of Social Workers, testified as a proponent of **SB 31**. (Attachment 12) Ms. Humphrey stated that the legislation requiring the six hours of safety awareness training does not increase the number of continuing education hours, but simply designates that the six hours will be on the topic of social worker safety awareness early in their career prior to licensure. The safety awareness training gives social workers the necessary knowledge and skills to prevent or handle violent situations.

The public policy benefits extend to employers because it saves on workers compensation premiums; the State will benefit because the training will prevent injury or death and the resulting claims; families will benefit by preventing injury or death of a family member. There is no cost to the State with the passage of this legislation because social workers already pay for their continuing education.

Ms. Humphrey stated that there are approximately 6,000 social workers in Kansas. The Departments of Social and Rehabilitation Services and Aging, as well as other agencies, support this legislation.

The suggested amendment language to **SB 31** was attached to her testimony.

Ms. Humphrey addressed the following questions:
Q: Are you aware if are there any indications given to the students of the dangers they could encounter as social workers?
A: There are discussions about safety issues in the field, but it's not a designated topic, just part of the education process.
Q: If the murdered individual had been offered the safety training early in her education, how far into her career was she?
A: She was in her second year of a masters in social work. She was working as a student caseworker, not a licensed social worker.
Q: Is there a way to get something at the educational level, before they get out of school and before doing an internship, having some awareness made regarding the safety issues?
A: It has been discussed. Universities are proprietary about setting their curriculum, and everyone is aware of the safety issues; Regents are aware of **HB 2118**, the companion bill to **SB 31**, and they think it's a great idea, but emphasis has not been made on it at the university level.
Q: Could the Kansas Chapter plan each year a reception for those social worker students and have safety training as part of the topic to bring attention? It could also be a good way to promote membership in the association.
A: Yes that could be a good idea.
Q: As an intern, would they be by themselves with a client, or have someone with them?
A: They could be, but are closely supervised. Internship is toward the end of their practicum.
Q: Could they work before they get their license?

A: No
Q: Explain the difference between a caseworker and a social worker. The person killed was a caseworker; are we not addressing caseworkers?
A: Some agencies, like community health centers, have jobs that require licensing as a social worker, but also have jobs likened to a paraprofessional, not requiring licensing. A non-licensed person doesn't have another body that they are accountable to like a licensed social worker would be, they don't have licensing fees, or educational requirements.

Comments from Committee members included the following:

- The association for social workers has that responsibility to notify the university/faculty about the safety training issue.
- Education needs to be more than just a discussion, but maybe should be taken to the National Board to be a part of the education.

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The briefing was closed on **SB 31**.

The next meeting is scheduled for March 4, 2010.

The meeting was adjourned at 5:00 p.m.

HOUSE AGING & LONG TERM CARE COMMITTEE

DATE: 3/2/2010

NAME	REPRESENTING
Steve Hatlestad	AmeriCare/KHCA
Harold J. Fowler	Village Villa, Inc — & KACE

Please use black ink

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

Disability Rights Center of Kansas
635 SW Harrison St. • Topeka, KS 66603
785.273.9661 • 785.273.9414 FAX
877.335.3725 (toll free TDD) • 877.776.1541 (toll free voice)
www.drckansas.org • info@drckansas.org

TESTIMONY TO THE HOUSE AGING AND LONG TERM CARE
HOUSE BILL NO. 2673
February 25, 2010

Thank you for the opportunity to speak before you, my name is Nick Wood, I am a disability rights advocate at the Disability Rights Center of Kansas. The DRC is a public interest legal advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. As such, DRC is the officially designated protection and advocacy organization for Kansans with disabilities. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of state government and whose sole interest is the protection of the legal rights of Kansans with disabilities.

We understand the bill would help maximize financial resources available to Kansas. The DRC supports the bill, and we also want to advocate further that revenue generated also be allocated to our state's Home and Community Based Waiver programs. We advocate that at least 20% of the dollars gained through this procedure to be allocated to all of Kansas' Home and Community Based service programs.

It only makes sense to include the HCBS Waiver programs as a target for any extra revenue. Kansans with disabilities who need these programs are forced to wait for services and supports. The current "freeze" on services for the HCBS physical disabilities Waiver and the more than 3,000 children and adults with developmental disabilities who must wait to receive services are critical concerns. Additionally, we are concerned about the level of funding for all HCBS Waiver services (frail elderly, children with autism, those with traumatic brain injuries, children with mental health needs, etc.). Waiting lists are bad for people with disabilities, bad for taxpayers and bad for Kansas. If services are not provided in the community, then people will be forced to be served in more expensive, and often times "entitled," institutional care settings. Community-based services are upwards of four times LESS expensive than their institutional counterparts. Cutting community based services and creating waiting lists only harms people with disabilities and seniors and costs taxpayers more in the end.

Tom Bell
President and CEO

TO: House Aging and Long Term Care Committee

FROM: Tom Bell
President

Chad Austin
Vice President, Government Relations

DATE: February 25, 2010

RE: House Bill 2673

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of House Bill 2673, which establishes the nursing home provider assessment program.

As many of you know, the Kansas Legislature passed a hospital provider assessment program during the 2004 session. That bill was the result of much discussion and attempted to address the chronic underpayment of Medicaid providers. As we considered the situation, we realized there were really only two choices. First, we could do nothing and continue to watch Medicaid rates erode as a percentage of what it costs to deliver the care. Or, we could be more proactive and attempt to develop a program that holds some promise of helping the state to solve the Medicaid reimbursement dilemma. We had numerous discussions with our board and membership and ultimately determined to follow the latter course. In its simplest terms, our hospital assessment program established a system whereby hospitals in Kansas would be assessed a certain amount of money for the purpose of generating additional federal matching funds to be used to increase Medicaid reimbursement rates for hospitals and physicians. In our opinion, this program has been successful thus far.

