

Report of the Kansas Senior Care Task Force to the 2022 Kansas Legislature

CHAIRPERSON: Representative Susan Concannon

VICE-CHAIRPERSON: Senator Richard Hilderbrand

OTHER LEGISLATIVE MEMBERS: Senators Cindy Holscher and Kristen O’Shea; and Representatives Charlotte Esau and Jarrod Ousley

NON-LEGISLATIVE MEMBERS: Kendra Baldrige, Leanna Chaffee, Janis DeBoer, Margaret Farley, Jamie Gideon, Annette Graham, Jan Kimbrell, Ernest Kutzley, Linda MowBray, Mindy Nicholson, Haely Ordoyne, Bill Persinger, Rachael Pirner, Camille Russell, Sarah Schlitter, and Debra Zehr

CHARGE

HB 2114 (2021 law) directs the Task Force to study topics on the provision of care for Kansas seniors who suffer from Alzheimer’s disease, dementia, or other age-related mental health conditions; administration of antipsychotic medication to adult care home residents; safeguards to prevent abuse, neglect, and exploitation of seniors in the state; adult care home surveys and fines; funding and implementation of the Kansas Senior Care Act; senior day care resources in the state; and rebalancing of home and community-based services.

Kansas Senior Care Task Force

PRELIMINARY PROGRESS REPORT

Conclusions and Recommendations

The Kansas Senior Care Task Force makes the following recommendations:

- The Kansas Department for Aging and Disability Services should reach out to universities for assistance in mapping the various senior services across the state.
- The Legislature should explore the possibility of using temporary aides in long-term care.
- A request should be made to the Legislative Division of Post Audit to perform a limited scope audit (less than 100 hours) to determine where broadband funding, including federal funding, has been spent in the state and to identify the differences between urban, rural, and frontier regions of the state.
- The Kansas Legislative Research Department should research the funding for broadband for the state.
- The Legislature should seek funding to produce a new Kansas Elder Count book, including a digital version.

Proposed Legislation: None.

BACKGROUND

The Kansas Senior Care Task Force (Task Force) was created by HB 2114 (2021 law), with a sunset date of June 30, 2023. HB 2114 directs the Task Force to study the provision of care for Kansas seniors who suffer from Alzheimer's disease, dementia, or other age-related mental health conditions; the administration of antipsychotic medications to adult care home residents; safeguards to prevent abuse, neglect, and exploitation of seniors in the state; adult care home surveys and fines; the funding and implementation of the Kansas Senior Care Act; senior day care resources in the state; and rebalancing of home and community-based services (HCBS).

The Task Force is composed of 22 members, who were required to be appointed on or before August 1, 2021. The appointing authorities were

required to provide notice of appointments to the Secretary for Aging and Disability Services. Vacancies on the Task Force are to be filled by appointment and accompanied by notice to the Secretary for Aging and Disability Services in the manner provided for the original appointment.

The Task Force is composed of the following members:

- The chairperson of the Senate Committee on Public Health and Welfare;
- A member of the Senate Committee on Public Health and Welfare, appointed by the President of the Senate;
- A member of the Senate Committee on Public Health and Welfare, appointed by the Minority Leader of the Senate;

- The chairperson of the House Committee on Children and Seniors;
- The ranking minority member of the House Committee on Children and Seniors;
- A member of the House Committee on Children and Seniors, appointed by the Speaker of the House;
- One representative of the Kansas Department for Aging and Disability Services (KDADS), appointed by the Secretary for Aging and Disability Services;
- One representative of the Kansas Department of Health and Environment (KDHE), appointed by the Secretary of Health and Environment;
- The State Long-term Care Ombudsman or the State Long-term Care Ombudsman's designee;
- An elder law attorney, appointed by the Governor;
- One representative of the Area Agencies on Aging, appointed by the Secretary for Aging and Disability Services;
- One representative of the Kansas Adult Care Executives Association, appointed by the Governor;
- One representative of LeadingAge Kansas, appointed by LeadingAge Kansas;
- One representative of the Kansas Health Care Association, appointed by the Kansas Health Care Association;
- One representative of Kansas Advocates for Better Care, appointed by Kansas Advocates for Better Care;
- One representative of the Kansas Hospital Association, appointed by the Kansas Hospital Association;
- One representative of community mental health centers, appointed by the Association of Community Mental Health Centers of Kansas;
- One representative of an adult care home, appointed by the Secretary for Aging and Disability Services;
- One representative of the AARP, appointed by the AARP;
- One representative from the HCBS community, appointed by InterHab;
- One representative of the Alzheimer's Association, appointed by the Alzheimer's Association; and
- A consumer of Kansas senior services, appointed by the Speaker of the Silver Haired Legislature.

The Task Force is authorized to meet in an open meeting at any time and at any place by any means in the state upon the call of the chairperson. The first chairperson of the Task Force is the chairperson of the House Committee on Children and Seniors. The chairperson of the Senate Committee on Public Health and Welfare is to serve as the first Task Force vice-chairperson. The positions of chairperson and vice-chairperson are to annually alternate on the first meeting of the Task Force each calendar year.

On or before the beginning of the 2022 Legislative Session, the Task Force is required to submit a preliminary progress report to the Legislature detailing the Task Force's study. A final report of the Task Force's study is due to the Legislature on or before the beginning of the 2023 Legislative Session. The bill requires the report to include recommended improvements regarding the well-being of Kansas seniors,

including recommended changes to state statutes, rules and regulations, policies, and programs.

Structure and Organization

After presentation by a representative of the Kansas Health Institute (KHI) of the working group concept at the September 9, 2021, meeting, the Task Force approved KDADS' offer to coordinate a contract directly with KHI to establish working groups for the Task Force, with KHI facilitating the working groups. The Task Force sought and received Legislative Coordinating Council (LCC) approval to create working groups to assist the Task Force in studying and making recommendations on the assigned topics. At the December 7, 2021, Task Force meeting, the final working group charter was presented by KHI, including the purpose, product, and scope of the work of the working groups.

Two working groups and one subgroup were formed. The two working groups are Quality of Care and Protective Services (Working Group A) and Access to Services (Working Group B). The subgroup was formed to study the workforce issue.

The primary areas of focus for each of the working groups are:

- **Quality of Care and Protective Services.** Administration of antipsychotic medications to adult care home residents; the safeguards to prevent abuse, neglect, and exploitation of seniors in the state; and adult care home surveys and fines; and
- **Access to Services.** Provision of care for seniors in the state who suffer from Alzheimer's disease, dementia, or other age-related mental health conditions; the funding and implementation of the Kansas Senior Care Act, KSA 75-5926 through KSA 75-5936; senior day care resources in the state; and rebalancing of HCBS.

KHI began facilitating working group and subgroup meetings on and after December 14, 2021. Working group meetings will continue virtually twice per month for 90 minutes each. The subgroup will meet virtually once per month for 90 minutes per meeting. The working groups and subgroup will meet during the 2022 Legislative Session with a goal

of finalizing and ratifying its report in July 2022, with a presentation of the report to the Task Force in August 2022.

The working groups and subgroup consist of a Task Force non-legislative member serving as chairperson, a legislative member serving as vice-chairperson, Task Force members volunteering by topic preference, and other relevant subject matter experts who may be requested to provide input on individual topics.

COMMITTEE ACTIVITIES

The LCC approved four meeting days for the Task Force. The Task Force met on September 9, November 11, December 6, and December 7, 2021. The Task Force members met in person, with the option for Webex attendance.

Additional details regarding each of the Task Force meetings, minutes, audio recordings, Task Force handouts, and written testimony submitted by conferees may be accessed on the Legislature's website on the Task Force webpage: http://kslegislature.org/li/b2021_22/committees/c/te_tf_ks_senior_care_1/.

September 9, 2021, Meeting

Overview of Authorizing Statute

A Revisor of Statutes reviewed the Kansas Senior Care Task Force authorizing statute, HB 2114, passed in 2021, summarizing the study topics, the deadlines for the preliminary and final report to the Legislature, and the sunset date for Task Force of June 30, 2023.

