

## LONG-TERM CARE SYSTEM - BACKGROUND MEMORANDUM

The 2007 Legislative Assembly approved Senate Bill No. 2109. Section 3 of the bill, attached as [Appendix A](#), provides for a Legislative Council study of the long-term care system in North Dakota, including capacity, geographical boundaries for determining capacity, the need for home and community-based services, a methodology to identify areas of the state needing additional nursing home beds, access, workforce, reimbursement, and payment incentives.

### PREVIOUS STUDIES

The **2001-02 Budget Committee on Human Services** studied the long-term care needs and nursing facility payment system in North Dakota. The committee received a report from a consultant hired by the Department of Human Services to review North Dakota's nursing facility payment system, which contained the following recommendations and the department's responses:

1. Evaluation of the 90 percent occupancy incentive - The consultant recommended the state continue the minimum occupancy percentage at 90 percent. The department concurred with this recommendation.
2. Evaluation of rebasing frequency - The consultant recommended the state:
  - a. Establish a maximum number of years between rebasing. The department believed this is a policy decision to be made by the Legislative Assembly. The 2005 Legislative Assembly provided that nursing home rates be rebased every four years.
  - b. Monitor and evaluate facility spending patterns during periods between rebasing that would identify:
    - (1) Significant changes in costs in excess of that estimated by the inflation index.
    - (2) Changes in the allocation of costs between direct, other direct, and indirect cost categories.
    - (3) Changes in a facility's resident acuity. The department concurred with the recommendation and believed additional analysis would be useful in establishing benchmarks to be used by the Legislative Assembly in determining if more frequent rebasing is necessary.
  - c. Change the method of calculating limits from the percentile method to a "median plus" method. The percentile method precludes a certain number of providers above the limit from receiving payments that cover all costs. The "median plus" method potentially would allow all facilities to operate at a level below the established limit. The department concurred with the recommendation and recommended the process be changed when limits are rebased. The 2005 Legislative Assembly approved using the "median plus" method.
- d. Set limits for direct, other direct, and indirect costs at the "median plus" 20 percent, 20 percent, and 10 percent, respectively, or in proportion with these recommendations in order to achieve the greatest cost coverage for the Medicaid funding available. If the method of calculating limits was changed, the department concurred with this recommendation. The 2005 Legislative Assembly provided funding based on limits being set at "median plus" 20/20/10.
3. Evaluation of North Dakota's equalized rate policy - The consultant recommended the state:
  - a. Continue the rate equalization policy of limiting rates for private pay individuals and other nongovernmental payers in semiprivate rooms to the comparable Medicaid rate.
  - b. Limit the additional amount nursing facilities may charge for a private room to \$10 per day. The department believed the decision to limit a nursing facility's ability to charge additional amounts for private rooms is a policy decision to be made by the Legislative Assembly. This recommendation would not affect the payments made under the state Medicaid program.
  - c. Change the current Medicaid property cost calculation to reflect the growing number of private rooms. The rate calculation should consider the square footage separately for private rooms and semiprivate rooms on a per resident basis. The department was reluctant to implement this recommendation because it would create a rate differential based on the type of accommodation that was not anticipated when equalized rates were implemented and would shift Medicaid savings to private pay residents who occupy private rooms. In addition, this change would add administrative complexities by requiring the department and providers to maintain 68 rates rather than 34 rates.
4. Review of the case mix payment system - The consultant recommended the state:
  - a. Implement a minimum data set accuracy audit program and if errors are found, change facility payment rates and recoup

overpayments. The consultant estimated annual Medicaid overpayments could be \$91,000, and the savings from the audits would provide funding for an additional staff person to conduct the audits. The department concurred with the recommendation and began to review the accuracy of the classification process, provide technical assistance, and recoup funds as appropriate. Because staff resources were limited, the department was able to visit only a few facilities each quarter. If the reviews indicated major problems, the department said it would attempt, within the resources available, to increase the number of reviews.

- b. Consider adopting the next version of the minimum data set when it becomes available from the federal government in 2004. The department said it plans to consider adopting the new version when it is available but will consult with the long-term care industry and the Legislative Assembly before making any major changes in the classification process.