We also had the benefit of working closely with legislative and executive leadership to craft our proposal. The program that we put together was truly a partnership between hospitals and the state. It was essential that any program we developed would need to ensure that the resources of Kansas hospitals and the communities they serve would be used to improve the health care system in a fair and equitable manner. In order for us to accomplish this, we identified several key provisions that would need to be included.

- The assessment rate and base need to be specified in the statute.
- The program must have a formal agreement between the State and any providers assessed.

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- To the extent permitted by federal regulation, assessment funds need to be returned to the providers in the most expeditious manner possible.
- The assessment and increased hospital payments must terminate if either is not eligible for federal matching funds.
- The increased provider payments financed by the hospital assessment must be required by the statute and an efficient and equitable mechanism to determine the specifics must be included.
- There must be a requirement for independent auditing of the program.
- There must be "maintenance of effort" by the state to prevent the diversion of new funds for other purposes or to supplant existing state funds.

While many of these provisions are addressed in House Bill 2673, there are still many "unknowns". It is difficult for any provider to "support" or "oppose" a provider tax program in absence of the assessment rate being known. In addition, these programs simply do not work as well without virtual unanimity of those being assessed. Providers should have the opportunity to determine how this program would impact not only their industry, but also their individual facility. Thus far, the provisions of House Bill 2673 do not allow this. We would encourage that all details be resolved prior to further advancement of House Bill 2673.

Thank you for your consideration of our comments.

KAHSA

creating the future of aging services

To: Chairman Bob Bethell and Members,
House Aging and Long-Term Care Committee
From: Debra Harmon Zehr, President
Kansas Association of Homes and Services for the Aging
Date: February 25, 2010

TESTIMONY IN OPPOSITION TO HOUSE BILL 2673

Thank you, Chairman Bethell and Members of the Committee.

The Kansas Association of Homes and Services for the Aging (KAHSA) represents 160 not-for-profit nursing homes, retirement communities, hospital long-term care units, assisted living facilities, senior housing and community service providers who serve over 20,000 older Kansans every day.

The State is facing serious budget trouble. One of the major problems facing the Legislature and Administration is how to adequately fund Medicaid. House Bill 2673 is being portrayed by some as the "only way" to restore Medicaid funding for nursing home care.

We do not agree.

We have not given up on the Legislature's ability to find a better way to restore Medicaid funding, not only for nursing homes, but for mental health centers, community-based service providers, hospitals and other Medicaid providers. Priorities can be re-examined. Revenue enhancements, as set out by the Administration or by other means, can be considered. It will be difficult work, but it can be accomplished. It is not time to take the "easy way out.

House Bill 2673 is bad public policy because:

1. Caring for the poorest of our citizens is a societal obligation that has historically been funded through broad-based taxes. House Bill 2673 is a profound and fundamental departure from that social contract.

2. There have to be losers. The federal authorities consciously designed their regulations to discourage the use of these taxes, through built-in features that penalize some residents and/or homes. There will be nursing homes that pay more in the tax than they get back.

   Some proponents have tried to shrug off the "losers" because they have relatively few residents whose care is paid for by Medicaid. Some of these providers are this way because they deliberately help their residents avoid Medicaid dependency through pre-planning and supportive housing and services. Some, because they concentrate on meeting the need for high acuity rehabilitation care in their community. Some, because there just aren't very many Medicaid-dependent people in their service area.

3. In Kansas about 37% of nursing home residents pay their own bill. Even if House Bill 2673 tries to obscure it by prohibiting a separate line-item in resident's bills, there will be nursing homes that increase rates because they cannot simply "absorb" the tax.

785.233.7443
kahsainfo@kahsa.org
fax 785.233.9471
1247 SE 8th Avenue
Topeka, KS 66603-3906

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Individuals and families who have scrimped and saved and are struggling to pay for their own nursing home care in old age will bear this additional cost. House Bill 2673 will not only penalize these people for exercising personal responsibility... it will put them at risk for premature reliance on Medicaid.

4. While there have been efforts to craft the bill so that damage to providers and nursing home residents is minimized, there will be strong pressure in coming years to change its provisions, to increase the tax and/or to use the money for other things. This has been a common occurrence in other states. Even here in Kansas, where there is a hospital provider tax, hospitals were not spared the recent 10% Medicaid cut.

I would like to offer an additional caution: There has been no accurate modeling on this bill so far. No one knows its facility-specific impact or how much the tax will be, not even the Department on Aging. I urge this Committee to insist on getting definitive, accurate numbers, so you can understand the impact and so you can make an informed decision.

In closing I would like to tell you about Mr. Scott, a friend of my family, who is not unlike many residents of Kansas nursing homes who manage to pay their own bill. He and his wife were educators. They lived below their means, paid their taxes, and saved all their lives for retirement so they would be able to pay for their own care in old age. Mr. Scott lost his wife to cancer before they were able to enjoy retirement together. He will turn 86 this summer. Today, despite suffering from diabetes, severe arthritis, cancer, incontinence and early dementia, Mr. Scott maintains a positive outlook on life. He has fallen three times in the last year. He needs assistance with most of his activities of daily living. The Kansas retirement community he calls home has been a godsend for Mr. Scott and his family.

I cannot fathom trying to explain to Mr. Scott that his nursing home bill is going up as much as $3000 or more a year because the Legislature couldn't find another way to fulfill their responsibility to properly fund Medicaid. He would be confused and upset, as would his family.