Presentation on Kansas Opens Meetings Act and Open Records Act

The Revisor provided a review of the Kansas Open Meetings Act and Kansas Open Records Act, noting the Task Force is subject to both.

Working Group Concept

A KHI representative discussed the general function of working groups. She stated her agency performs process facilitation, which uses evidence-based information and research to meet the goals of the group. She said facilitators

remain neutral and keep the working groups focused toward actionable conclusions and recommendations that are presented to the whole Task Force. The KHI representative discussed several group facilitation tools. She noted a challenge of working groups is the necessity of a clearly defined topic or goal and that overlap and gaps can exist among different working groups working on behalf of the primary group.

Update on Senior Care Services and Programs and State Plan on Aging

The Secretary for Aging and Disability Services (Secretary) addressed the Task Force. She noted the aging of the American population, stating the U.S. Census Bureau estimates in 13 years, for the first time in history, older adults (age 65 and older) are expected to outnumber youth.

By 2030, when all the baby boomers are 65 years old and older, they will make up 21 percent of the population, up from 15 percent of the current population. In Kansas, the population aged 85 and over is expected to expand from 63,848 individuals in 2014 to 230,299 in 2064.

Older Americans Act

The Secretary noted that as required by the 1965 federal Older Americans Act (OAA), the State must submit a State Plan on Aging to the U.S. Administration on Aging. The fiscal year (FY) 2022–FY 2025 State Plan (Plan) was submitted to the federal Administration for Community Living. The Plan was formed with input from older Kansans, families, and stakeholders through listening tours across the state, as well as a statewide Aging Survey. A copy of the Plan was provided.

The Plan includes five goals:

- Coordinate efforts to support older Kansans;
- Inform Kansans of systems and supports for self-sufficiency with emphasis on those with the greatest economic or social need;
- Engage community partners to advance OAA programs;
- Educate and advocate for the prevention of elder abuse, neglect, and exploitation; and

- Maximize utilization for home and community-based services and Medicare.

The Secretary discussed the federal OAA and the programs it supports.

OAA Title III provides grants for several programs:

- Supportive Services (Title III-B) such as homemaker, attendant care, transportation, case management, and legal assistance;
- Nutrition (Title III-C), which includes congregate and delivered meals and nutrition education;
- Disease Prevention and Promotion (Title III-D); and
- Family Caregiver Support (Title III-E) for respite, counseling, information, support groups, and homemaker.

OAA Title VII supports elder rights protection, including:

- The Long-Term Care Ombudsman Program;
- Prevention of Elder Abuse, Neglect, and Exploitation; and
- The State Legal Assistance Development Program.

Oversight of Medicare Programs

The Secretary noted KDADS oversees the following Medicare programs:

- Senior Health Insurance Counseling for Kansas, which helps individuals with questions related to Medicare;
- Senior Medicare Patrol, which educates on Medicare and Medicaid health care

fraud and abuse and identification and reporting of scams; and

- The Medicare Improvements for Patients and Providers Act, which provides application assistance for the Medicare Part D plan and the Medicare Savings Program, which helps pay for Medicare Part B premiums.

Aging and Disability Resource Centers

The Secretary described the Aging and Disability Resource Center program implemented through the 11 area agencies on aging (AAAs) across the state. This program is available to anyone, regardless of income, to obtain assistance in planning for their future long-term service and support needs. Aging and Disability Resource Centers also provide the functional assessment necessary to determine eligibility for HCBS and can complete the Client Assessment, Referral and Evaluation (CARE) assessment required for admission to a nursing facility.

HCBS Waivers

The Secretary discussed the HCBS Medicaid waiver services that serve seniors: the Frail Elderly (FE) and Brain Injury (BI) waivers.

The FE waiver is an alternative to nursing home care by providing services that promote independence within the community and allow for residency in the most integrated environment. There is currently no waiting list for this waiver.

A recent change to the BI waiver allows persons with an acquired injury, such as a stroke, to qualify for services. Previously, only individuals with a traumatic brain injury qualified for the waiver. It is a rehabilitation waiver that provides therapies and services needed after an injury to allow individuals to improve and rely less on supports as they become more independent.

Program of All-Inclusive Care for the Elderly

The Secretary noted the Program of All-Inclusive Care for the Elderly (PACE) is a Medicare program with a Medicaid state option. PACE provides comprehensive health services, in the home or at the PACE center, that would normally be

provided by Medicare and Medicaid. It is available in specific service areas of the state and uses day services to help keep persons living in their own homes. Ascension Via Christi Hope, Midland Care, and Bluestem Communities provide this service in Kansas.

Nursing Facility Program

The Secretary said the Nursing Facility Program provides oversight regarding Medicaid enrollment, change of ownership, reimbursement and rate setting, auditing, quality care assessment, federal Centers for Medicare and Medicaid Services (CMS) enforcement, the ventilator program, and Promoting Excellent Alternatives in Kansas Nursing Homes 2.0. There are 316 Medicaid nursing facilities across 4 regions: 282 are traditional, 10 are for mental health, and 24 are long-term care units that are connected to a hospital.

Presentation on Senior Care Act

The Deputy Secretary of Programs, KDADS, provided a review of the Senior Care Act (SCA), a Kansas-specific program established in 1989. The program assists older Kansans who have functional limitations but are able to reside in the community with support services. The services prevent premature nursing home placement for persons who have not exhausted their financial resources.

The Deputy Secretary said that in FY 2021, the program served about 2,100 seniors each month at an average cost of \$279 per person. The program also permits one-time services, such as dentures, glasses, daily care items, and other items. The program is implemented through the 11 AAAs across the state. The program utilizes a functional assessment, and a plan of care is developed. Seniors direct their care and may choose their caregiver.

The Deputy Secretary noted staffing is an issue, as the State contracts with home health agencies to provide services. She noted the funding in FY 2022 will increase to \$10.0 million, but staffing shortages could mean the extra funding may not be spent. There are about 300–400 persons on the waiting list for SCA services. It was noted KDADS is hopeful the

\$3.0 million increase in funding will help reduce the waiting list if staffing is available.

A Kansas Legislative Research Department (KLRD) fiscal analyst discussed the fiscal history of the SCA. The program is funded by the federal Social Services Block Grant and the State General Fund (SGF). Persons also pay for services based on a sliding scale. Funding has generally been at \$7.0 million per fiscal year, with about \$4.5 million from federal funding and \$2.5 million from the SGF. In FY 2017, the SGF moneys were reduced to \$415,000 for the program.

Funding was restored in FY 2018. SGF funding for FY 2022 was increased to about \$5.5 million for a total funding of a little more than \$10.0 million.

Presentation on 2020 Alzheimer's Disease Plan and Status of Recommendations

The Deputy Secretary of Programs, KDADS, presented the 2020 Kansas Alzheimer's Disease Plan. She noted that every 65 seconds, an individual in the U.S. develops Alzheimer's disease or other dementia. Dementia is an umbrella term for a decline in cognitive functioning, and Alzheimer's is a type of dementia. Dementia risk factors include age, family history, and heredity. Currently in Kansas, there are about 54,000 persons age 65 or older living with Alzheimer's and other dementia, and the number is estimated to increase to 62,000 persons by 2025. About 151,000 caregivers and family members in Kansas provide care and support for persons with the disease.

