

## MINUTES

### LONG-TERM CARE SERVICES TASK FORCE

April 7, 2003  
Room 313-S—Statehouse

#### Members Present

Representative Bob Bethell, Chair  
Senator Paul Feleciano, Jr.  
Senator Janis Lee  
Senator Chris Steineger  
Senator Susan Wagle  
Representative Patricia Barbieri-Lightner  
Representative Willa DeCastro  
Representative Jerry Henry  
Representative Nancy Kirk  
Representative Brenda Landwehr  
Representative Jim Morrison  
Representative Melvin Neufeld  
Representative Judy Showalter  
Representative Jerry Williams

#### Non-Legislative Members Present

Pat Maben  
Mark Baily  
Linda Lubensky  
Dr. Carol Moore  
Bob Smith  
Sister Beth Stover  
Janis DeBoer  
Margaret Zillinger

#### Staff Present

Mike Heim, Kansas Legislative Research Department  
Nikki Kraus, Task Force Secretary

#### Conferees

Janet Schalansky, Secretary, Kansas Department of Social and Rehabilitation Services  
Pamela Johnson-Betts, Secretary, Kansas Department on Aging  
Janis DeBoer, Deputy Secretary, Kansas Department on Aging

Chris Gianopoulos, Director, Bureau of Elder Services, Maine  
Roger Auerback, Rutgers Center for State Health Policy, Camden, New Jersey

**April 7, 2003  
Morning Session**

Representative Bob Bethell, Chair, called the meeting to order at 8:45 a.m., and welcomed everyone on the panel and in the audience to the meeting of the Long-Term Care Services Task Force. He explained that the Task Force had invited the members of both the President's Task Force on Medicaid Reform and the House Social Service Budget Subcommittee to attend the meeting. He reminded the Task Force members that this was their fourth year and that their responsibility was to look at long-term care issues in the broadest spectrum.

Chair Bethell introduced Representative Melvin Neufeld, Chair of the House Appropriations Committee. Representative Neufeld reminded the members that for the past three years, Senator Sandy Praeger had been either the Chair or Vice Chair of the Task Force, but that she was now Insurance Commissioner and because of other responsibilities, he would no longer be on the Task Force either. The new Chair and Vice Chair would be Representative Bethell and Senator Salmans, respectively. Representative Neufeld encouraged the Task Force to move forward with recommendations and reminded them that this was the fourth year in a five-year task force, so they are getting near making recommendations for the years ahead. He added that two other House members were also new to the Task Force: Representatives Jim Morrison, Chair of House Human Services Committee, and Patricia Barbieri-Lightner, Chair of House Insurance Committee. He concluded by welcoming members of the Appropriations Budget Committee for Human Services, including Representatives Henry, Williams, and DeCastro.

Representative Brenda Landwehr, Chair of the Social Services Budget Subcommittee, addressed the Task Force and explained that her House committee was responsible for the Department of Social and Rehabilitation Services (SRS) budget, the Department on Aging, and the Department of Health and Environment. This year, they focused on looking at what they can do with limited funds and the kind of policy changes that the state needed. Many of those ideas were similar to or the same as ones that had come before the Task Force in the past. She expressed enthusiasm for the possibility of implementing some of the recommendations and major policy changes discussed in order to benefit the individuals that the Legislature serves.

Chair Bethell introduced and welcomed Secretary Janet Schalansky, SRS. Ms. Schalansky said that long-term care is a growing area in the state as people live longer and those with illnesses, injuries, and impairments from birth need continued assistance. She noted SRS was the Medicaid state agency as required by federal law, and partners with the Department on Aging to manage a large part of the Medicaid program. She explained that within SRS they have created Community Supports and Services (CSS) to manage all the waivers in healthcare policy. She introduced Margaret Zillinger, Acting Director of CSS. After reviewing the types of waivers, Ms. Schalansky emphasized the growth of community-based waivers and said that SRS continued to try and find the right service at the right time in the right amount, and that she looked forward to working with the Task Force.

Pamela Johnson-Betts, the new Secretary of the Department on Aging, said that she had come with the intention of listening and learning, and she applauded the existence of the Task Force and hoped that they would be inspired to make recommendations for the efficiency and effectiveness of the long-term care program in Kansas.