Mr. Scott, and many others like him, cannot speak up for themselves. I hope the Legislature will do what it takes to fund Medicaid without passing House Bill 2673, and without burdening Mr. Scott and others like him.

Thank you. I would be happy to answer questions.

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

Testimony Presented to
The House Committee on Aging and Long Term Care
Representative Bob Bethell, Chair

Requesting Consideration of Amendments to HB 2673

By
Mike Oxford, Executive Director
February 25, 2010

The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization. Our mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC has been providing cross-age, cross-disability advocacy and services for over 30 years to people with disabilities across the state of Kansas. Our agency has been particularly interested in and committed to assuring that people who require long term care services have access to information, services and supports that offer choices; choices that promote freedom, independent lifestyles and dignity, including the dignity of risk.

We believe that over the years, the State of Kansas has increasingly come to support these interests, as well, as evinced by increasing the number of home and community program options and by increasing the funding for these programs. At the same time, there has been a significant struggle to continue to find the budgetary resources necessary to fund both the facilities and the home and community alternatives to facility-based long term care services.

SB 546 proposes a method for increasing revenue dedicated to long term care services that would be new to Kansas. This funding mechanism is based on the nursing facility census and has been used by many states over the years to increase funding for the nursing facility industry. Some of the states that have utilized this method have also been very creative in demonstrating leadership in the development and delivery of home and community services and supports. This method not only raises the targeted revenue, but by having and using this kind of direct revenue, these states have also been able to avoid additional costs to the general revenue and have been able to use this "cost savings" to further fund creative home and community service options. Other states have raised billions of dollars through a similar fee. In tight budget times, shouldn't we be looking for ways, especially tried and tested ways, to raise revenue for the growing demand for long term care services?

The need for assuring the availability and quality of long term services and supports exists in all settings, from the facility to home and community. SB 546 offers a resource for skilled nursing facilities to promote quality assurance activities and to replace lost funding. TILRC proposes amending the bill so that 20% of the amounts collected from the proposed fee would go to home and community-based services and supports for individuals who otherwise qualify for nursing facility level of care. This proposed amendment is in keeping with our support for SB 585 of the Session of 2008. We believe that the resources derived from a quality assurance fee based on nursing facility census counts should be committed to home and community services that are an institutional equivalent. Currently, this means the FE and PD Waivers.

We think our amendment underscores the state's commitment to assuring that people have choices in long term care services. Our amendment is part of a long tradition in our state of supporting independence and dignity of long term care service recipients. Finally, we hope that our amendment is part, along with the MFP grant project, of a new beginning addressing the potential of nursing facilities working together with home and community agencies to create the seamless, quality long term service and support system that out state's consumers deserve.

Proposed amendment is in *italics, below:*

Sec. 1.(d)(4)*(G) 20% of the moneys in the fund shall be used exclusively for the following purposes:*

(1) equitably fund PD and FE Waiver covered services;
(2) restore service cuts and remove service caps implemented January 1, 2010
(3) restore the Medicaid rate reductions implemented January 1, 2010, including enhancing wages of attendant workers under self directed programs;
(4) restore funding up to 2008 levels for fiscal year 2010;
(5) equitably fund PD and FE Waiver quality assurance activities
(6) The remaining amount, if any, shall be expended for quality enhancement and improvement activities of the PD and FE Waivers

TILRC also would support a direct tax on in-home services providers to be used for the same purposes as above. This would seem to make the most sense. The problem is that such a tax is likely to be disallowed, as in the case of Missouri. Missouri's attempt to assess an in-home services provider tax was not approved by CMS. Perhaps in the future, an approved method will be promulgated. In the meantime, the PD and FE Waivers and the nursing facilities are serving a population that is, to a certain extent, shared. Why not also share efforts to enhance quality assurance and protect good services by replacing lost funding; whether an individual chooses facility-based or home and community-based services?

INDEPENDENCE
INCLUSION
INNOVATION

INTERHAB

February 25, 2010

TO: Rep. Bob Bethell, Chair and Committee Members
House Committee on Aging and Long Term Care

FR: Tom Laing, Executive Director, InterHab

RE: Testimony in support of House Bill 2673

Thank you, Mr. Chairman, and members of the Committee, for today's hearing.

Support Provider Assessment Legislation: Our organization supports the position of the Kansas Health Care Association regarding House Bill 2673.We applaud the efforts of the bill's authors to establish an assessment on skilled nursing facilities to help the State provide a more adequate and reasonable financial foundation for these programs. We believe this approach is sensible, defensible and necessary.

Consider Provider Assessment-aided Financing for DD Waiver: Our community developmental disability services are not addressed in this bill, but we believe it important to establish the basis for such an approach, to take a necessary first step for Kansas to employ this funding methodology. Many states have achieved major benefits from the use of provider assessments, and we should do so as well. We will encourage and support similar legislation for the community developmental disability waivers, and other waivers which have languished during this period of budget retrenchment.

Quality Services Rely in part upon an Adequately Financed Workforce: We appreciate that this proposal establishes a "quality assessment fund" to help finance quality services. We have too often witnessed an approach to human services that limits budget growth to caseload growth, without a recognition that good stewardship in the human service arena allows for the costs of services to be upgraded as needed. For human service care providers, the key component of quality services is the ability to rely on a consistent work force which is well trained and experienced. Without adequate resources to sustain a consistent work force, quality is the first casualty. Good management of human services can only go so far in assuring quality. Good managers depend on a quality workforce for the effectuation of quality service principles.

Next Steps to be Taken: There is current activity underway among legislators and community service leaders to address this same financing approach for the Medicaid HCBS waivers. We appreciate the willingness of this committee to take these additional matters under advisement in the coming weeks, and look forward to working with you to expand the concept in this bill into other programs as well.