The Deputy Secretary said that in consideration of the public health crisis, the Kansas Alzheimer's Disease Task Force was established in May 2019 by Executive Order No. 19-08. The Deputy Secretary reviewed the six key recommendations of the Kansas Alzheimer's Disease Task Force included in the 2020 Kansas Alzheimer's Disease Plan and KDADS' response to each:

- Establish a state Alzheimer's Disease Advisory Council to report on the implementation of the state plan goals and objectives: KDADS wonders if the Task Force could help address some of the concerns that would have been addressed by such an Advisory Council;

- Introduce legislation to allow persons 60 years and younger with younger-onset Alzheimer's to qualify for services through the SCA: KDADS' high-level estimate indicates the \$10.0 million SCA program would need to have its funding doubled to meet this recommendation;
- Create a website as a central entry point to information and resources: KDADS acknowledges and supports the need to increase awareness but has not done much to increase awareness on its website. KDADS is in the process of adding Alzheimer's information, resources, and links to other organizations on its website, but this initiative was not a priority in the past year due to the COVID-19 pandemic;
- Create a tax incentive for family caregivers to obtain training to expand knowledge and skills about Alzheimer's disease: The OAA allows for group and individual caregiver training;
- Require training on dementia and cognitive decline for Adult Protective Services (APS) workers and law enforcement personnel: The KDADS Aging Team works with the Department for Children and Families APS workers and will continue to coordinate with them on this recommendation; and
- Provide funding for Alzheimer's-specific respite programs regardless of age or financial status: KDADS allows for Alzheimer's support services, which can include respite. The AAAs can choose how they spend their OAA Supportive Services (Title III-B) allocation based on the needs of their communities. KDADS requires AAAs to provide respite services under the Family Caregiver Support Program.

A Task Force member representing the Alzheimer's Association, who is also a member of the Kansas Alzheimer's Disease Task Force, provided comments regarding the Kansas

Alzheimer's Disease Plan recommendations. She noted the second recommendation to expand SCA services to those younger than age 60 with younger-onset Alzheimer's is based on action one year ago at the federal level providing Title III-E services under the National Family Caregiver Support Program [Note: These services are not available under other OAA Title III programs.]

The Kansas Alzheimer's Disease Task Force member said the recommendation to provide a tax incentive to family caregivers to obtain training came from a private pilot program in Kansas and noted the desire to expand the program statewide. The representative clarified the Advisory Council was intended to be ongoing with renewable two-year terms for members and could be created by legislation or executive order.

Presentation on Adult Care Home Surveys and Fines

The Deputy Secretary of Hospitals and Facilities, KDADS, discussed the Adult Care Home Surveys, Finding and Fines report. The Deputy Secretary described the Survey, Certification and Credentialing Commission (Commission) within KDADS, which inspects and licenses adult care homes, as defined in state statute by KSA 39-923. Facility types are defined by KSA 39-2002 and include residential care facilities, residential and day support facilities for individuals with developmental disabilities, private psychiatric hospitals, psychiatric residential treatment facilities, community mental health centers (CMHCs), and substance use disorder treatment facilities. The Commission is comprised of five divisions, including the Survey and Certification Division and the State Licensed Adult Care Home Division.

The Survey and Certification Division operates in partnership with CMS on compliance with federal regulations. The Deputy Secretary of Hospitals and Facilities explained there are about 330 nursing facilities that must be surveyed or inspected no less than every 15.9 months, with an overall survey average of every 12 months.

The Deputy Secretary of Hospitals and Facilities said the State Licensed Adult Care Home Division approves state-licensed only (SLO) facilities, including assisted living, residential health care, adult day care, and board care homes for licensure

under state law, rule, and regulation. There are about 350 free-standing facilities and 100 state-licensed facilities attached to a SLO nursing facility. Registered nurses conduct the Long Term Care Surveys. At the time of the September 9, 2021, meeting, there were 37 certified staff members and 17 vacancies for survey staff.

The Deputy Secretary of Hospitals and Facilities reviewed the 2021 Survey results. In the SLO facilities, 279 deficiencies were written, and the top citations were for infection control, negotiated service agreements, health care services, and disaster and emergency planning. In nursing facilities, 615 deficiencies were written, and the top citations were for food procurement, drug regimen review, unnecessary prescription of drugs, and free-of-accident hazards or supervision devices. The COVID-19 pandemic caused the facilities and the agency to follow CMS protocols that included infection control surveys. The agency is currently engaged in survey activity in certified nursing facilities and SLO adult care homes. Kansas mirrors the national trends for civil monetary penalty (CMP) in nursing facilities. The increase in CMP in 2021 were largely for CMS citations and fines.

According to the Deputy Secretary of Hospitals and Facilities, KDADS has a total of eight registered nurse positions it can fill to do surveys, but these are difficult positions to fill. KDADS does not believe it has enough surveyors and will ask for more in its budget request. Some states use a licensed practical nurse or other lesser credentialed nurse, but Kansas uses registered nurses because they can exercise more independent evaluation.

The Deputy Secretary of Hospitals and Facilities said there are three licensed adult day cares in Kansas and several other facilities that have adult care services but are licensed as assisted living facilities.

Regarding CMPs imposed, the Deputy Secretary of Hospitals and Facilities stated the CMP is collected by CMS or the State, and the State receives a share of the fines, which can be used for approved projects for quality initiatives. Some CMP funds were reserved for 22 receiverships. One facility remains in

receivership, and CMP funds are being reserved for that receivership.

With any deficiency in a survey, a facility can appeal the finding and penalty through a formal or informal dispute resolution.

Presentation of Data on Antipsychotic Drug Use in Nursing Homes

The Deputy Secretary of Hospitals and Facilities discussed antipsychotic drug use in nursing facilities. The Deputy Secretary stated KDADS provides regular reports to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight. He shared a chart showing the three KanCare managed care organizations (MCOs) – Aetna Better Health of Kansas (Aetna), Sunflower State Plan (Sunflower), and UnitedHealthcare Community Plan (UHC) – and the number of patients receiving antipsychotic medication.

Persons with a diagnosis of schizophrenia, Huntington’s Disease, or Tourette’s Syndrome receiving antipsychotics were not included in the totals. The MCOs have incentive pay based on lowering the inappropriate use of these medications. CMS is engaged in a national partnership to reduce the use of antipsychotic medications and increase the use of non-pharmacological approaches to person-centered dementia care practices.

According to the Deputy Secretary of Hospitals and Facilities, Kansas has been at about 15.0 percent quarterly prevalence of antipsychotic use for long-stay residents for several years.

Presentations from Individuals, Providers, and Organizations

The Task Force heard testimony from multiple conferees regarding long-term care (LTC) facilities.

A private citizen indicated support for 2021 HB 2004, which would assure protections from involuntary discharge from adult residential care facilities. She shared her experience of losing her husband, who did not survive such a move.

The Executive Director of the Kansas Association of Area Agencies on Aging and Disabilities testified the primary goal of AAAs is to

help people remain in their homes, generally referred to as “aging in place.” She reviewed the work of the AAAs across the state, including providing services supported through the OAA and contracts with the State.

The Executive Director of the Kansas Home Care and Hospice Association explained her association represents agencies that provide skilled nursing care in a patient’s home. Payment sources are Medicare, some Medicaid, Veterans Administration, and private pay. The Executive Director noted there has been a loss of home care and hospice agencies, especially in the rural parts of the state, and the closures diminish access to care. She expressed urgent concern regarding workforce staffing shortages due not only to reimbursement, but also a need for better training and career opportunities.

The Co-Director of the University of Kansas Alzheimer’s Disease Center described Alzheimer’s disease as a public health crisis of immeasurable human impact and a cost of over \$250 billion, paid mostly by Medicare and Medicaid. He said the Center is on the front lines of research, training, direct care, and finding a cure. It is one of 31 centers on Alzheimer’s, designated by the National Institute on Aging. He noted the Center’s efforts are aligned with the recommendations in the Kansas State Plan for Alzheimer’s Disease and invited the Task Force to consider the Center as a resource for information and for leverage, as appropriate.

The Director of the Cognitive Care Network, University of Kansas Alzheimer’s Disease Center, explained the activity of the Center focused on supporting families, especially prior to entering institutional care. An extensive list of the Center’s efforts designed to increase the capacity of providers and build access to care for persons living with dementia was provided. She mentioned the Cognitive Care Network, in which providers are trained in the use of early diagnosis assessments. The Cognitive Care Network supports practices in Kansas City, central and southeast Kansas, and, soon, north central Kansas. The Director noted many families lack care due to insufficient personal resources while not meeting criteria for aid.