The committee received the following preliminary findings and recommendations of the long-term care needs assessment conducted by a consultant hired by the Department of Human Services:

1. North Dakota's population over age 55 is generally healthier than the national average.
2. North Dakota's reservation population is generally much less healthy than the national average and less healthy than the remainder of the state's population.
3. Generally, North Dakota's chronic disease rates are lower than national norms but higher among the state's elderly American Indians.
4. Sixty-nine percent of North Dakotans age 50 and over do not plan to relocate in the next 10 years.
5. North Dakotans living in rural frontier counties are the most committed to staying in their homes and communities.
6. The presence of functional limitations does not impact plans to move--even those with emerging disabilities plan to stay in their homes and local communities.
7. The number of services available declines from urban to rural to rural frontier.
8. Availability of services is a major issue.
9. Transportation to services is a major issue.
10. Nursing home insurance has been purchased by 25.9 percent of North Dakotans over age 50.
11. Affordable assisted living services are needed, especially in the rural and reservation communities.
12. Health promotion and wellness activities designed to prevent functional limitations are

needed to allow individuals to remain independent.

13. Family and informal caregiving should be developed and integrated into a broad plan of long-term care.
14. Formal and informal caregivers should be organized into regional alliances to provide a full range of services.
15. Rural development in North Dakota should include service sector jobs.
16. North Dakota must develop a system of service delivery for home and community-based services to serve the rural elderly.
17. "Telehealth" should be explored to offer additional support for a dispersed model of services for offsite diagnosis and evaluation.
18. A special task force should be organized to address the long-term care needs of reservation populations because the number of American Indians over the age of 65 is increasing rapidly.
19. Long-term care workers' wages should be regularly monitored with adjustments made to maintain competitive salaries.
20. North Dakota's wages for long-term care workers are slightly less than national averages. Salaries for registered nurses are 94.1 percent of the national average, salaries for licensed practical nurses are 94.7 percent of the national average, and certified nurse assistants are 100 percent of the national average.
21. Providing benefits to all full-time workers, especially health insurance coverage, will assist with worker retention.

The committee learned the Governor issued an executive order in August 2001 establishing an Olmstead Commission to study North Dakota's compliance with requirements of the Olmstead decision. The Olmstead decision resulted from a Georgia lawsuit relating to providing adequate care to the elderly and disabled in the least restrictive environment.

The commission was awarded a \$900,000 federal grant to develop the following five pilot projects:

1. Person-centered care, which is designed to broaden the local continuum of care provided by long-term care facilities. This project was to involve two rural and two urban nursing facilities providing a more client-driven model of care, including less restrictive alternatives and/or home care when appropriate.
2. Financial pooling, which is designed to allow funding to follow the client. All public and private funds available for a client will be pooled and the client given the ability to purchase services as necessary. The provider must include a health system or long-term care facility.
3. Living in place, which is designed to allow individuals to live in their homes and receive

necessary personal services, modifications, and assistive technology.

4. Cultural module, which is designed to build capacity for home care among American Indians by utilizing existing training available at the United Tribes Technical College enhanced with the necessary components to enable students to provide in-home care to people with disabilities on the reservations.
5. Informational access to services, which is designed to coordinate existing resources such as the senior information line, Children's Services Coordinating Committee directories, and other resources to ensure that available services throughout the state are identified and may be accessed from one contact.

The **1999-2000 Budget Committee on Health Care** studied, pursuant to Senate Concurrent Resolution No. 4004, the possibility of creating an incentive package to assist rural communities and nursing facilities close or significantly reduce bed capacity and provide alternative long-term care services. The committee recommended that the 2001 Legislative Assembly consider requiring that money generated through the intergovernmental transfer process and deposited in the health care trust fund be used for projects and programs relating to the long-term care industry, including funding for projects that provide alternatives to nursing facility services and projects that reduce nursing facility bed capacity.