Thank you for your thoughtful consideration of this legislation.

HOUSE AGING & LONG TERM CARE
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KANSAS HEALTH POLICY AUTHORITY

February 25, 2010

House Aging and Long Term Care
Testimony on HB 2673

Andy Allison
Executive Director
Kansas Health Policy Authority

Mr. Chairman and members of the committee, thank you for allowing me to testify about the proposed nursing facility assessment.

The bill as proposed would authorize KHPA to seek federal approval to assess a per bed fee on nursing facilities. This fee or assessment would be paid by the nursing facilities to KHPA on a quarterly basis. KHPA would match the assessment revenue with federal Medicaid dollars to increase payments back to the facilities. The bill requires additions to rates that would restore the 10% payment reduction in the Governor's allotment, to rebase the nursing facility rates based on the existing state plan, to pay the administrative cost of the assessment, and to make other improvements in the quality of care provided. The rate changes would require approval from the Centers of Medicare and Medicaid Services and would have to meet several requirements for provider assessments and rate setting described in regulations. In our experience, the approval process will take between 9 and 12 months.

Over the past 18 months, the KHPA Board of Directors has discussed the implementation of a nursing facility provider assessment as a means to maximize Medicaid dollars for Kansas. The Board also considered the opposing views on the merits of such a tax as presented by the two nursing facility trade associations: the Kansas Association of Homes and Services for the Aging; and the Kansas HealthCare Association. In November 2008, the Board determined that a workgroup be convened to develop an impact analysis and implementation options for a nursing facility provider assessment. The Board also agreed that the following objectives should be met for such a proposal: a) compliance with the Center of Medicare/Medicaid Services policies; b) the proposal would be data driven; c) sister state Medicaid agencies would be supportive; and d) the proposal would align with KHPA goals to improve access and quality of care. The Nursing Facility Technical Assistance Workgroup, led by the Department on Aging, convened in early 2009. A final report and analysis was presented to the KHPA Board in November 2009. After further discussion at the January 2010 Board meeting, it was clarified that the Board was being asked to accept the technical composition of the analysis but would not be taking action to advance this assessment forward. The Board then voted to Receive the Final Report as prepared by the NF Technical Assistance Workgroup in January 2010, We have provided copies of testimony that our Board Chair, Joe Tilghman, provided to the House Appropriations Committee describing the process the Board carried out to review nursing facility assessment options.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

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KHPA, as the single state Medicaid agency, would be responsible for overseeing the approval process for the nursing facility assessment. The bill gives KHPA the responsibility to get the assessment through the federal approval process, assess the nursing facilities, collect the money, and work with the panel created by the bill to oversee the distribution of the money. It is within our scope of responsibility to determine if the assessment is consistent with federal rules and provide support to the approval process. However, we have delegated responsibility for the nursing facility program to the Kansas Department on Aging (KDOA). Staff at the KDOA have regular contact with nursing facilities and perform the entire process to set rates under the current Medicaid state plan. KDOA is in a much better position to oversee the direct processes of charging and collecting the assessment and following the process for calculating new nursing facility rates. This is consistent with the current relationship between KHPA and KDOA. The fiscal note prepared for the bill was done in concert with KDOA and reflects the additional staff and resources needed by either agency to implement the provisions of SB 546. If the staff and funds are approved for KHPA, we intend to transfer the positions and funding to KDOA to have the assessment administered by the agency with the most direct responsibility over that part of the Medicaid program.

One final comment about the bill as proposed is a potential issue with the drafted bill language. In subsection (d)(5) on page 3, line 30 of the bill would require that the increased rates should "first be made to reimburse the portion of the assessment imposed." One of the federal requirements for a provider assessment is that a provider can not be held harmless from the imposition of a tax or the effect of a tax. CMS may interpret that line of the bill to mean that the state intends to ensure that each provider gets all of their tax payment back before any other payments are made. This is by definition a hold harmless and would not be approvable. KHPA would suggest that this section be removed from the bill.

Thank you for accepting my testimony and I would be happy to answer questions.

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KANSAS HEALTH POLICY AUTHORITY

House Appropriations Committee
Consideration of the Nursing Home Provider Tax

October 12, 2009

Joe Tilghman
Chairman of the Board
Kansas Health Policy Authority

Chairman Yoder and Members of the House Appropriations Committee:

My name is Joe Tilghman. I am a retired federal employee with 34 years experience working with the Medicare and Medicaid programs at the federal level. I am currently the chairman of the Kansas Health Policy Authority Board.

I am here this morning to testify regarding the consideration of a Nursing Home Provider Tax in the Kansas Medicaid program.

This issue has been simmering in Kansas for a number of years, and rather than simply walk away from it, the KHPA Board chose to look at it earlier this year. We felt this was appropriate in light of the current budget problems confronting the State and the possibility of this becoming a source of additional federal revenue to the State.

In the way of background the most current data I have shows that 41 states have one or more forms of a provider tax in place for their respective Medicaid programs:

- 30 have a nursing home tax
- 18 have a hospital tax (including Kansas)
- 22 have an ICF-MR tax
- 14 have an HMO tax

Workgroup

We convened a workgroup to look at this issue about six months ago. It is chaired by myself and the Secretary of the Department of Aging, initially Secretary Greenlee, then Secretary Kennedy after her departure. It

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includes representatives from both the for-profit and non-profit state associations, as well as the Medicaid waiver community. Staff from KHPA and KDOA also participate. All meetings have been open to the public.

The purpose of the workgroup was to determine what a nursing home provider tax should look like in the State of Kansas if the legislature and Governor decide to consider this revenue source as a way to mitigate the current budget shortfalls.

