

Date: August 25, 2010

Kansas Department on Aging
Economic Impact Statement

In 2003, the Kansas Legislature passed K.S.A. 39-925, transferring administration of the adult care home licensure act from the secretary of the Kansas Department of Health and Environment (KDHE) to the secretary of the Kansas Department on Aging (KDOA), including certain KDHE rules and regulations, effective July 1, 2003. The adult care home regulations transferred to KDOA are being re-organized as they are updated to reflect new standards of care, and a new numbering system has been developed to accommodate this change. The following is a list of the regulations included in this series, along with a brief description of significant revisions.

I. Summary of Proposed Regulation(s), Including Purpose:

K.A.R. 26-39-100 - Definitions. The amendment to this KDOA regulation coincides with the proposed Nursing Facility (NF) Physical Environment regulations listed below, with the following revisions incorporated: 1) Definitions for “addition,” “alteration,” “minor alteration,” and “renovation” of an adult care home have been added or revised; 2) nursing unit in a nursing facility has been re-defined to serve no more than 30 residents; and 3) certain terminology has been changed to promote resident-centered care.

K.A.R. 26-39-101 - Licensure of adult care homes. The amendment to this KDOA regulation updates regulatory references to coincide with the proposed NF Physical Environment regulations listed below. In addition, requirements have been removed for providers who are making alterations, remodeling, or relocating required rooms that do not involve structural elements.

K.A.R. 26-39-105 - Adoptions by reference. The amendment to this KDOA regulation coincides with the proposed NF Physical Environment regulations listed below and centralizes adopted standards applicable to adult care homes into a single regulation. Certain materials adopted by reference in existing KDHE NF Physical Environment regulations have been incorporated into this regulation and updated to reflect current standards.

K.A.R. 26-40-301 - Nursing facility physical environment; construction and site requirements. This is a new regulation that updates the standards and terminology that were originally adopted by KDHE’s K.A.R. 28-39-162. Minor provisions have been added, including requirements for adequate parking and access for service vehicles.

K.A.R. 26-40-302 - Nursing facility physical environment; applicants for initial licensure and new construction. This is a new regulation that updates the standards and terminology that were originally adopted by KDHE’s K.A.R. 28-39-162a. Please note that requirements established by KDHE’s regulation have been separated into two new regulations. K.A.R. 26-40-302 establishes standards for new licensure and new construction, whereas K.A.R. 26-40-303 establishes standards for currently licensed nursing facilities. Changes to requirements for new licensure and new construction reflect the movement in nursing home care to a smaller group of

residents living in a home environment. Significant changes in regulatory requirements include an increase in square footage in resident rooms and other certain areas; an increase in the minimum percentage of private rooms from 5% to 50%; and an increase in the minimum number of resident toilet rooms and showers.

K.A.R. 26-40-303 - Nursing facility physical environment; existing nursing facilities. This is a new regulation that adopts the standards that were originally adopted by KDHE's K.A.R. 28-39-162a. This regulation applies only to nursing facilities licensed as of the date this regulation becomes effective and primarily reflects current regulatory standards. However, this regulation does limit the number of residents in a single room to two and will impose minimal changes to other regulatory requirements, e.g. updating the Food Code that is adopted by reference. The regulation has been reformatted and the terminology revised to enable stakeholders to more readily identify and understand regulatory requirements.

K.A.R. 26-40-304 - Nursing facility physical environment; details and finishes. This is a new regulation that updates the standards and terminology that were originally adopted by KDHE's K.A.R. 28-39-162b. This regulation is applicable to both new and existing nursing facilities; however, provisions have been included that allow nursing facilities licensed before certain dates specified in the regulation to maintain regulatory compliance. The regulation has been reformatted and includes applicable requirements previously included in other regulations.

K.A.R. 26-40-305 - Nursing facility physical environment; mechanical, electrical, and plumbing systems. This is a new regulation that updates the standards and terminology that were originally adopted by KDHE's K.A.R. 28-39-162c. However, most of the technologically-related mechanical, electrical, and plumbing requirements included in KDHE's regulation have been replaced with the adoption of professional codes and standards. The regulation has also undergone significant reformatting. Changes to ventilation and lighting requirements reflect recommendations obtained from professional sources.

K.A.R. 28-39-162; K.A.R. 28-39-162a; K.A.R. 28-39-162b; and K.A.R. 28-39-162c - Revoked.

II. Reason or Reasons the Proposed Regulation is Required, Including Whether or Not the Regulation is Mandated by Federal Law:

These regulations establish minimum standards and requirements relating to the location, building, construction, size, equipment, and amenities of nursing facilities, in accordance with K.S.A. 39-932. These requirements are deemed necessary to promote the health, safety, well-being, and comfort of the residents. The proposed regulations are not mandated by federal law, nor are they required to participate in, or implement, a federally subsidized or assisted program.