Discussion of Topics for Upcoming Meetings

The Task Force members discussed topics for presentations at its upcoming meetings.

Regarding the Task Force's authority to ask another agency to enter into an agreement to establish and implement the concept of working groups on behalf of the Task Force, the Revisor noted it was within the purview of the Task Force to give a directive to establish subgroups to assist the Task Force. The Task Force approved a motion to accept KDADS' offer to coordinate a contract directly with KHI to establish working groups for the Task Force.

Discussion of Possible Recommendations on Topics Discussed in Meeting

The Chairperson said possible recommendations will be discussed at the end of each Task Force meeting and will be considered for approval by the Task Force at the December 2021 meeting for inclusion in the preliminary report due to the 2022 Legislature before the beginning of the 2022 Session.

Possible recommendations offered were:

- The need for regulations for assisted living centers and appeals protections for residents for involuntary or improper discharges;
- Keeping distinctions between mental health issues and dementia; and
- Creating a separate Senior Care Act-like program to provide services to persons with younger-onset Alzheimer's with its own funding allocation that would go solely to that population and consider the specialized services needed that would be different for this population.

November 10, 2021, Meeting

Agency Responses to Previous Task Force Questions

The Deputy Secretary of Programs, KDADS, reviewed detailed responses to the questions the Task Force asked at the September 9, 2021, meeting. She also provided two additional documents: the

Assisted Living Facility/Residential Health Care Facility/Home Plus (ALF/RHCF/HP) Health Resurvey Deficiency Data, January 1 – September 30, 2021, and the Health Resurvey Deficiency Data for the same time frame. The topics addressed in the responses included: the CMP Fund balance; movement from OAA services to the FE Waiver; Kansas Aging Management Information System (KAMIS) data availability; FE waiver data; eligibility criteria for the BI waiver; nursing facilities' monthly average eligibility caseload and Medicaid participation by state region; nursing facility census; number of Aging and Disability Resource Center assessments; exceptions to and data on the CARE assessment; and available maps showing population growth and services across the state.

The Deputy Secretary of Programs showed the Task Force members some of the interactive maps that have been created by the Wichita State University Center for Economic Development and Business Growth that may answer some of the population and service availability questions posed by the Task Force. She noted it would be helpful to review those maps to avoid duplication of maps already available.

The Deputy Secretary of Programs provided the following information in response to Task Force members' questions:

- The AAA in Hays is the contractor for administrative case management and subcontracts with the other 10 AAAs in Kansas.
- With regard to mapping the elderly population and services available, it may be helpful to have two maps showing the location of the current population and the location of the future population, with an overlay of the location of services available. The trend shows most elderly people who live in western Kansas are staying there. The baby boomers may trend differently and relocate to the cities.
- The Intellectual and Developmental Disability (I/DD) waiver program is designed to facilitate the ability of

individuals to stay in their community. More individuals on the I/DD waiver are entering nursing facilities because of the aging process.

The Deputy Secretary of Hospitals and Facilities, KDADS, reviewed the detailed responses to questions asked by the Task Force at the September meeting pertaining to regulatory issues in LTC. The topics included data on deficiencies, remedies, and fines and on the tracking of antipsychotic drug use.

Presentation on Distinctions Among Adult Care Homes, Nursing Facilities, Assisted Living Facilities, Home Plus Facilities, and Senior Day Care Facilities

The KDADS Deputy Secretary of Hospitals and Facilities presented the distinctions of the various types of adult care home facilities. He discussed each type of facility, including licensure and capacities. The eight classifications of adult care home are nursing facilities, nursing facilities for mental health, intermediate care facilities for people with intellectual disability, assisted living facilities, residential health care facilities, home plus, boarding care home, and adult day care facilities. Each of these types of adult care home facilities are required to be licensed by KDADS.

Oversight of nursing facilities is provided by KDADS and CMS. Oversight of assisted living, residential health care facilities, and home plus is provided by KDADS and, if HCBS services are delivered at the facility, by the three KanCare MCOs. All of these facilities provide services 24 hours a day.

Adult day care facilities are facilities operating for less than 24 hours a day for individuals who need supervision or assistance with activities of daily living. Oversight is provided by KDADS and, if HCBS services are provided, by the MCOs.

The right to appeal an involuntary discharge or transfer from an adult care facility is afforded to a resident in a federally certified nursing facility and found under the resident rights sections of 42 CFR 483.10. There is no corresponding state statute or regulation that affords residents of an adult care home licensed only by the State the same right.

If enacted, 2021 HB 2004 would be designated as Charlie's Law and would create the right to appeal an involuntary discharge or transfer in state statute. The other rights of all adult care home residents are located in regulations at KAR 26-39-103. The Deputy Secretary of Hospitals and Facilities provided the following information in response to questions from Task Force members:

- During surveys for CMS-certified skilled nursing facilities, the surveyors look at the notice requirements for involuntary discharges or transfers, and the facilities could be cited for failure to comply with the notice requirements. Such a review is not required in regulations for surveys of SLO facilities. If Charlie's Law were enacted, then the surveyors would review the procedures during a survey for a SLO facility to ensure the process and notice requirements were followed. For SLO facilities, if a complaint was made to KDADS regarding involuntary discharge or it was brought up during a survey, the facility could be cited for not following notification procedures. Notice of the process for discharge or transfer must be provided in the contract signed upon admission to an adult care home facility.
- Regarding the length of time for the appeals process for an involuntary discharge or transfer, on the skilled nursing side the appeals process can take several months to resolve. A Task Force member clarified the Charlie's Law legislation currently includes a requirement that the resident appeal within 10 days and the appeals process must be completed within 30 days.
- Home plus facilities are in both rural and urban areas. A Task Force member noted there is a trend for more home plus facilities in Sedgwick County and other urban areas.
- The process that could take place if a facility could not provide the level of care a resident needed includes: discharge to a more skilled level of care,

more services provided by MCOs to a Medicaid member where they are living, or having the resident seek an FE waiver for additional services. The options would depend on the level of need and the services available.

- Regarding whether KDADS has sufficient surveyors for the SLO facilities, the Deputy Secretary stated additional resources would enable the agency to do more. He noted a request for additional surveyors was made in the KDADS budget submission for this budget cycle, especially for surveyors for SLO facilities. All facilities may provide skilled nursing care but only if they have the sufficient qualified staff to provide the services the residents need.
- KDADS' position is that individuals have the right to choose where they want to live, the services they need, and who provides those services.
- Antipsychotic use for conditions other than schizophrenia, Huntington's Disease, and Tourette's Syndrome is not automatically considered inappropriate use. The measures used by the MCOs to work through appropriate use include peer-to-peer or doctor-to-doctor outreach for those providers with much higher than average antipsychotic prescriptions issued. The use of antipsychotics is tracked for CMS-certified facilities only, and the data is gathered through the minimum data set.

A Task Force member clarified that for skilled nursing facilities, CMS sends out a Hand-in-Hand training on dementia care. Part of the licensure requirement includes dementia training. A facility is required to track the training of its staff.

Rebalancing of Home and Community Based Services

The Deputy Secretary of Programs, KDADS, presented on the topic of rebalancing, which means providing alternatives to institutionalization. She stated CMS issued a digital toolkit on rebalancing long-term services and supports (LTSS) in

November 2020. CMS defines rebalancing as achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care. CMS allows rebalancing through different funding mechanisms. States are required to provide institutional services, such as in nursing facilities, medical institutions, and hospitals. HCBS are optional, and Kansas opted to offer HCBS. HCBS do not include the cost of room and board.

The Deputy Secretary provided a time line demonstrating the development of HCBS, from changes in the federal Social Security Act in 1981 to the HCBS Final Rule of 2014 and quality improvement efforts of 2017.

She stated the political will and community will both hold HCBS services as a priority. HCBS cost less than institutional care. The Deputy Secretary noted the caseload for the FE waiver, as an institutional alternative, is increasing. Kansas now has a managed LTSS system. The capitated rates cells were designed as an incentive to support, maintain, and build on HCBS.