To be clear: the Board is not necessarily endorsing such a tax, but rather putting forward an option that we feel is a good model for such a tax if the legislature and Governor choose to go this route.

If we do put forth such a model, it will be a product of the KHPA Board. As such it will be a non-partisan product and will not represent any consensus from the workgroup members, but only the consensus of the KHPA Board.

Workgroup Criteria

While we are not looking for consensus from the participants, we did want to hear their concerns and, where possible, address these in the modeling. By informing ourselves of their concerns we hope to mitigate as much as practical any adverse impact on residents or providers.

The model we will put forth must be approvable by the federal government, i.e., CMS.

The model must meet the policy goals of KDOA, which has the program lead in this area; however, we will not ask KDOA or the Governor's Office to endorse the model although they are welcome to do so. We will not put forward a model that KDOA objects to from a policy viewpoint.

The model should provide savings in State General Funds if practical.

Where we are today

The KHPA Board reviewed two possible models at our September 15 meeting and directed the workgroup to help blend these two models for presentation of a single "final" model for consideration at our November 17 meeting. (There is no Board meeting in October.) The workgroup is meeting this afternoon to review the blended model.

My best guess is that the KHPA Board will forward a suggested model to the legislature following its meeting on November 17.

I can't give you any specifics right now on what this model will look like; however, I can lay out in very broad brush strokes what it will likely accomplish as well as the primary pros and cons of adopting it. Keep in mind, I can't really get "into the weeds" because both the workgroup and the Board have yet to weigh in on the blended model.

I'm going to do this in three pieces. The first piece will lay out in very rough terms the likely trajectory of nursing home payments in the Medicaid program if nothing is done in terms of adopting a provider tax. The second piece will lay out the "pros" of adopting the likely model. And the last piece will lay out the "cons". Keep in mind, at this point these are my personal views and that other parties may present a different perspective .... and that this is still very much a work in progress.

What the world will likely look like if we do nothing

Secretary Kennedy can provide you a better glimpse into the crystal ball in this area, but in very broad terms my understanding is that the Medicaid rates for nursing homes were frozen last year due to budget concerns, and could be at risk again this year. KDOA estimates that an inflationary adjustment for Medicaid payments to nursing homes would cost around $16 million in SFY 2011 (about $6.5 million in SGF).

Increases in funding for the Home and Community Based Services Waivers for the frail elderly and developmentally disabled are also at risk.

This will probably not lead to access problems in nursing homes, but could cause some problems (such as waiting lists) in the waiver programs. The world doesn't fall apart, but it certainly doesn't get better … and it will likely get a bit tougher for providers and some waiver recipients.

The nursing home and waiver programs will essentially be "on hold", with no new initiatives to improve quality, reduce the number of unused beds, or expand (or possibly even maintain) the number of people using the waivers.

PROs of a Provider Tax

1) The model will likely generate at least $16 million in revenues from the nursing home tax itself. This, in turn, will generate another $24 million in matching federal funds, for a total of about ***$40 million in new Medicaid funds*** – and this will be done at no cost to State General Funds.

The option we put forward will likely propose that 80 -85% of this funding be returned to the nursing home community. This means that in return for the $16 million they pay in the new tax, they get back between $30 – 34 million. Roughly double what they put in. The Secretary of Aging would have final responsibility for how this funding would be used, but it would likely go towards inflationary adjustments in the Medicaid rates and to drive quality improvements. We also anticipate that the Secretary of Aging would consider input from an advisory council in coming to his decisions regarding the use of these revenues, and that this advisory council would look a great deal like the workgroup we've been dealing with for the past six months.

The remaining balance, $6 – 10 million would be directed to the HCBS waiver programs.

2) The model will ***meet the policy goals of KDOA*** in three ways:

A. By taxing certified beds it will encourage providers to reduce the number of unused beds in the state. This will result in long term savings in health costs.
B. It will provide a means to promote quality improvements in nursing homes using incentive payments.
C. It is designed in such a way as to encourage providers to accept more Medicaid residents.

3) The model will provide a new revenue stream to ***fund the appropriate inflationary adjustment in Medicaid payments to nursing homes*** which entails a total cost of approximately $16 million. Absent the nursing home tax, this adjustment would either not take place due to budget constraints or, if implemented, would cost $6.5 million in SGF. Additionally the model would provide $5 million to drive quality improvements in nursing home care.

4) The model would provide ***$6 – 10 million in new funding for Home and Community Based Waiver services*** for the elderly frail and/or developmentally disabled. Absent this funding these services will likely be cut or held at current levels. Depending on how these funds are used it could save $2.5 – 4 million in SGF or

expand the use of these services without the use of any additional SGF..

5) We can give you a 99% assurance that any model we put forth ***will be approvable by CMS***. However, we will also caution that such approval goes through some very hard scrutiny and that any tinkering with the model may jeopardize its approval by CMS. That's not to say you can't tinker with it, but to strongly suggest that you involve the experts in KDOA to make sure any changes will, in fact, be allowed. As an aside, from the viewpoint of an old fed, I've been very impressed with the expertise KDOA has in this area.

CONs

Now to switch to the downside of the model.

1) The "for profit" nursing homes will likely support the new tax, as will the waiver community (although the waiver folks will likely be more supportive if they receive 20% of the funds rather than 15%). However, the "non-profit" nursing homes will likely continue to oppose any such tax. They have expressed two general concerns during our meetings:

A. Some nursing homes may have to raise their rates to private pay patients since they would like to charge private pay patients less than the Medicaid rate. This is a valid concern, although it is important to note that the option we are developing with the help of KDOA staff allows some of the increases in Medicaid rates to be exempt from the the rule that Medicaid must be lowest payer, and

B. There will be winners and losers, with the losers being those homes with small Medicaid populations. Federal laws for health care taxes virtually require that there will be some losers. I would add that KDOA staff have worked pretty hard to assure that there are many more winners than losers, and that those losses are minimized.