Chair Bethell introduced Chuck Palmer from the Millbank Foundation and said that the Task Force appreciates his involvement with the State of Kansas; he complimented the Millbank Foundation, which has helped Kansas look at policies and move ahead on issues shared with other states. He noted Millbank helped to bring both Roger Auerback and Chris Gianopoulos before the Task Force. Chair Bethell said the Task Force would primarily be addressing the admissions into services and related areas of concern; when looking at reduced revenues, it would be important to note areas of increased efficiency.

Mr. Auerback introduced himself and spoke briefly about his background working as the Director of the State of Oregon Senior Disabled Services Division. He reviewed his present work with the federal government via the Centers for Medicare and Medicaid Services and said that under the President's new Freedom Initiative, states like Kansas have received money for community living grants. He outlined his current work with multiple states, including Kansas, and explained that he had moved from working full time in state government to working full time as a consultant for multiple states.

He presented information entitled, "Senior and Disabled Services Division Guiding Principles" (Attachment 1). This presentation addressed the development of a comprehensive long-term care system in Oregon, and although the information for the presentation was put together over two years ago, Oregon was still a good example of lessons learned about the transition from institutional care to community-based care. It was the Legislature of that state who decided to put into law the kind of service they wanted for the least cost and least confinement of individuals. This included the consolidation of funding streams such as the Older Americans Act, Medicaid for home and community-based services (HCBS), and the nursing home budget. They all became one budget under one agency with the goal of a more holistic view. In some states, there are sometimes conflicts between human services programs and licensing, so this consolidation helped Oregon to avoid those conflicts. A similar policy was set up for regulatory functions. Case managers at the local level were more able to determine what individuals needed to support informal care giving.

Following an outline of long-term care options, he emphasized the main strategies:

- Develop and coordinate needed health and other services to allow people to live as independently as possible;
- Develop affordable and accessible housing and transportation to allow people to continue living in communities;
- □ Foster preventative and chronic health care;
- □ Focus on quality care;
- □ Create state government structure which focuses on independent living for seniors and disabled;
- Help consumers stay healthy and better manage chronic diseases;
- Engage private sector in capacity development and secure local government partnership in service delivery;
- De-medicalize long-term care;
- Support family and other informal care giving; and

- □ Prevent inappropriate or premature institutionalization.

Mr. Auerback then reviewed a packet entitled, “State Nursing Home Level of Care Criteria” ([Attachment 2](#)). He said that if the State of Kansas wants to build something similar, family is the core; those without are the ones who really need the government’s help.

Chris Gianopoalos reviewed her experience as the Director of the Bureau of Elder and Adult Care Services in Maine since 1987. She advised the Task Force to take her comments as statements of what has worked for her state, rather than a recommendation for what Kansas should do. Back in the early 1990s, Maine went through a serious budget downturn similar to what they are experiencing right now, and nursing care costs were one area in which they had seen exponential growth. The three factors they considered modifying were: eligibility, reimbursement, and the kinds of services covered. Maine’s goal was to reduce reliance on nursing care and put those excess funds into more home and community-based care. Maine looked at changing eligibility, but did not feel that was a solution; instead, it focused on changing the level of care threshold as an entry point for change. The state focused on developing a more objective eligibility screening by contracting with an outside company. Ms. Gianopoalos explained that her department realized a special need for residential alternatives to nursing care if some people were going to be found ineligible for the latter. Although the state had listened to seniors and people with disabilities who were wanting alternatives to nursing care, it had to mend fences with families who were resistant and with whom the state had not spent enough time. The resistance came as a result of what had become an almost universal expectation in Maine: when the time came, families expected to be able to put their family members in a nursing home.

Because the eligibility threshold was based on needing nursing care and help with activities of daily living, many individuals with issues like Alzheimer’s or dementia were no longer qualified. To deal with these people, the state developed small residential facilities with 16-30 people, and they turned out to be better locations because generally, nursing homes are not well designed to serve people with dementia. Maine considers this an example of lessons learned by trial and error.