The Deputy Secretary of Programs provided the following information in response to questions from Task Force members:

- The rate structure holds the MCOs accountable and incentivizes strengthening the HCBS system because it is more cost effective for the MCOs to increase the number of individuals receiving HCBS than to provide nursing facility services. Several 1915(c) waivers are up for renewal, and this may be the time to reevaluate the I/DD waiver. The MCOs will be asked to be involved in any such reevaluation.
- KDADS will determine if amendments are needed to continue day services flexibility resulting from the COVID-19 pandemic, including family caregiver, telehealth, and respite care. The pandemic brought options to waivers that may not have been considered previously.

- Residential health care facilities were missed in the initial survey for purposes of meeting the Final Settings Rule. Those facilities will be included in Round Two of the Final Settings Rule process. At that time, KDADS will be better able to answer if HCBS providers will be lost due to the Final Settings Rule. One of the projects with the 10 percent increase in the Federal Medical Assistance Percentage (FMAP) is to provide a small amount of money to help the residential health care facilities meet the Final Settings Rule.

A KLRD fiscal analyst shared two documents: HCBS Waiver Expenditures from FY 2011 Actuals to FY 2022 Approved and a Historical Timeline of Nursing Facility Daily Reimbursement Rate Increases.

Medical Doctor Perspective on Use of Antipsychotic Medications in Nursing Facilities

A family physician discussed when the use of antipsychotic medications is appropriate and how to curtail their use for nursing facility residents. He noted that no antipsychotic medication is approved by the U.S. Food and Drug Administration (FDA) for dementia-related behaviors, such as agitation, aggression, delusions, hallucinations, paranoia, wandering, depression, apathy, disinhibition, or sleep disturbances. The family physician noted the use of medications in the frail elderly population is complex. He stated when a difference in behavior occurs, the behavior indicates a need for a detailed assessment to determine if there is a medical condition that is causing the sudden change in behavior. He stated if medically correctable causes are ruled out, the next actions are non-pharmacological interventions, such as distraction, calming responses, and other alternate activities.

The family physician stated the use of antipsychotic medications is appropriate if the behavior may be amenable to targeted medication intervention. This could include when the behavioral symptoms are causing significant distress to the patient or pose a threat to others or staff. He discussed the general idea of off-label use of medications and noted that such use is a standard of care. He stated using medications for off-label use is determined by the risk versus the benefits for the

specific patient, including side effects and complications. He noted using antipsychotic medications in nursing facilities is to improve the patient's quality of life and not to sedate or restrain the elderly patient. The family physician noted the CMS quality rating, counting all antipsychotic use in nursing facilities, tends to penalize smaller, rural facilities due to higher percentages for the same number of patients.

In response to Task Force members' questions, the family physician stated he has seen a drop in the use of antipsychotics, such as Haldol, because of the preponderance of problems in nursing facilities that used Haldol. He noted the use of any medication that causes a behavior change needs to be evaluated by a physician. With dementia patients, the physician needs to look at cognition over time to determine if behavior changes are a result of the natural progression of the disease or a result of the medication.

A psychiatrist, who addressed the Task Force virtually, stated there are approximately 350 nursing facilities in the state, with more than 16,000 residents total. More than half of the residents have some form of dementia or cognitive impairment. Dementia is identified as a Major Neurocognitive Disorder in the Diagnostic and Statistical Manual 5th Edition (DSM-V). Dementia is a progressive brain disease. About 90 percent of patients have at least one disruptive behavior, and 45 percent have at least four disruptive behaviors. The psychiatrist discussed the use of non-pharmacological interventions to reduce the intensity of the symptoms of dementia. These include staff education, therapeutic activities, patient-centered care, and sensory interventions.

The psychiatrist stated medication intervention for behavioral symptoms of dementia is appropriate if the medications improve the quality of life or the safety of patients and staff. He stated using antipsychotic medications should be done slowly and using low dosages. He noted aggressive behavior, hallucinations, delusions, severe distress, and agitation are generally appropriate indications to consider the use of antipsychotics. Behaviors such as wandering, nervousness, non-social behavior, fidgeting, restlessness, impaired

memory, or apathy are not indications to use antipsychotic medications.

In response to Task Force members' questions, the psychiatrist noted that justification for the use of antipsychotics when the diagnosis is not schizophrenia, Huntington's, or Tourette's Syndrome should be supported by documentation from a psychiatrist. The psychiatrist indicated a traumatic brain injury or other medical condition may be the cause of intractable cases of violent behaviors that cannot be controlled with non-pharmacological processes. Some facilities do not have access to psychiatrists, so education should be provided to physicians and nurse practitioners to assist with these patients. The use of telepsychiatry is also an option.

Regarding options to mitigate harm available to address a resident with sudden excessive behavior, the psychiatrist stated, when a crisis happens, the need for help is immediate. Options to address the sudden behaviors include a contract with a community mental health center, a one-time, per-month lunch-and-learn session for staff to provide education, phone call access to a specialist, and access to psychiatrist through the ECHO Project for pediatric cases.

Interaction among Mental Health, Dementia, and Alzheimer's Disease

A neurologist and Co-Director of the University of Kansas Alzheimer's Disease Center addressed the Task Force. He stated dementia is the broad term, and Alzheimer's is one type of dementia. Other types of dementia include vascular dementia or strokes, dementia with Lewy Bodies, frontotemporal dementia, and Parkinson's disease. Dementia tends to manifest as mental health issues and behavior and personality changes. Symptoms include anxiety, depression, agitation, hallucinations, and delusions and are generally not related to previous mental health concerns. He noted Alzheimer's disease is a public health crisis as nearly six million citizens across the country are living with the disease in 2021. In Kansas, 65,000 people are impacted by the disease. For individuals 65 and older, 1 in 10 have Alzheimer's. For individuals 85 years and older, 1 in 3 have Alzheimer's.

The Director of the Cognitive Care Network, University of Kansas Alzheimer's Disease Center,

discussed three groups of people impacted by dementia and Alzheimer's. These are individuals with pre-existing mental health conditions, individuals with neuropsychiatric symptoms that emerge in dementia, and individuals with intellectual and developmental disabilities. She noted the risk factors, such as cardiovascular issues, persistent depression, early life trauma, schizophrenia, and Down Syndrome. The Director stated families tend to expect obvious decomposition in mental health, but changes in their loved one can be subtle. She suggested unsettled past issues in a person's life may play out in dementia symptoms. Depression also plays a role in dementia.

In response to a question, the Director stated an unsettled past such as violence, family trauma, and unresolved grief may emerge as neuropsychiatric symptoms in dementia. She stated dementia tends to dismantle a person's coping strategies. The Director noted the use of depression measurement scales are limited for persons with dementia because the individual may not be able to understand or fully respond to the questions such scales ask.

Presentation on Abuse, Neglect, and Exploitation

The Regional Director for Department for Children and Families (DCF) discussed the agency's approach to Adult Protective Services (APS). She noted, in contrast to child welfare services, APS does not have federal funding or oversight. Each state is responsible for its APS program. Four state entities investigate allegations of adult abuse. These are DCF, KDADS, KDHE, and the Office of the Attorney General (OAG). DCF maintains a registry for individuals who have been substantiated of committing abuse, neglect, and/or financial exploitation (ANE). The registry is accessible to employers.

The DCF Regional Director stated cases are assigned as abuse, neglect, financial exploitation, and self-neglect. A protection specialist will make two unannounced face-to-face visits with the involved adult. Records may be requested to determine the validity of the allegations. After information is collected, the case is staffed and a case finding is determined. Case findings must be

completed within 30 business days, except for financial exploitation cases, which have 60 days. In 2021, HB 2150 modernized the APS statutes, and the Regional Director noted the statute changes are leading to better results. The protection specialist will assist the involved adult in locating services and resources to maintain physical or mental health. Services are offered but not imposed. If a case involves potential crimes, local law enforcement and the OAG are notified.