2) There are still details to work out as to how to structure incentive payments to promote quality improvements and there is a question as to whether we are putting enough money on the table to really drive quality improvements. Personally, I'm not too concerned about this and feel confident we can work something out. There are lots of options out there – and whatever we do is going to be better than doing nothing to promote quality care.

Summary

The state has wrestled for years with the concept of a tax on nursing homes. If this were an easy choice, the state would have moved forward long ago. The state's success in providing home and community based services helps lower the role of Medicaid in financing nursing home services, and this may make these sorts of taxes a little more difficult. Clearly there are at least some trade-offs involved in a nursing home tax, and the KHPA Board acknowledges those trade-offs. However, in a year in which state funding for health care services will be at risk, we felt it was important to put options on the table that might help fill the gap.

Our plan is to complete work on an option and present it to the Legislature and the Governor for consideration. We will not promote the option, but I'm sure our staff and KDOA's staff will be available to support the process and to make sure you have the information you need.

This concludes my testimony and I will be happy to stand for questions.

Kansas Advocates for Better Care

"Advocating for Quality Long-Term Care" since 19[illegible]

February 22, 2010

House Aging and Long-Term Care Committee
Chairman Bethell, Vice Chairman Hill and Members of the Committee

Thank you for the opportunity to present testimony on HB 2673, which would provide for assessments on nursing facilities. I regret that I am not able to present this testimony in person, after having worked over the past 18 months with KHPA, KDOA, KHCA, KAHSA, SILCK, and other interested parties to craft possible models and implementation strategies for a provider tax.

Kansas Advocates for Better Care (KABC) is a non-profit organization, founded in 1975, to speak-out on behalf of elders and adults living in Kansas nursing homes. KABC is made up of members and volunteers across Kansas whose goal is to improve the quality of long-term care in Kansas. It is to that end that we provide testimony today.

Kansas Advocates for Better Care is neither endorsing nor opposing HB 2673 and its companion bill SB 546. Our testimony today is for the purpose of raising a few crucial issues on the impact of the proposed legislation and a few suggestions for improving impact for residents.

This assessment legislation, if passed and implemented, would likely result in an increase, either wholly or in part, in the amount private pay residents will be charged for care by nursing homes. The private pay residents will see their resources dwindle more quickly. If they reside in a facility that will not receive federal matching dollars due to non-Medicaid participation, or will receive a proportionally smaller amount than the facility pays in due to small Medicaid participation, those persons may actually see their care decline. On the other side, the portion of KABC's population who reside in Medicaid certified facilities might see improvements to their care.

Kansas Advocates would respectfully request your consideration of several important issues related to the proposed legislation.

- Over the past year, 132 nursing homes were cited for Abuse, Neglect or Exploitation. This represents 40% of nursing homes, out of the just over 300 nursing homes in Kansas. Although the legislation refers to this as a "quality care assessment," **nothing in this legislation provides assurance that residents will receive quality or improved or better care.** The assumption is that if more funding is provided it will be used to maintain or improve the care that residents receive, but there is NO assurance of that in the provisions of this legislation.

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913 Tennessee Suite 2 Lawrence, Kansas 66044-6904
phone: 785.842.3088 fax: 785.749.0029 toll-free: 800.525.1782 e-mail: info@kabc.org website: www.kabc.org

2) Nursing homes receive reimbursement on a cost basis. This presumes that they are reimbursed for the cost of care. Nursing homes did not receive an inflationary cost adjustment for this fiscal year and they received a 10% reduction in their Medicaid reimbursements beginning January 1, 2010. Depending upon the amount of the assessment, most nursing homes stand to recoup from this tax more than what they have lost. Referencing the bill, Section 1 (d) (4) (F) "The **remaining amount, if any**, shall be **expended for quality enhancement of skilled nursing care facilities,** but shall not be used directly or indirectly to replace existing state expenditures for payments to skilled nursing care facilities for providing services pursuant to the state Medicaid program." This language provides no direction that mandates improved quality of care to residents and implies that quality is an afterthought…should there be funds left over.
★Prior history informs this concern. A few years back, the legislature provided for funding to enhance direct care staff wages, the funding went to providers but in many instances was not actually utilized in the manner intended by the legislature to enhance wages but only to supplement anticipated annual increases.

3) Nothing in this legislation promotes long-term care delivery in less expensive settings, such as providing care to persons in their homes through Home and Community Based Services. Care at home costs less and is what elders and persons with disabilities overwhelmingly choose when asked where they wish to reside and to receive services. Monies from this assessment could in fact go to nursing homes for the intent and purpose of diversifying the long-term care services that they could offer in the nursing home and in the community.

   Including diversification provisions in this bill would:
   - address consumer desire to remain at home as long as possible;
   - expand access to health care services that diversified nursing homes could provide to communities, especially in rural areas;
   - reduce the consistently increasing dollars required to fund nursing home care; and
   - stabilize or expand employment opportunities in communities across Kansas. A significant issue for the health of Kansas communities and the state's revenue stream.

   There are a few forward-looking nursing homes in Kansas who have already chosen to diversify their long-term care offerings to include home and community based services.