Ms. Gianopoalos explained that the best way to learn about anything was to try and change it. During the first two years of changes, there was a great deal of resistance from families and providers. Like other states, Maine had a well-developed nursing home system that assumed that these changes were temporary; however, from the state’s position, there was no money to continue the former system. Eventually, more forward-looking nursing home facilities began changing part of their facilities to lower-level care. This was important because not only did the state raise the threshold, but it reassessed cases once individuals were admitted, and after a certain time period, if they were better, told them they could go home or discharged them to lower levels of care. This reassessment was critical to the success of Maine’s efforts. Additionally, these policies have changed the culture of nursing home care because older people no longer see them as “lobster traps” that people enter and never leave; furthermore, nursing home staff deal with Medicaid residents differently now because they realize that many of those people will come in and then go home.

Maine’s program reforms remained intact because of an ongoing deficit for a few years that did not allow the state to back out, strong support from seniors and disabled individuals, and very good data. Ms. Gianopoalos directed the Task Force’s attention to a sheet entitled, “Long-term Care in Maine: Where are the People Receiving Services?” ([Attachment 3](#)). To address concerns about a lack of beds, Maine has taken a lesson from the State of Washington and begun participating in bed banking. The nursing home de-licenses the bed, but does not give it up; if the nursing homes need it, they go through a certificate of need process, but since the adoption of the policy in 1995, there have not been any requests to get beds out of the bank. After explaining the charts to the Task Force, she explained that Maine used to have a 100 percent nursing home occupancy with waiting

lists and people backed up in hospitals. She said that now families have more choice. In Maine, 72 percent of nursing home residents depend on Medicaid, which is higher than in Kansas; that was a major factor in Maine's decisions. In closing, she emphasized that each state has to come up with its own recipe and that there is no simple solution. Although nursing home care may not always be the solution, neither is home-based care a panacea, so there have to be options.

The Chair thanked the speaker and opened the meeting for questions for the two speakers.

Ms. Linda Lubensky asked what was going on with community-based services programs at the same time this was going on; she wanted to know if they were making changes in eligibility levels there, too, and what the waiting list was currently.

Ms. Gianopoalos said that Maine had to make changes in its community-based waiver threshold because it was tied to the nursing home threshold, but, interestingly, the number of people served on the waiver went up, not down. She speculated that this was because nursing homes were not in the business of informing people that they could receive the same services at home, and the state could not or should not have expected them to do so, so they did have to raise that threshold. Additionally, the entire system tied together eligibility, service level, and reimbursement to be based on acuity, so for programs with a low threshold of eligibility, the state would not authorize a high amount of service and would tend to pay less per hour for those services. She said that Maine had the regular mandatory Medicaid home health service, which they pay at the highest rate. It is generally limited to post-acute care and they offer service under their home and community-based waiver, as well as the personal care option under the Medicaid state plan. Like Kansas, Maine has a well established, state-funded home care program that pays for individuals who are not financially eligible for Medicaid, and that program essentially mirrors what Medicaid offers. The purpose in doing this is to keep differences between the programs transparent for the individual receiving them, in case they become financially Medicaid-eligible.

Ms. Gianopoalos stated that up until this year, Maine has operated its home-care programs with no waiting lists. It has managed its home and community-based waiver as an entitlement and has never operated that on a waiting list. Their theory is that if there is a waiting list for the service, they are going to go into a nursing home, which costs the state twice as much. By managing the program that way and being strict about what it allows for services, Maine has been able to increase the number of people being served in the system by 30 percent over the last seven years, and spending has only increased 17 percent, or about half of the national rate of increase.

Ms. Lubensky asked for clarification of the personal care option under Medicaid and whether that was under straight Medicaid or under waiver. Ms. Gianopoalos explained that it was under straight Medicaid and what Maine called a state-plan service, although she did not know Kansas' equivalent. Ms. Lubensky said that Kansas did not have it because they were always afraid of the woodwork factor. Ms. Gianopoalos said that was something to be afraid of if it was not managed well. She said that she had this conversation with people from other states when they looked at places like New York, where they are covering 24-hour care under their personal care option. She said if you want to spend a lot of money, then you can set it up that way, but if you do not, then you can set it up to make sure that you do not spend a lot of money.

Representative Barbieri-Lightner wanted to know if they had experienced a problem with being able to pay health workers enough to retain them and avoid the turnover problem that Kansas was experiencing.