The DCF Regional Director provided information on the staff makeup for APS. She noted APS utilizes an advisory group that meets quarterly to provide input and feedback on how APS can improve the work it does. HB 2114 (2021) requires the Attorney General to appoint an Elder and Dependent Adult Abuse Multidisciplinary Team Coordinator to facilitate the convening of an Elder and Dependent Abuse Multidisciplinary Team in each judicial district to enhance the investigation and prosecution of cases.

With regard to the calls received, the DCF Regional Director noted self-neglect is the highest type of substantiated case, and financial exploitation is the lowest. The federal Administration for Community Living established the Coronavirus Response and Relief Supplemental Appropriations Act: Grants to Enhance Adult Protective Services to Response to COVID-19 Program, which provides grants to enhance the ability of APS to investigate allegations of ANE. Federal relief funding includes a total of \$768,741 in COVID-19 funding, American Rescue Plan Act (ARPA) Grant 1 funding of \$704,707, and a proposed ARPA Grant 2 of \$2,178,155 to use into 2024.

In response to a question, the DCF Regional Director stated the agency is working to obtain training on dementia for the protection specialists.

A Deputy Attorney General presented on the Fraud and Abuse Litigation Division at the OAG. The ANE Unit was established by statute in 2006 and amended in 2016 to narrow the focus of cases requiring mandatory review by the OAG. It also permitted the OAG to assist in the investigation, prosecution, and prevention of cases involving ANE. The ANE Unit was moved to the Fraud and Abuse Litigation Division in 2016. The Deputy Attorney General noted many states do not have specific

statutes related to elder abuse like Kansas does. The number of ANE referrals received in FY 2020 and the number of substantiated cases against residents or adults were also provided.

The Deputy Attorney General stated the OAG does not have original jurisdiction regarding criminal prosecution of elder ANE. The County or District Attorney must request that OAG prosecute the case.

The Deputy Attorney General provided the following information in response to Task Force members' questions:

- The next OAG annual report will be published in January 2022 for FY 2021.
- Certified nurse aide (CNA) and nurse registries are public. The other registries discussed under ANE are not public, and access is limited by statute. Typically, these registries are only available to employers. It is a public policy decision whether those registries should be open to law enforcement or an investigative agency. According to the Deputy Attorney General, generally, the more information law enforcement or any investigative agency has, the better off they are. In most situations, if law enforcement is communicating with DCF or KDADS, then law enforcement will be aware of the substantiation.
- Regarding ANE, most offenders are not regulated health care providers but are family, friends, unlicensed caretakers, or neighbors. Strangers are not a high percentage of the offenders, unless it involves scams.
- HB 2114, enacted in 2021, provides funding for the Kansas Elder and Dependent Adult Abuse Multidisciplinary Team Coordinator, but does not provide funding for the teams in every judicial district. Multidisciplinary Teams allow individuals with particular expertise to volunteer their time to help with ANE cases.

- A CNA or nurse can continue to work while under investigation for ANE. The FY 2020 average time frame from the date reported to substantiation of ANE for DCF was 85 working days and 488 working days for KDADS. Survey agencies are required to send referrals to the OAG if evidence of ANE is found. The number of ANE referrals for FY 2020 from DCF, KDADS, and KDHE were provided. By statute, KDHE, KDADS, and DCF are required to report substantiation of ANE to the state regulatory authority that regulates the individual in question.

Presentation on Other States' Efforts to Address Workforce Shortages

A KLRD research analyst provided a memorandum on several states' actions related to the recruitment, retention, and education of workers in long-term services and supports (LTSS). The LTSS workforce is expected to increase by 41 percent between 2016 and 2026. Staffing shortages predated COVID-19 and have affected both institutional care and community-based care. He highlighted caregiving strategies and staffing programs started in Georgia, Maine, Maryland, Minnesota, Montana, and Tennessee. He noted it is too soon to have measurable data for some of the states' programs. Minnesota's efforts have been well reviewed, but research studies are still being completed on older programs.

Discussion of Working Groups

A KHI analyst described the working group charter process and procedures. KHI will provide the administrative support, facilitation, and the report of working group recommendations. The report will include recommended changes to state statutes, rules and regulations, policies, and procedures. Topics include: care for seniors with Alzheimer's, dementia, and age-related mental health; antipsychotic medications in adult care homes; safeguarding against abuse, neglect and exploitation; surveys and fines; funding through the Senior Care Act, senior day care resources, and HCBS rebalancing. The issue of workforce will cross all topics.

Two options for working group structure were presented. Based on prior discussion with Task Force leadership, it was agreed two working groups

and one subgroup would be formed. The KHI analyst reviewed the timeline for the working groups. The timeline anticipates the working groups' report to be presented to the Task Force by August 2022.

Chairpersons and co-chairs were determined for the Quality Care and Protective Services Working Group, the Access to Services Working Group, and the Workforce Subgroup. Discussion was had regarding the need to have less than the quorum of Task Force members participating in any working group or subgroup to avoid a Kansas Open Meetings Act violation.

The plan is for the working groups to begin meeting after the December 2021 Task Force meeting.

Discussion of Possible Recommendations on Topics Discussed in Meeting

Task Force members suggested possible presentation topics for future meetings, including public comment from residents of LTC facilities; KDADS' investigation process on complaints involving a LTC facility; MCOs' efforts on HBCS rebalancing; the Kansas Guardianship Program; geriatric services available through the CMHCs; the amount of care provided by family caregivers and what the caregiver pool looks like; and the perspective of assisted living and skilled nursing facility chief executive officers (CEOs) on what it is like to be regulated.

KLRD staff distributed a map provided by KDADS depicting the percentage of the population that is age 65 and older in each Kansas county in 2015 and projected for 2025.

December 6, 2021, Meeting

Agency Response to Previous Task Force Questions

The Deputy Secretary of Programs, KDADS, reviewed the detailed responses to questions asked by Task Force members in a previous meeting. Responses included references and citations to regulations at both the federal and state levels, distinctions between the State's access to data and the MCOs' data, the difference between institutional services and HCBS, and a comparison of state rankings for LTSS.

Follow-up Information from November 10 Meeting

A KLRD research analyst provided follow-up information from the previous Task Force meeting: a KLRD memorandum on the Tennessee LTSS Workforce Program and a revised KHI Working Group Charter. A list of resources recommended by Task Force members was provided.

Presentation on Formularies for Psychiatric Medications and Step Therapy Impacting Senior Population

The Medicaid Pharmaceutical Program Manager, KDHE, explained the Medicaid State Drug Formulary is the set of drugs CMS requires to be covered by Medicaid. The set of drugs can change on a daily basis. The preferred drug list is a subset of the formulary and is applied as a management tool to try less expensive medications before more expensive medications. The process of using a less expensive medication first is referred to as step therapy and informally described as “fail first.” The Program Manager stated fail first is not an accurate description of step therapy because almost 80 percent of Medicaid patients are on the first line of drugs, or the less expensive medications. She noted the Guiding Principles of Step Therapy, approved by the Drug Utilization Review Board, is used when any new step therapy criterion is proposed.

The Program Manager stated based on a 2017 CMS report on the use of antipsychotic drugs in the nursing home population, the State added two medical necessity criteria. She noted management of opioid drug prescribing is at the point-of-sale (retail pharmacy), and patients must fall into one of four categories. Medicaid providers are also required to check the Kansas Prescription Drug Monitoring Program (K-TRACS) for a patient’s drug history before prescribing a controlled substance. In response to a question, she stated step therapy management is for new patients only.