4) If private pay residents are required to pay a higher price for their care to off-set the cost of the assessment, how will that accelerate the spend down of their resources, and push them onto Medicaid rolls for payment of their care? KABC has raised this question numerous times previously when this assessment was discussed or legislation proposed, but to date we have not seen any projections that would address it.
   The assessment rate is not yet set, but could be as much as $2,500 annually. Kansas has a demographic of 85+ year old citizens that is large and growing. This is the demographic most likely to need nursing home level of care. Therefore, the question raised above seems a prudent one to anticipate the impact. Many residents of nursing homes have siblings and children who are already contributing financially to the cost of loved ones nursing home care. Given the current difficult economy will they continue to try to privately fund care or choose to apply for Medicaid if faced with a significant increase?

5) One other thought, Ohio uses <u>all</u> the money from their "provider assessment" to fund their long-term care ombudsman program, ensuring that all persons receiving long-term

care, whether in a nursing home, assisted living, or personal residence, has access to an authorized and independent advocate/mediator. Our current ombudsman program is understaffed by two regional ombudsman based upon the National Institutes of Health report which sets the standard of 1 ombudsman for each 2,000 residents. In addition, the long-term care ombudsman does not serve persons living in nursing homes for mental health, developmental disabilities treatment settings or those who receive long-term care in the community.

Should the Committee find value in the provider assessment bill, Kansas Advocates for Better Care would strongly urge and encourage the members to include language that would actually establish quality improvements for residents in Kansas nursing homes and/or which would improve the quality and cost of long-term care provided through home and community based services in the person's home or other place of residence.

Possible options for improving quality for residents in nursing homes:

A. Provide reimbursement for an increased ratio of direct nursing care for residents. National research reveals that increased direct nursing care is one of two top indicators for resident wellness & well-being. The current required standard in Kansas for direct care nursing is an average of 2 hours of nursing care per resident per day. Many nursing homes provide more than the minimum, but few if any provide the 4.13 hours of direct nursing care per resident, per day, recommended by federally funded long-term care reports. Nursing staff who provide care include RNs, LPNs, Certified Nursing Assistants (CNAs) and Certified Medical Assistants (CMAs).

B. Funding for Restorative Care provided to residents by direct care workers under the supervision of a qualified restorative care provider and that would keep residents at the highest level of practicable functioning.

C. Reimbursement to facilities that improve care through implementing a combination of 1) consistent staffing on all shifts; 2) reduced usage of temporary/agency staff, and 3) increased direct care staffing for all residents. Staff who are knowledgeable about the residents for whom they are responsible, are able to better serve the resident's wants and needs.

D. Provide reimbursement for long-term care delivered through home and community based services either through nursing home diversification or reimbursement to other entities providing HCBS in the community.

E. Reimburse facilities for the 10% Medicaid provider reduction that were implemented January 1, 2010.

Thank you for your consideration of our testimony. I regret not being able to be present to present this testimony and stand for questions. I would be pleased to respond to any questions you might have.

Sincerely,

Mitzi E. McFatrich, Executive Director
Kansas Advocates for Better Care, 913 Tennessee, Ste. 2, Lawrence, KS 66044
785-842-3088 or mitzim@kabc.org

AMERICANS FOR PROSPERITY
KANSAS

February 25, 2010

Mr. Chairman and Members of the Committee:

On behalf of the nearly 40,000 Kansas members of Americans for Prosperity, I want to thank you for the opportunity to provide testimony in opposition to HB 2673.

This bill is the latest version of a provider tax on adult care homes, a rather large tax that could end up being up to 5.5 percent of revenues, which would be more than $4,000 per bed per year.

Regardless of the reason for introducing it this bill represents a tax increase, plain and simple. Residents of these adult care home facilities will incur an additional tax burden; it's evidently their reward for responsibly putting money aside for their later years in life.

To top it off the tax would not apply to homes owned by the State of Kansas, but rather, non-government owned homes would be subjected to the tax. What makes it even more convenient for the proponents and legislators that favor this tax increase is the language declaring "No skilled nursing care facility shall create a separate line-item charge for the purpose of passing through the quality care assessment to residents." How convenient for all involved, with the exception of course of the residents who are being taxed, let's pass a tax increase then do our best to cover it up. This is an insult to previous attempts this Legislature has made in the name of transparency of taxpayer dollars.

Medicaid spending now makes up 16 percent of our state general fund budget, a number that is expected to increase even more. We appear to be spending plenty on Medicaid, thus we should focus our efforts on evaluating current Medicaid programs to see what is and is not working before embarking upon yet another scheme to increase funding to programs whose effectiveness is still undetermined.

Sincerely,

Derrick Sontag
State Director
Americans For Prosperity-Kansas

2348 SW Topeka, Suite 201 ▭ Topeka, Kansas 66611
785-354-4237 ▭ 785-354-4239 FAX
www.afpks.org

Apostolic Christian Home

511 Paramount Street, Sabetha, KS 66534
785-284-3471 Fax: 785-284-3697

February 25, 2010

To: Chairman Bob Bethell and Members,
House Aging and Long Term Care Committee

PLEASE OPPOSE HOUSE BILL 2673

I want to thank you for allowing me to testify today before your committee. My name is Ed Strahm and I am the Administrator of the Apostolic Christian Home in Sabetha. We are a Continuing Care Retirement Community with the continuum of care from independent living to skilled nursing care. We have about 220 residents on our campus. Many of our residents in our nursing home, including my dad, have advanced to the point they can no longer care for themselves. They are among the frailest, most vulnerable members of our society.

In round numbers, our nursing home patient revenue is about $4.4 million dollars. Senate Bill 546 could translate into an annual tax on our home of $242,000, if it goes up to the federally permitted maximum – which is what the bill allows.

Since there have been no accurate facility-specific numbers on this new tax on nursing home care, no one really knows how our home will come out. Over the past several months I have seen different lists of "winners" and "losers." In some, Apostolic Christian Home is a "loser", in some we are a "winner." But how are Senate Bill 546 supporters defining winner? If the amount of tax our home pays is less than what we get in Medicaid restoration, then are we a "winner?" That is like saying that if a friend borrows $100 dollars and I pay him $40 to get it back, I'm a winner.