Mr. Auerback said he served on a national committee to advise the Robert Wood Johnson Foundation, which had just allocated \$11 million to the problem of long-term care workforce across the country, because it is a problem everywhere. There are some answers that are not only money, but deal with job honor, increased training, mentorships for people who are new on the job, and

management that is good and supportive of workers who sometimes feel very isolated, or feel as though they are not given the chance to make decisions by themselves. People have to have opportunities for cost-of-living increases and promotions, but it is the other factors which really account for someone staying with this very important work.

Ms. Gianopoalos reinforced what Mr. Auerback said and added that many are certainly seeking more control over their work, rather than only seeking more money. She said that in Maine, they had seen people leave nursing facilities where they were earning more per hour to go into home care because they were attracted by the flexibility and the feeling of having more control over how they did their work, which was evidence that it was not all about the money.

Patricia Maben thanked the speakers for sharing their insights, and noted that she had used a great deal of Oregon's information. She asked Mr. Auerback about issues Oregon had experienced with assisted living because she felt that Kansas might run into some problems with things like the overbuilding of assisted living.

Mr. Auerback said that during his time as administrator of Senior Disabled Services, Oregon began to address the issue of overbuilding in assisted living. They were concerned about it because during that same time, there was an increased number of people living in assisted living that were on the Medicaid program. In 1995, the percentage statewide of occupancy of assisted living by Medicaid was around 25 percent and generally remained in the 20 percent range. Over a period of years, it got close to 40 percent, and that was starting to look very high. They looked at occupancy in new assisted living facilities, and those were 95 percent rented out before the doors opened, yet less than 90 percent were actually occupied three months after the opening. Because of Oregon's cost-based system for nursing facilities, the state was paying for unused beds; Oregon felt that assisted living might fall into this same pattern. Part of the solution from the Governor's office was to ratchet down the reimbursement by Medicaid to the assisted living facilities to send a message to the industry to stop building. An actual moratorium went into effect for two years on the approval of any new facilities. He clarified that his department's suggestion had been more along the lines of looking at the situation in more detail and analyzing what was really needed in the way of services.

Ms. Gianopoalos said that in Maine, they limit the number of assisted living and residential care beds Medicaid will pay for and they do that by the amount of appropriation they have available; otherwise, the only way you can deal with it, referencing the trinity of eligibility, services, or reimbursement, is to start ratcheting down the reimbursement. Maine's goal was to pay an appropriate and fair price for the right number of beds, whether they are in nursing facilities or residential care, because when you start doing it on the cheap, quality suffers.

Senator Feleciano stated he was intrigued that they try to maintain a zero waiting list in Maine. This was a less expensive way of providing care.

Ms. Gianopoalos said that the legislators had to trust them in the beginning, and they had to show them that the programs did not get out of control. She emphasized that when things are in a crisis, people are more willing to take those necessary risks. By having that high threshold, that is a way of managing access to that program, but it has never been operated with a waiting list.

Senator Feleciano asked for more detail about the software that was tracking individuals and the services they were receiving. He asked if providing services earlier on through assisted living or home care reduced the amount of critical care services needed later.

Ms. Gianopoalos stated that she would think that the data is similar to Kansas'; Maine's waiver costs are about half the cost of a nursing home, and because they collect this assessment data in a database, they have been able to show that the people being helped at home on the waiver functionally look like the people in nursing homes. Legislators might be thinking that these are

people who would not go into the nursing home anyway. The assessment data show that these two groups are very much alike and show that the people at home could be in a nursing home, because they are just as functionally impaired.

Senator Feleciano said it is evident that 95 percent of the states are swimming in red tape. He asked how a waiting list was avoided and what Ms. Gianopoalos thought about Maine's attempts to purchase pharmaceuticals from Canada, the lawsuits that had been filed against them in the wake of that decision, and what the dollar advantages of such a move might be to the people being served.

Mr. Auerback responded to the first question by explaining that although the Legislature had been uncomfortable making those decisions, they had made their best efforts to serve those who needed help the most and to deny services to those who needed them the least in the interests of being able to do the former focusing on early services. There are two ways that people qualify for waiver/community-based services:

- They become more impaired living in the community; and
- They may have had a traumatic incident, are in the hospital, and need short-stay rehabilitation.