Overview of Community Mental Health Center System and Services Available; Certified Community Behavioral Health Clinic Transition

The Executive Director of the Association of Community Mental Health Centers of Kansas provided an overview of the state’s mental health system. He stated licensing regulations require the CMHCs to provide services to all Kansans needing

mental health care, regardless of their ability to pay. The CMHC system is the state’s safety net for mental health care. The CMHC system is comprised of 26 facilities serving specific regions and employs over 5,000 persons, but current estimates indicate an approximately 12 percent staff vacancy rate. He noted in FY 2019, 145,000 Kansans were served. The state has two state mental health hospitals: Osawatomie State Hospital (OSH) serving eastern Kansas and Larned State Hospital (LSH) serving western Kansas. Former hospital patients rely on the CMHC system for mental health treatment to maintain their ability to live in the community. Funding for these services has been cut by about 30 percent over the last decade. If mental health services are not provided in a timely manner, the individuals may end up in the state hospital, emergency rooms, or jail, all of which are more expensive than community-based mental health services. In recent years, some funding has been restored to the CMHC contract funding.

In 2015, KDADS placed a moratorium on all voluntary admissions to OSH due to the decertification of the hospital by CMS. The Executive Director stated OSH has reached maximum capacity multiple times. He noted, when state hospital beds are not available, the CMHCs are responsible for maintaining patients in a safe environment until a bed becomes available, which can take days. [Note: On December 16, 2021, Governor Kelly announced KDADS planned to lift the moratorium at OSH on January 3, 2022.]

Some CMHCs provide specific services for seniors such as caregiver support groups and therapy provided in nursing facilities. The CMHCs are partnering with other agencies, such as Meals on Wheels and AAAs, and about 30 percent of CMHC staff specialize in aging services. The Executive Director noted future services should include more telehealth, though gaps in broadband access and lack of technology hardware continue to be a barrier.

The Executive Director explained the certified community behavioral health clinic (CCBHC) model’s services and training requirements. The CCBHC model is anticipated to provide a sustainable approach for necessary resources.

The Chief Executive Officer of the Wyandot Behavioral Health Network stated his facility is preparing to seek state certification as a CCBHC in May 2022. He noted the facility served 1,600 clients over 50 years of age, and 200 of those clients were over 65 years of age. He noted the facility works closely with a local nursing facility for mental health and Midland Care.

Presentation on Efforts to Address Workforce Shortages with Focus on Services Impacting the Senior Population; Network Adequacy

The Deputy Secretary of Hospitals and Facilities, KDADS, stated KDADS reports workforce numbers in LTC to the National Healthcare Safety Network. Facilities report to KDADS on their staff shortages for nurses, clinicians (physicians), and aides. Up to 344 facilities have been reporting their workforce numbers to KDADS since May 2021. Shortages of nurses and aides peaked in the fall of 2021 during the outbreak of the COVID-19 delta variant. To address workforce concerns, the Deputy Secretary stated KDADS is meeting weekly with nursing facility trade associations, coordinated a discussion with KDHE and the Division of Emergency Management, made state contracts available for nursing staff, met with schools to determine barriers to training additional students, and is working to identify clinical sites for training. He noted various relief funding sources during the COVID-19 pandemic from both the federal and state governments, some of which was used to address workforce issues.

The KDADS Deputy Secretary stated the KDHE and KDADS joint HCBS FMAP enhancement spending plan (ARPA) has been submitted to CMS, and the agencies are waiting on full approval. KDADS expects to draw down approximately \$80.3 million in additional federal match and of that, the final investment portfolio designates \$57.1 million dollars spent on workforce including a \$2,000 bonus per worker, \$200 training grant per worker and \$1.0 million dollars to investigate opportunities to create a career track.

The Director of Community Health Systems, KDHE, said the agency identifies areas of the state with health professional shortages and medically underserved populations. She described the four programs related to workforce shortages.

The Student Loan Repayment Program is offered to medical, dental, or mental health providers in exchange for up to five years of service commitment in a designated area, at an eligible practice site. The State Conrad 30 J-1 Visa Waiver Program assists international medical graduates in obtaining an H-1B or L-1 visa by waiving the two-year home county residency requirement in exchange for a commitment to practice medicine in a Health Professional Shortage Area. The Community Based Primary Care Clinic Program is for primary care or dental health. The Kansas Recruitment and Retention Center utilizes University of Kansas Medical Center residents and faculty to temporarily fill positions.

The Aetna Better Health of Kansas (Aetna) Director of LTSS discussed the MCO's efforts to address workforce shortages impacting the adequacy of the network of providers. Activities include reviewing areas of shortages and strategies to reduce the shortage impact on members, identifying providers who are not able to accept referrals due to staffing shortages, exploring out-of-network provider alternatives, leveraging single case agreements for enhanced rates, and removing unnecessary administrative hurdles for providers. Aetna also closely monitors member service utilization to identify potential gaps in care.

The UnitedHealthcare Community Plan (UHC) CEO described the direct service worker challenge by noting the comprehensive scope of duties expected, such as assistance with dressing, bathing, eating, housekeeping, meal preparation, mobility and getting out of bed (some persons require a Hoyer lift for all transfers), and support to attend medical appointments. He contrasted the Kansas Medicaid reimbursement rate of \$11.84 per hour with no paid time off and no benefits for direct service workers to a starting pay of \$15.00 to \$18.00 per hour with benefits at other work opportunities. He noted several strategies the MCO uses to address workforce shortages. The strategies include providing care through technology solutions and implementing alternative payment arrangements through single case agreements and mileage reimbursement.

The Sunflower State Plan (Sunflower) Vice President of LTSS stated the MCO has focused

on three areas to address the workforce shortage. These are the use of technology to increase member independence and decrease the reliance on in-person care, pursuing a shared living model that requires fewer people to implement, and preparing recommendations to present to KDADS regarding paid family caregivers. She stated the company is exploring the sequential intercept model for persons with I/DD and challenging behaviors. Originally, this model was utilized for persons with substance use disorder and mental illness.

Presentations from Managed Care Organizations on Strengthening and Rebalancing Home and Community Based Services, Process for Determination of Measures and Appropriate Use of Antipsychotics, and Value-added Services Specific to Seniors

The UHC Chief Fiscal Officer stated the company is incentivized to rebalance through the structure of capitation payment and pay for performance (P4P) metrics, established by KDHE and KDADS. Three of the 13 P4P metrics focus on transitioning persons from nursing facilities to the community.

The UHC Health Services Director discussed the Community Transitions program, designed to help members transition from a nursing facility to the safest and most independent setting possible. Individuals must have resided in a nursing facility for at least 90 days, and it can take an additional 90 days to make the transition. Some challenges for successful transition are persons with past history of evictions, criminal background, and violent behavior. She stated 1,000 persons have been transitioned to the community since the 2019 contract.

The UHC Medical Director addressed the use of antipsychotic medications in the geriatric population. He stated since June 1, 2020, in compliance with KanCare requirements, UHC monitors the use of antipsychotic medications for patients with dementia without an FDA-indicated diagnosis. If a patient has been prescribed an antipsychotic without an FDA- indicated diagnosis within the 30-day look back period, UHC asks the prescriber to provide documentation with a clinical rationale for the medication. If the reviewer does not agree with the rationale, a verbal peer-to-peer discussion takes place.

The Sunflower Vice President of LTSS stated 77.4 percent of Sunflower members in LTSS utilize HCBS, and 22.6 percent are in a nursing facility. Since 2019, 749 persons have transitioned from a nursing facility to the community.

She stated Sunflower engages in value-based payments and, in addition to covered benefits, offers services outside of covered benefits to increase quality outcomes. These include value-based payments to transition coordination service providers, transition funds for setting up the new household, home-delivered meals during transition, extra in-home visits, in-home wellness checks, nursing facility liaisons, and a dedicated service coordination transition team.

The Sunflower Vice President of LTSS described the nursing facility antipsychotic monthly outreach. Outreach includes communications with the nursing facility medical directors, prescribers, Minimum Data Set coordinators, and the nursing facility director of nursing.

The Aetna LTSS Director stated Aetna encourages members to move to community settings by utilizing the transition program. Currently, 116 members, who have a 24/7 plan of care, receive HCBS. Service coordinators assess and develop a person-centered discharge plan. The service coordinators work with community providers to help members access housing and community resources, obtain accessibility assessments, set up utilities, and purchase household items. The target goal is for 70 percent of LTSS members to reside in a community setting.