The **1997-98 Budget Committee on Long-Term Care** studied a wide range of long-term care issues, including basic care rate equalization, Alzheimer's and related dementia population projects, American Indian long-term care needs, long-term care financing issues, and home and community-based services availability. Committee recommendations included:

- The repeal of basic care rate equalization (1999 Senate Bill No. 2033).
- The Department of Human Services continuation of the Alzheimer's and related dementia population pilot project (1999 Senate Bill No. 2034) and providing an exception to the case mix system to allow for the establishment of a 14-bed geropsychiatric nursing unit within an existing nursing facility (1999 Senate Bill No. 2035).
- The continuation of the moratorium on nursing facility and basic care beds through the 1999-2001 biennium and an exception to the basic care bed moratorium for the establishment of a traumatic brain-injured facility in western North Dakota (1999 Senate Bill No. 2038).

The **1995-96 Budget Committee on Home and Community Care** studied the use of the state's resources and services in addressing the needs of elderly residents. As part of the study, the committee received the report of the Task Force on Long-Term Care Planning. Based on that report and the committee's study, it recommended House Concurrent

Resolution No. 3004 and House Bill No. 1039 relating to the expansion of home and community-based services availability.

## **REAL CHOICE SYSTEMS CHANGE GRANT**

In September 2004, the Department of Human Services received a three-year \$315,000 Real Choice systems change grant to provide a single point of access to long-term support and care services for the elderly and individuals with disabilities. The Department of Human Services contracted with the North Dakota Center for Persons with Disabilities in Minot State University to conduct the project. The project, known as the Real Choice Systems Change Grant - Rebalancing Initiative, was to develop a plan for rebalancing funds between long-term care services and those services provided in home or community settings. The project is also involved in the development of a new system for providing a single point of entry for services for the elderly and individuals with disabilities who are considering long-term care and home and community-based services. The project has brought together representatives from public and private organizations involved in assuring that the North Dakota elderly and individuals with disabilities have options and access to the continuum of long-term care services in the state. The grant will end in September 2007.

## **HEALTH CARE TRUST FUND/LONG-TERM CARE FACILITY LOAN FUND**

The health care trust fund was established by the 1999 Legislative Assembly (Senate Bill No. 2168) for providing nursing alternative loans or grants. House Bill No. 1196 (2001) provided that money in the fund may be transferred to the long-term care facility loan fund for nursing facility renovation projects and used for other programs as authorized by the Legislative Assembly. Money was generated for the health care trust fund as a result of the Department of Human Services making government nursing facility funding pool payments to two government nursing facilities--McVille and Dunseith. Payments were made based on the average amount Medicare rates exceeded Medicaid rates for all nursing care facilities in the state multiplied by the total of all Medicaid resident days of all nursing homes. Federal Medicaid funds were available for these payments and required a state match. Payments were made to the two government nursing facilities and were subsequently returned to the state, less a \$50,000 transaction fee retained by each of the two government nursing facilities. Once returned to the state, the state's matching share was returned to its source, and the federal funds were deposited in the health care trust fund. Money in the fund is invested by the State Investment Board and any investment earnings are retained in the fund. The federal government has eliminated this

intergovernmental transfer program. As a result, North Dakota's final intergovernmental transfer payment was received in July 2004.

North Dakota received a total of \$98.2 million under this program from 2000 to 2004. Of the total, \$11.3 million was used for long-term care facility loans and the remainder for other programs and purposes. [Appendix B](#) is the current analysis of the health care trust fund which indicates a projected June 30, 2009, fund balance of \$2,019,842.

Under North Dakota Century Code Chapter 50-30, subject to legislative appropriations, money may be transferred from the health care trust fund to the long-term care facility loan fund for the purpose of making loans, as approved by the Department of Human Services, for renovation projects. Each loan is limited to \$1 million or 90 percent of the project cost,

whichever is less. Under the program, 22 loans have been approved totaling \$11.3 million. As of June 2007, \$9.7 million of outstanding loans remain. Of the approved loans, 1 was for an assisted living facility, 13 for nursing home facilities, 1 for a basic care facility, and 7 for combination nursing, assisted living, and basic care facilities.

### LONG-TERM CARE SERVICES FUNDING

The following schedule presents the 2007-09 legislative appropriations for long-term care related services and the average number of clients that are anticipated to be served during the biennium based on the appropriations.