Ms. Gianopoalos said that in her state, prescription drugs were the number one expense, and that it had been number one per capita in pharmacy spending for several years, which brought the issue to the forefront. Maine has been working with the Northeast Coalition of Legislators on a cooperative pharmacy benefit manager initiative, as well as talking to Michigan about joining their group purchasing benefit. Given Maine's geography, the state does a great deal to assist seniors in obtaining drugs from Canada. The state is hopeful that Congress will come up with a Medicare prescription drug benefit, because it should not be a function of which state you live in. On the demand side of that issue, states should look more closely at the drugs people are using and how useful they really are to those people. In Maine, 57 percent of older individuals on Medicare are using some kind of psychotropic drug, which seems high. She indicated that there are good systems in place for monitoring inappropriate use of prescription drugs but that may be lacking for people living out in the community.

Representative Bethell drew the Task Force's attention to the *President's Task Force on Medicaid Reform: Final Report to the 2003 Kansas Legislature* ([Attachment 4](#)).

Senator Lee asked Mr. Auerback if Oregon paid the actual fee for assisted living or if it only paid for the services received.

Mr. Auerback said that Oregon paid for assisted living through the state's home and community-based care waiver; of all their community-based alternatives, the state paid the highest rate for assisted living: 80 percent of the nursing facility rate. His predecessor made the decision that they would have a high reimbursement for assisted living, but that by the end of his own term in 2000, assisted living was closer to 60-65 percent reimbursement. Medicaid does not allow you to pay room and board. Oregon required people to make those contributions if they are on the Medicaid program, but services above that up to the facility rates were covered.

Senator Lee asked if they were fudging on how they were charging that, and Mr. Auerback clarified that it was not fudging, but accepting amounts lower than their standard fee. An example might be a stated charge of \$2,400, but accepting a Medicaid package of \$1,800 for the whole service package.

Senator Lee asked Ms. Gianopoalos where individuals who are released from nursing homes go, once released.

Ms. Gianopoalos explained that these people go back to the home from which they came. Generally, if people are going home, they do so in the first 90 days, and they are not charged for their cost of care. Another option may be a residential care facility or boarding home, or assisted living. Similar to Oregon, Maine pays for care in boarding homes and assisted living or adult family care homes under Medicaid. She clarified that if a person goes into a nursing home and he or she is qualified for Medicaid, he or she will be covered for the first three months.

Senator Lee asked for additional detail about the differences between those receiving HCBS and some in nursing homes, and why everyone is not in home and community-based situations.

Ms. Gianopoalos responded that the amount of family support tends to affect that decision. People with similar levels of physical impairment, those who have some family in the picture, are more likely to be able to stay home because that is a crucial part of that family's care system. Family has to be willing to step into those situations. Nursing homes take away these staffing issues and, for this reason, many families eventually decide on nursing care if they are unable to handle the situation.

Representative Neufeld asked Mr. Auerback about the reimbursement of family members and whether or not it was the same as that of other providers.

Mr. Auerback explained that family members, aside from the spouses or parents of minor children, as prohibited by federal law, are paid at the same rate as workers. Case managers speak not only with the eligible individuals, but with their families. Based on these discussions, the case managers determine a workable situation for that family to continue supporting that person at home. People are often asked if they know someone who is willing to provide that service for them, so this solves the problem of recruitment that was discussed earlier.

Representative Neufeld asked Mr. Auerback if other states around the country are implementing the plan that Ms. Gianopoalos mentioned about covering the first three months of care.

Mr. Auerback explained that he is not familiar with other states doing that, but that he felt legislative and executive branches need to be very mindful of whether or not there is a transition plan, and that in Oregon and Washington, they were sure to go back into facilities and reevaluate whether or not there is a plan to make this a short stay with a transfer back home.

Maine has had a range of experiences paying family members, some of which provide the very best in care and some the very worst in care. This state not only goes back into nursing homes and reassesses the situation, but periodically does the same for home care. If care givers have become dependent on funds, they are not very happy if the reassessment takes those away.

Representative Neufeld asked for clarification of Maine's ability to eliminate the waiting list on HCBS, and if that was achieved by restricting services.