The Aetna Chief Medical Officer discussed the use of antipsychotic medications. She stated the Aetna medical directors conduct a clinical review of the person's medical record, history, current status, medications, diagnoses, behaviors, recent changes, lab results, and other information pertinent to the review. If the use of antipsychotic medication is considered inappropriate, the medical director reaches out to the prescriber to discuss alternatives. She noted it is up to the prescriber to make changes to the member's care plan.

December 7, 2021, Meeting

Public Comments from Long-Term Care Consumers, Providers, and Stakeholders

The Kansas Long-Term Care Ombudsman provided an overview of the testimony for the conferee who was unable to present in person due to illness and summarized the written-only testimony from residents and family members of persons residing in nursing facilities.

The Long-Term Care Ombudsman stated the Office of the State Long-Term Care Ombudsman has seven staff across the state, and they advocate for the rights of residents in LTC facilities and before the Legislature.

LTC residents and their family members indicated being pleased with the care received and the food served and feeling compassion for the staff.

Concerns expressed included whether future funding will be enough to care for people going into LTC who have memory issues; overnight issues disturbing the ability to sleep; not receiving medications; residents being treated differently; staffing lacking at other times; cold food; long periods without hair washing and bathing care; infrequent undergarment changes, with one resident reporting limiting fluid intake because the facility runs out of briefs or is too short staffed to change the resident more than twice a day; vermin problems; long waits for call light responses; lack of necessary equipment to accommodate physical limitations; the facility not providing food the resident is able to eat and digest; unnecessary transfers to behavioral health facilities for unmet needs due to dementia; improper discharges; the need for more resources for senior advocacy; lack of communication between family and administration and other staff; the use of antipsychotic medications including Haldol to calm residents; the need for facility staff to have training in dementia; issues with Medicaid; and frustration at the previous year's COVID-19-related restrictions.

A member of the Silver Haired Legislature and the Task Force spoke as a private citizen about her concerns. She and her husband want to age in place in their chosen community and have adapted their home to their health and quality of life issues. She stated health care is intertwined with electronic and digital communications, but the lack of reliable

broadband is a barrier to care. She noted there is no industry standard governing signal strength, and each company uses its own algorithm resulting in inconsistent signals and dead zones with no signals. She asked the Task Force to consider adding regulations for consistent strength of signal across the state and address the quality and affordability of the service on which so many depend.

Presentation on Survey Process, Deficiency Levels, and Fines

The Survey and Certification Commissioner, KDADS, addressed the Task Force. She provided a list of the number and type of LTC facilities in the state and a map showing the four regions for the district offices of the Survey and Certification Commission. She noted during the first two quarters of 2021, 102 surveys were completed in state-licensed only facilities, with 279 deficiencies written, and 109 surveys were completed for nursing facilities, with 615 deficiencies written. She described the steps in the survey process and outlined the timeframes for reports and responses and deadlines for facilities to request an Informal Dispute Resolution.

The Commissioner discussed the survey process pertaining to treatment and services for dementia. She noted there is an abbreviated survey conducted that is based on complaints received. She noted the civil monetary penalties (CMPs) issued by KDADS are generally \$500 per day up to \$2,500 and can double based on certain criteria. All civil penalties go to the SGF. CMS may impose fines according to their requirements. A portion of the federal civil monetary penalty is returned to the State for reinvestment to support activities to the benefit of nursing home residents. The CMP fund balance at the time of the meeting was \$5,565,715, and KDADS generally keeps \$4.0 to \$5.0 million in the fund for emergency receiverships.

Presentation on Survey Process from a Provider Perspective

The Administrator of Locust Grove Village stated her facility is the only continuing care retirement community in a multi-county region and noted the number of skilled nursing beds,

assisted living units, and independent senior living apartments they provide. She stated there is a highly regulated and punitive system of multiple government agencies providing oversight of the facility's work. She listed the multiple considerations of regulations, including a 696-page document from CMS. In addition to the regulation and oversight of the services, the business must also comply with the regulations of the federal Occupational Safety and Health Administration, Kansas State Fire Marshal, Kansas Department of Labor, and the Kansas Department of Transportation. The Administrator noted the round-the-clock, year-round nature of the business. She suggested instead of a punitive model of regulation, it should be a quality improvement model using a collaborative approach.

The President of Advena Living joined the Task Force meeting virtually. Advena operates seven small- to mid-sized senior communities in the eastern half of the state, in mostly rural or underserved areas of larger communities. He stated the regulatory system is punitive in nature and puts people in a fearful position that increases natural defensiveness. He stated the system and regulations are subjective rather than objective because survey results depend on an interpretation and whether the surveyor agrees with the actions taken by the facility.

Presentation on Kansas Guardianship Program

The Executive Director of the Kansas Guardianship Program (KGP) testified before the Task Force. The KGP recruits citizens who are willing to be appointed as a guardian or conservator for persons who do not have a willing or able family or friend to assist them when they become unable to make informed decisions on their own behalf. The program works closely with Adult Protective Services and the state hospitals through KDADS. A person is eligible for services if they are an adult, on Medicaid, have no family, and have an open case with APS at DCF or are an individual residing in a KDADS facility. Either DCF legal services or attorneys for the state hospitals petition the courts for legal appointment. The KGP Executive Director outlined the volunteer recruitment, training, supports, and assistance KGP provides.

The Executive Director stated the agency served 1,394 persons in FY 2021 and has 772 volunteers

serving as guardians or conservators. Most of the individuals served have intellectual/developmental disabilities, mental health and/or behavioral health issues, or are aged individuals.

She provided statistics on the age range, residency, and type of services provided to those served. She noted alternatives for appointed guardianship can be informal help such as family, a Social Security or Veterans Administration payee, a durable power of attorney, supported decision-making, or voluntary conservatorship. The process from petition to appointment can take close to a year.

Status of Working Group Process; Working Group Charter

A KHI analyst reviewed the working group charter, including the purpose, product, structure and scope, and the two working groups and one subgroup to be formed. She reviewed the operating process and the timeline. She noted the Task Force will need to determine how the working groups are to prioritize their work. The three groups will meet the week following this meeting and then follow a recurring schedule of meetings. All meetings will be from 9:00 a.m. to 10:30 a.m. and will be conducted virtually.

Discussion of Short-term and Long-term Goals for Task Force and Working Groups

The KHI analyst discussed the visioning and goal setting for the Task Force. Task Force members discussed language for a vision statement. Task Force members discussed considerations for setting goals for the working groups.

Regarding a statutory definition of what age a person is considered a senior, a Revisor stated the Kansas Senior Care Act (SCA) is within the KDADS statutes (KSA 75-5902) and defines seniors as age 60 years or older. Task Force members also pointed to varying ages for seniors defined in the Older Americans Act and Medicaid law. When defined by funding, the age considered as a senior is 60 years of age and older. The Task Force approved the designation of senior as defined in the SCA.

CONCLUSIONS AND RECOMMENDATIONS

Discussion and Recommendations for Senior Care Task Force Report to the 2022 Legislature

Members of the Task Force submitted suggestions for recommendations, which were compiled by KLRD staff into a chart and distributed to the Task Force members for use during the discussion.

At the December 7, 2021, meeting, most recommendations on the chart were assigned to a working group for further discussion and review. A fiscal note was requested to examine and modify the HCBS/FE rate-setting methodology before including it as a recommendation from the Task Force.

The Task Force adopted the following recommendations at its December 7, 2021, meeting:

- KDADS should reach out to universities for assistance in mapping the various senior services across the state.
- The Legislature should explore the possibility of using temporary aides in long-term care.
- A request should be made to the Legislative Division of Post Audit to perform a limited-scope audit (less than 100 hours) to determine where broadband funding, including federal funding, has been spent in the state and to identify the differences between urban, rural, and frontier regions of the state.
- KLRD should research the funding for broadband for the state.
- The Legislature should seek funding to produce a new Kansas Elder Count book, including a digital version.