Program/Service	Budgeted Numbers to Serve	General Fund	Federal Funds	Other Funds	Total
Nursing facilities	3,494 beds	\$133,318,915	\$237,630,703	\$525,597 <sup>1</sup>	\$371,475,215
Basic care facilities	458 beds	6,097,305	5,701,454	2,284,362 <sup>2</sup>	14,083,121
TBI waiver	27 recipients	651,999	1,157,522		1,809,521
Aged and disabled waiver	170 recipients	1,479,575	2,420,804		3,900,379
Personal care option	678 recipients	6,886,688	12,227,357		19,114,045
Targeted case management	340 recipients	332,692	590,633		923,325
SPED	1,345 recipients	11,347,860		597,256 <sup>3</sup>	11,945,116
Expanded SPED	141 recipients	763,149			763,149
Total		\$160,878,183	\$259,728,473	\$3,407,215	\$424,013,871

<sup>1</sup>Health care trust fund.  
<sup>2</sup>Department "retained" funds.  
<sup>3</sup>County funds.

The 2007 Legislative Assembly provided funding to:

1. Allow for a 4 percent inflationary increase for the first year of the biennium and a 5 percent increase for the second year for all department service providers.
2. Rebase nursing home rates effective January 1, 2009.
3. Pay qualified service providers using a fee-for-service method based on 15-minute units of service.

### CONTINUUM OF CARE SERVICES FOR THE ELDERLY

The following is a summary of the programs that comprise North Dakota's continuum of care for the elderly:

Nursing home care - Provides facility-based residential care to individuals who, because of impaired capacity for independent living, require 24-hour medical or nursing services and personal and social services.

Basic care - Provides facility-based residential care to individuals who, because of impaired capacity for independent living, require health, social, or personal care services but not 24-hour medical or nursing services.

Medicaid waiver for the aged and disabled - Provides in-home and community-based care to individuals who otherwise would require nursing home care and who are Medicaid-eligible. Services available include:

- Adult day care.
- Adult foster care.
- Adult/traumatic brain-injured (TBI) residential.
- Chore services.
- Emergency response system.
- Environmental modification.
- Case management.
- Homemaker.
- Transportation (nonmedical).
- Respite.
- Specialized equipment/supplies.
- Supported employment.
- Transitional care.
- Nurse management.
- Attendant care service.

Service payments for elderly and disabled (SPED) - Provides in-home and community-based care to individuals who are impaired in at least four activities of daily living (examples include toileting, transferring, eating, etc.) or at least five instrumental activities of daily living (examples include meal preparation, housework, laundry, medication assistance, etc.). Services available include:

- Adult day care.
- Adult foster care.
- Chore services.
- Emergency response system.
- Environmental modification.
- Family home care.
- Case management.
- Homemaker services.
- Respite care.
- Personal care.

Personal care services - Provides in-home care to individuals who are impaired in at least one activity of daily living (examples include toileting, transferring, eating, etc.) or in at least three of the four following instrumental activities of daily living--meal preparation, housework, laundry, and medication assistance. The individual must be Medicaid-eligible to receive personal care services. These services include assistance with bathing, dressing, toileting, transferring, eating, mobility, and incontinence care and also assistance with meal preparation, housework, laundry, and medication assistance.

Expanded SPED - Provides in-home and community-based care to individuals who are not severely impaired in activities of daily living (examples include toileting, transferring, eating, etc.) but who are impaired in at least three of the four following activities of daily living--meal preparation, housework, laundry, and medication assistance, or who have health, welfare, or safety needs, including requiring supervision or a structured environment. This program is an alternative to basic care. The individual must be Medicaid-eligible to receive services under this program. Services include:

- Adult day care.
- Adult foster care.
- Chore services.
- Emergency response system.
- Environmental modification.
- Family home care.
- Case management.
- Homemaker.
- Respite care.

[Appendix C](#) is a Department of Human Services document comparing selected long-term care programs.

## **NURSING FACILITY PAYMENT SYSTEM**

North Dakota's nursing facility payment system has been in place since 1990 and requires equalized rates, which means nursing facilities may not charge private pay residents a higher rate than individuals whose care is paid for through the Medicaid program. Nursing facilities may, however, charge higher rates for private occupancy rooms.