I am asking you to please consider other ways the responsibility of caring for our frail elders can be shared by our society as a whole - not by a relatively small, vulnerable segment of our society. Make sure you are making decisions based on accurate facility-specific data. Make sure you understand the burden this proposed tax will place on nursing home residents who pay for their own care, because we will have no choice other than to pass on the tax as a rate increase to them.

Again, I thank you for allowing me to testify here today, and I urge you to vote NO on Senate Bill 546.

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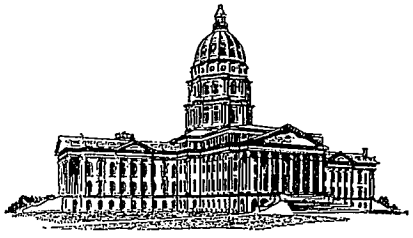
STATE OF KANSAS
HOUSE OF REPRESENTATIVES

STATE CAPITOL
300 S.W. TENTH STREET
TOPEKA, KANSAS 66612
(785) 296-7687
cindy.neighbor@house.ks.gov

10405 W. 52ND TERRACE
SHAWNEE, KANSAS 66203
(913) 268-9061
cindyneighbor@aol.com



CINDY NEIGHBOR
18TH DISTRICT

COMMITTEE ASSIGNMENTS
ENERGY AND UTILITIES
FINANCIAL INSTITUTIONS
HEALTH AND HUMAN SERVICES
INSURANCE

Thank you, Mr. Chairman, and members of the Committee. I have never stood before this Committee two times before in one year. Today, I am here because of HB 2118/ SB 31 which are companion bills tat address an issue that is very close to me.

Several years ago a social worker, whom I will refer to as Terry, made a visit to one of our students in their home to evaluate and work with the young high school youth. Unfortunately, the visit didn't accomplish the goal, and Terry was murdered under horrible circumstances during that visit.

Terry was a devoted social worker who had just begun her career and was also planning the rest of her life with her new husband. Terry had hopes and dreams and was committed to her job as a social worker to provide the best support and resources possible to each of her clients and their families. Unfortunately, there were two tragedies. The death of Terry and the youth who committed the crime, along with his family, brought concerns to the community and the Shawnee Mission School District.

I stand before you today to say that there is a solution that will better prepare and provide the knowledge and understanding for Social Workers working in the field if situations like the one Terry faced present themselves. I can't say it will eliminate all such possibilities, but I can say it will provide training for the awareness of the signs and how to defend and protect the individuals from such attacks.

For every Social Worker who has been trained, we have provided for a safer workplace and the ability for employers to have lower Worker Compensation premiums. Preventing injury or death not only saves money, but it is critical in keeping families stable.

The Social Workers I know are very dedicated and have heavy workloads. They care about all of the families they work with. They care deeply about the work they do and all of the individuals they come in contact with. The one thing we can provide them is the opportunity for safety training, which will protect them in their daily responsibilities.

HB 2118/SB 31 does not cost the State General Fund one dollar. It requires that 6 CEU's of the 40 required every two years be for safety training. I believe that is a small and much needed request if only for one life. Please make this happen for Terry and all the other Social Workers who care so deeply for our citizens. Give them the tools to be successful by passing this most important piece of legislation.

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Thank you for your time and I will stand for questions at the appropriate time.

Cindy Neighbors

NASW KANSAS CHAPTER ...the power of social work
National Association of Social Workers

TESTIMONY
HB 2118

March 2, 2010; House Aging and Long Term Care
Presented by Terry Humphrey

The language of SB 31/HB 2118 requires new social workers to have 6 hours of safety awareness training. Current law requires social workers to complete 40 hours of Continuing Education (CE) every two years to maintain their license. This legislation does not increase the number of required CE. It simply designates that six hours of CE will be on the topic of social worker safety awareness.

Policy Background

Social workers are frequently put in harms way while delivering professional services. Some clients are extremely vulnerable and may be prone to unexpected violence. The social worker's skill in calming a tense situation can prevent a client from lashing out. Safety training gives social workers the necessary knowledge and skills to prevent or handle violent situations.

Public Policy Benefits

Preventing violence will keep people safe and save precious resources. Social workers, employers, staff, clients, family members, and the State have a vested interest in a safe workplace. Safety training, as part of professional continuing education, is the way to achieve the goal.

- Employers will benefit. A safe workplace keeps Workers Compensation premiums low and from rising.
- The State will benefit. Preventing injury or death saves money. Death and injury claims, criminal prosecution and other services will not be utilized if social workers and their clients remain safe during their work together.
- Families will benefit. Preventing injury or death of a family member is critical in keeping families stable.
- There is no cost to the state with the passage of the legislation. Social workers are already responsible for their Continuing Education.

The attached amendment language addresses concerns in the original language of the bill. It clarifies that the CE is for safety awareness training and not martial arts training such as kung fu or other similar training.

Updated Amendment language:
On and after January 1, 2011, an applicant for first time licensure renewal as a baccalaureate social worker, master social worker or specialist clinical social worker, as part of such continuing education, shall complete not less than six hours of social worker safety awareness training. If the applicant has already taken such training, as part of a previous level of social work licensure renewal, then the applicant is not required to complete an additional six hours of social worker safety awareness training.

KNASW asks for favorable passage of the amendment and the legislation.

Jayhawk Towers, 700 SW Jackson Street, Suite 801, Topeka, KS 66603-3740
(785) 354-4804 • FAX: (785) 354-1456 • sky@knasw.com • www.knasw.com

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