Ms. Gianopoalos said that Maine is very careful in the amount of care that is authorized, with the goal of offering just the right amount, even going so far as putting time limits on the amount of time authorized for daily activities like bathing. By using one agency that has statewide staff and using only nurses to do the pre-admission assessment, the state has been able to make sure people are doing their work consistently.



Representative Neufeld expressed his interest in Maine's ability to increase the number of nursing home admissions, while the percentage of discharges was also increasing. He asked for clarification on the meaning of "going home."

Ms. Gianopoulou said that going home referred only to home, not assisted living.

Representative Landwehr asked if Maine had done anything in the realm of personal accountability and responsibility in the area of long-term care insurance, and said she would like to know what either state had done in the way of estate recovery.

Mr. Auerback explained that there had been many attempts in Oregon for long-term care insurance; at this point, there is very little incentive for it. The state implemented a program for state employees, affecting 6,000 to 7,000 workers. Its popularity continues to grow, although the state has not quite gone down that road yet. At the same time, many are hoping that at the national level there will be more emphasis on long-term health care insurance. Regarding personal accountability, in the home and community-based care waiver program, the eligibility is set at 300 percent of the supplemental security income (SSI) amount. The amount of money above the SSI amount, save a small amount for an individual allowance, goes right back into the program. The SSI amount now is about \$540; putting the excess back in is a form of personal accountability.

Oregon was number one in the percentage recovery per capita, based on the cost of the program, of anywhere in the country during Mr. Auerback's term there. The state believed that money should be recycled back into the program, although they learned about estate recovery the hard way. Some people are very skittish about estate recovery because it looks like the government is walking in and taking part of the estate left by an individual. Three important lessons he shared with the Task Force were:

- Emphasis in the training of case managers to communicate:
  - Be clear when initially signing people up for services and explain that when a spouse is cared for by the state, their estate will be subject to those costs associated with care to go back into the program; and
  - Case managers must spend time on this point and be very clear with the family.
- Be kind:
  - Focus on the ideas of customer service so that recovery agents do not look like they are grabbing the assets that some people have been waiting for as an inheritance; be sensitive to the situation.
- Implement an exemption provision:
  - Be broad in nature if this estate recovery would cause undue hardship to the survivors such as children and people with disabilities, because by taking these assets, these people may be thrown into reliance on the state for support because they could not afford their own care.

He again emphasized that it is vital to communicate with families.

Representative Landwehr asked for a comparison between similar states in terms of qualifications for HCBS waivers and what waiting lists are doing. She said that being told the state was basically killing people because they were dying on waiting lists was absolutely appalling. She would like to look at the issue in further detail as to what waiting lists mean and what their effects are.

Ms. Gianopoalos explained that Maine heard the same things about people dying while on waiting lists, especially after nursing home eligibility standards were raised, but there had been no data to back that up. In fact, there were fewer people backed up in hospitals waiting for a nursing home bed. Although they had not had that experience, it was something about which people rightfully worry. But as systems mature, you can see that sometimes people experience bad outcomes and those cannot be entirely prevented.

Ms. Lubensky expressed her concern with comparing apples and oranges: Kansas has lifted eligibility on present waivers, and she was interested if anyone had compared our eligibility with other states.

Ms. Gianopoalos explained to the Task Force that nursing home stays had been cut in half, and that this had a great deal of positive impact for both the system and the care recipient (Attachment 5).

Ms. DeBoer distributed an informational packet to members entitled, "Level of Care Presentation for the Long-Term Care Task Force, the Medicaid Reform Task Force, and the House Social Services Budget Committee" (Attachment 6).

Ms. DeBoer told the Task Force that the HCBS waiting list was over 1,000, but she had not seen an increase in case load. Although she has seen a correlation between the level-of-care score and the cost-of-care services, the system cannot completely explain informal services. She explained that there were difficulties working with family members, but many times, there was also a great deal of value gained by family dealing with personal care issues like bathing, eating, and so forth.

In response to a question from Representative Bethel, Task Force members discussed admission rates to assisted living facilities. Ms. DeBoer explained that the cost of living in assisted living was more because the state purchased more. They are working on trying to explain the increase in levels in assisted living above others.