The North Dakota nursing facility payment system consists of 34 classifications. Classifications are based on the resident assessment instrument (minimum data set) required in all nursing facilities. The rates for each classification vary by facility based

on each facility's historical costs. Residents in higher classifications pay more than residents in lower classifications at the same facility.

Facility rates change annually on January 1 and may change throughout the year due to audits or special circumstances. Revenue received by a facility changes throughout the year based on the classifications of the residents receiving services. Each resident is reviewed within 14 days of admission or reentry from a hospital and every three months subsequently. A resident's classification may change only at the scheduled three-month interval or if hospitalization occurs. The facility is required to give 30-day notice to its residents whenever the facility's rates change. If an individual's classification changes, no notice is required and the rate is retroactive to the effective date of the classification.

## **NURSING CARE AND BASIC CARE BED MORATORIUM**

Senate Bill No. 2109 (2007) continues through July 31, 2009, the moratorium on the expansion of nursing facility bed capacity above the state's gross licensed capacity of 6,383 beds. The provisions allow, not more than once in a 12-month period, a nursing facility to convert licensed nursing facility bed capacity to basic care bed capacity and a basic care facility to convert basic care bed capacity back to nursing facility bed capacity. The 2007 Legislative Assembly provided an exception to the moratorium on expansion of long-term care bed capacity and allowed the Veterans Home to convert 14 basic care beds to skilled care beds. The new Veterans Home facility will be authorized 52 skilled care beds and 98 basic care beds. Senate Bill No. 2109 also continues through July 31, 2009, the moratorium on basic care bed capacity. The bill provides that except for a nursing facility that is converting nursing facility bed capacity to basic care or unless the applicant demonstrates to the State Department of Health and the Department of Human Services that a need for additional basic care bed capacity exists, the department may not issue a license for additional basic care bed capacity above the state's gross licensed capacity of 1,527 beds.

North Dakota Century Code Section 23-16-01.1 allows nursing facilities to transfer beds from one facility to another and Section 23-09.3-01.1 allows basic care facilities to transfer beds from one facility to another. Under both these sections, the facility receiving the beds has 48 months in which to license the beds. As of June 2007, 177 nursing home beds have been transferred and are awaiting licensure and 40 basic care beds have been transferred and are awaiting licensure. These amounts are in addition to the licensed bed capacity referred to above.

## **SINGLE POINT OF ENTRY**

Senate Bill No. 2070, approved by the 2007 Legislative Assembly, appropriates \$40,000 from the general fund to match \$800,000 of federal funds



which, if approved by the federal government, will allow the Department of Human Services to establish or contract for an Aging and Disability Resource Center to provide a single point of entry to North Dakota's continuum of care services for the elderly and disabled.

## DEMOGRAPHIC INFORMATION

[Appendix D](#) provides information prepared by the North Dakota State Census Data Center relating to North Dakota's aging population and demographic projections to 2020.

## STUDY PLAN

The committee may wish to proceed with this study as follows:

1. Receive information from the Department of Human Services on North Dakota's long-term care system.
2. Receive information from representatives involved in the Real Choice Systems Change Grant - Rebalancing Initiative regarding findings and results of the initiative.
3. Receive information on the Olmstead Commission regarding outcomes of long-term care-related pilot projects and other activities and findings and recommendations of the commission.
4. Gather and review information on long-term care and home and community-based care

services available and waiting lists for services by geographic areas of the state, including a comparison of the elderly population to the number of nursing home and basic care beds available by region of the state.

5. Compare projected elderly population in North Dakota by location to the capacity of services available in these locations.
6. Receive status reports from the Department of Human Services regarding the level of spending, utilization, and cost of long-term care services and programs for the 2005-07 and 2007-09 bienniums.
7. Receive information from the State Department of Health regarding licensed bed capacity and any request for transfers of nursing facility bed capacity to basic care bed capacity or vice versa.
8. Receive testimony from interested persons, including the North Dakota Long Term Care Association, regarding the long-term care system in North Dakota.
9. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
10. Prepare a final report for submission to the Legislative Council.

ATTACH:4