III. Anticipated Economic Impact Upon the Following:

a. Kansas Department on Aging:

Costs to the agency, other than staff time, will include publication in the Kansas Register, revision of policy manuals, training materials, and staff consultation to providers, as needed, to clarify the new requirements.

b. Other Governmental Agencies:

In addition to KDOA, the Department of Administration, the Attorney General, the Kansas Legislature (through the Joint Committee on Rules and Regulations and the Legislative Research Department), and the Secretary of State shall bear the costs associated with the adoption of these regulations.

c. Private Business or Individuals:

These regulatory changes were made in response to input obtained from numerous professionals, including architects, nursing facility providers, and representatives from nursing facility associations, consumer organizations, and the Centers for Medicare and Medicaid Services (CMS). In addition, changes were made in response to the national movement in nursing home care, led in part by many Kansas providers, to a resident-centered, home environment. These new models of long-term care endeavor to provide elderly individuals with the warmth and sanctity of home, offering the individual a sense of autonomy and dignity.

The following changes could have an economic impact on newly licensed nursing home providers and consumers:

- Decrease in the size of nursing units from 60 resident to 30 residents;
- Increase in square footage required for certain areas, including resident rooms and dining area;
- Percentage of private rooms increased from 5% to 50%;
- Resident toilet rooms required for each resident room (1 or 2 residents), rather than shared between two rooms (up to 4 residents);
- Shower required in 100% of the toilet rooms adjacent to private rooms and at least 50% of the toilet rooms adjacent to shared rooms.

The elimination of three and four-bed wards for a small number of existing licensed nursing facility providers may have a minimal economic impact on these providers. According to a KDOA survey, there are eight licensed providers (less than 1%) with three and four bed wards. This practice has only been allowed for those facilities licensed before January 1963.

An analysis of construction costs, estimated to be \$150 per square foot in Kansas, was completed with assistance from a well-respected architect who participated in the development of these proposed regulations. According to these estimates, a 60-bed nursing home built to meet current regulatory requirements would require at least 275 square feet per resident and 16,516 in total adjusted square footage. The estimated cost for the current model would be \$2,477,344. A 60-bed nursing home built to comply with

the proposed regulations, consisting of two resident units of 30 residents each, would require 397 square feet per resident and 23,841 in total adjusted square footage. These calculations are based on the assumption that certain support service areas are centrally located and shared by two resident units. The estimated cost for the proposed model would be \$3,576,188. Although this scenario proposes a significant increase in initial construction costs, there are many other variables involved in determining the overall economic impact of these changes. Costs associated with new construction may be offset with improved staff effectiveness and efficiency, resident contentment and improvement in overall health status, and community acceptance of the project. KDOA staff have been presented with a wide variety of floor plans with significant differences in the average square footage per resident, indicative of the wide range of options available to meet regulatory requirements.

A recently published research report entitled “*Exploring the Cost and Value of Private Versus Shared Bedrooms in Nursing Homes*” by Margaret Calkins, Ph.D., and Christine Cassella, estimated the construction cost, including debt service, of a traditional shared room to be \$20,506, compared to \$36,515 for a private room. This research also found that the additional costs could be recouped in less than two years if the beds are occupied, and less than three months if a shared bed remains unoccupied at average (national) private-pay room costs.

The average daily private pay rate in Kansas for nursing home care is \$148.89, according to data reported to KDOA by providers. A national financial group reports that a private room in a Kansas nursing home costs \$155.00 a day, compared to \$142.50 a day for a semi-private room. It is unknown how much of this variance is due to the customer’s preference for a private room, thereby increasing the cost to customers, weighed against the availability of private rooms. The current Kansas nursing home occupancy rate is 83%.

Missing from these estimates is the intrinsic value of immeasurable benefits to the resident, staff, and facility. The benefits to a resident of having a private room include a sense of normal living with privacy, control of personal belongings, normal visits with family and friends, an improved sense of well-being, shorter walking distances, and the reduced chance of infection from a roommate. Benefits to staff include assisting a smaller group of residents, thereby enabling staff to become more knowledgeable and intimate with residents. In addition, staff have smaller areas to cover and are able to work more efficiently. Benefits to the owner include improved marketability and increased resident, staff, and family satisfaction. While it is virtually impossible to place a monetary value on these benefits, these factors weighed heavily in the development of these regulations.

d. Kansas Association of School Boards:

None

IV. Less Costly or Intrusive Methods That Were Considered, but Rejected, and the Reason for Rejection:

KDOA's proposed regulations were developed based on the adult care home regulations transferred from KDHE that are currently in effect. Revisions to these regulations were made based on consideration for the protection of the health, safety, and well-being of nursing home residents, weighed against recognized and unknown costs to the provider and/or consumer. Stakeholders, including providers, representatives from the provider associations and consumer protection organizations, and professionals in related fields have participated in discussions of these revisions and feedback was encouraged. We believe we have reached a reasonable compromise between what is in the best interests of the resident and the provider.