Ms. DeBoer and Representative Bethell discussed HCBS customers entering facilities and making temporary living arrangements. In this case, a temporary code is assigned, a process that has been in place for several years. This temporary stay used to be defined as the month of entrance plus an additional 60 days, but now it is the month of entrance plus an additional 90 days. In most short-stay cases, a patient probably stays in the hospital first and then is moved to a nursing home, but the whole stay is probably not paid by Medicare.

Representative Landwehr asked what caused short-term stays, and Ms. DeBoer replied that it usually referred to rehabilitative stays; Medicare only pays for about 30 days and many people need short-term care and then leave. It is not rehabilitation alone that reduces stays; people who are more familiar with community services are able to assess those too.

Following discussion, Ms. DeBoer explained to the Task Force that currently, there was a hard freeze on the waiting list because of funding for FY 2003.

## Afternoon Session

Ms. DeBoer directed the Task Force again to the informational packet on State Nursing Home Level of Care Criteria (see Attachment 6). Comparison of the scores show that it has moved from 26 to 30 now. Cognition is something to consider, but harder for agencies to score.

Representative Kirk asked about measurements for memory loss and other topics. Ms. DeBoer responded that Linda Redford, from the University of Kansas Center for Aging, had tested the instruments used by the state for both validity and reliability. Examples of such tests are having someone draw a clock or other basic exercises. Linda has met with others many times. Kansas activities of daily living (ADLs) and IADLs are consistent with other states, although risk factors may be somewhat greater.

Representative Bethell asked if reassessment in nursing homes would help. Ms. DeBoer replied that Maine has tried to link its system very closely with MDS, and in that system, the support of the family was also a trigger. That means if there was no support from the family, no community support, or a reply that an individual was comfortable where they were, the score would be affected. Many places have refocused their interest on the entrance point, choosing to try to increase awareness of community programs available.

The Task Force discussed the importance of nursing homes for public relations, the relationship between them and the waiting lists, and the freeze that has been placed on services. Representative Showalter asked what would happen to an individual who is qualified for a service and has gotten worse over time. Ms. DeBoer confirmed that they would have to wait on the list no matter how bad their condition, because no one can be added during a freeze. She clarified that those with priority status get on the list first, and that Kansas Department on Aging actually has a person working full time, doing nothing but tracking money and expenditures.

Representative Showalter wanted to know what the result was of someone on the list dying, and Ms. DeBoer replied that it would just make them closer to the allotment for FY 2003, rather than opening a slot on the other end.

In response to a question from Representative Landwehr, Ms. DeBoer explained that the state did not take a cookie cutter approach, but looked to alternatives that would best fit. An example might be the use of adult daycare for an individual, as opposed to something else, or switching someone from one program to another that might work better. Also, they look at what Mr. Auerback mentioned regarding guidelines for how long something should take versus what the provider or family member is saying it takes.

Representative Landwehr felt that looking at the budget, it would be important to address financial criteria for eligibility, because some people hide assets and the state needs to find a way to tighten up some of these loopholes.

Following discussion of informal support, Chair Bethell said that family support is just what it is, and that is what our society is built on.

Ms. Lubensky expressed concern for those in rural areas who have no form of support. Ms. DeBoer said that the elderly waiver has 55-60 percent cost effectiveness and that there was more of a medical model with assistance with ADLs and IADLs. The task-driven-with-medical-model approach is quite rigid.

Representative Landwehr requested the number of individuals getting HCBS. She emphasized her concern that only a few people are getting what they want, rather than focusing on making sure that more people are getting what they need. Many people say they do not want to burden their kids, and that burden carries over in increased taxes.

Sister Beth asked if there was a cost cap on HCBS/FE and what the criteria were for that.

Ms. DeBoer replied that the criterion equaled the cost of care; if that is over \$1,999/month, it triggers a review. The case manager cannot approve \$2,000 or more per month for their plan of care. The majority of the most expensive plans, however, usually do not exceed six months.

Sister Beth said these issues went back to the previous discussion, and that this is a philosophical discussion of giving more to one and denying more people for lesser levels of care.

Following more discussion, Chair Bethell said that the federal government had many of the same issues as the states, in terms of the importance of cost effectiveness.

The meeting adjourned at 3:30 p.m.

Prepared by Mike Heim and Nikki Kraus

Approved by Task Force on:

July 30, 2004

(date)