Caring for Kansans at Home

Kansas Home Care & Hospice Association

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TO: Kansas Senior Care Task Force
FROM: Jane Kelly, Executive Director, KHCHA

I appreciate this opportunity to briefly address this task force for Senior Care issues for the state of Kansas. First, I would like to briefly explain that Kansas Home Care and Hospice Association represents agencies that are for the most part provide skilled nursing care in patient's homes – those homes being wherever the patient lives. Some payment sources are Medicare, some Medicaid, some are VA, some are private pay. The majority of our member agencies are Medicare certified. We have agencies that are stand-alone, hospital-based, licensed through the county health department, not-for-profit and some for-profit. In Kansas we have relatively few large national chains running agencies. We have member agencies that have both home care and hospice licenses. We have some agencies that participate as members in one category or the other.

Our association operates as a 501c6. Our purpose is to educate, advocate and communicate with and for our members and through this, help them serve their patients better. As many of you, it has been a real challenge over the last decade. Although being cared for in ones home is the first choice a person wants, especially after leaving the hospital or other acute care setting and in most cases it is the most economical; Medicare and Medicaid make it harder and harder on those that provide this care. Our association has been in the forefront with our national association in leadership positions for the last 20 years, trying to keep the message of rural healthcare providers front and center. As I know a lot of you will agree – the job has not gotten any easier, in fact it feels like it's only gotten harder. Let me give you a few examples.

If you look at a map of Kansas showing our member agencies, we have lost a number home care and hospice agencies in the western part of the state over the last 5 years. Some have closed as part of a hospital wherein the hospital administrator believes cutting this service will save money and they can refer to a neighboring county. When they try to refer to a neighboring home care or hospice agency, that agency does the mileage calculations to serve that patient and it doesn't pay them to travel that far – so it becomes an access to care issues. I tried to testify to this issue many times in the KanCare Oversight Committee, only to be contradicted later in the day by either the Managed Care Companies or the state agencies themselves – saying there was no access to care issue. If we as providers can't be backed up – where do we go? Believe me – when agencies are closing and a patient can't get services, there is an access to care issue! In other cases, as many of you know – the hospital themselves have closed.

Another example is in our KanCare – Medicaid Managed Care. Over the time that we have had KanCare – the number of my member agencies services the Medicaid patient has dwindled for two reasons. One is referrals. I won't do a deep dive into that but believe me the number of referrals has shrunk. The other reason is the financial bottom line – the agencies simply cannot afford those patients. Before KanCare – they couldn't afford these patients – but they took care of them anyway because sometimes they could make it work financially and they felt like it was a community service. But now they just

cannot afford to take these patients on. It has been so long since they have received any kind of rate increase for Medicaid services and with the increased staffing it has taken for submitting claims and trying to handle the issues of getting paid by the Managed Care companies, most of the agencies in Kansas that are still in business are barely hanging on.

I hesitate in some ways to talk about some of these issues because as some of you on this task force are in the same predicament and could be seen as competitors. But I believe we are all in the business of caring for the patients; the citizens of Kansas. Whether it be our vulnerable population of long-term chronically ill; mentally or physically disabled or our elderly. I know after 14 plus years in this position that home care is more economical way to care for a patient. But I also know (especially after the last 6 months of caring for my 91 year old mother-in-law with stage 5 kidney failure) and trying to keep her in her home and directing her home care and getting her to her twice a week dialysis – that sometimes there will come a time when home care is no longer feasible. And of course there are very few people this day and age that have not been touched in some way by hospice. So – I decided I wasn't going to beat around the bush about where we are.

Three of the national organizations The National Association of Home Care & Hospice, The Home Care Association of America (which is mostly non-skilled agencies); and the Partnership for Medicaid Home-Based Care (which is comprised of organizations representing home care agencies, associations, managed care organizations and other payors & business affiliates); are all three joining together to increase awareness in the critical nature of the workforce staffing shortage and how that affects all areas of care – and of course, would affect senior care and the issues this task force is studying. What happens when a patient is denied care because there isn't available healthcare (an agency in their home town or enough staff at an agency or they don't have a family member to care for them or they don't have a nursing home to go to or they aren't at the spend down level for a nursing home yet).

Nothing else can really matter until the workforce situation is addressed. The alliance of the three associations believes it's not just increased reimbursement as the lever. We must look at a variety of triggers, all happening together to help resolve this issue – immigration reform, childcare reform, improving the image/brand of the aide through better training and career opportunities.

I just finished last year a 4 year stint as the chair of the Forum of States Association which is the group of state home care and hospice associations under the National Association of Home Care & Hospice (NAHC) – all of the state executive directors meet monthly (weekly during the height of the pandemic) and in-person twice a year; in this position I also sat on the NAHC board of directors, so I was able to work hand in hand with many national leaders. One of my state association colleagues is now the executive director of The Home Care Association of America and has established a new working relationship with the state associations. The Medicaid Partnership has a board of directors that works directly with our group of state association execs as well – so as a leader in this group – I've worked hard at carrying the torch for rural states. I was just appointed to a task force for NAHC to study rural health issues and we will be having our first meeting in a few weeks. This will be led by NAHC's Vice President for Policy, Mary Carr. I am happy to share information on the this and any of the work the three national organizations will be doing on workforce issues. I look forward to hearing what this group comes up with and look forward to giving any other input I can that will help the providers and the patients they serve.

Respectfully submitted,

Jane Kelly, Executive Director
Kansas Home Care & Hospice Association