1999 SENATE HUMAN SERVICES

SB 2033

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2033

Senate Human Services Committee

❑ Conference Committee

Hearing Date JANUARY 11, 1999

Tape Number	Side A	Side B	Meter #
1	X		
1/13/99 2	X		3,350
Committee Clerk Signature			

Minutes:

The meeting was called to order; all senators were present. The hearing on SB2033 was opened.

SENATOR KRAUTER introduced the bill. His testimony was taken from the Task Force Report from Dept of Human Services; the Health Dept; Interim Committee minutes on Long Term Care. This report and the minutes are available in the Library.

A recap of interim committee; there were five issues considered.

1. Study of basic care equalization; cost impact of state and private pay residents.

2. Conversion of existing nursing facility or basic care capacity to be used by the Alzheimer or related dementia population in the implementation of expanded case management systems for elderly persons and disabled persons.

3. Expanding home and community based service availability; option for training additional qualified service providers; the adequacy of geropsychiatric services and the feasibility of

combining service reimbursement payment sources to allow payment to flow to a broader array of elderly and disabled service options.

4. In relation to the American Indian long term care needs; the relationship between the state and their service-type units.

5. Long term care financing issues to determine changes necessary to develop alternative services and the feasibility of a managed care system for the long term care service.

SB2033 - written testimony- preventing cost shifting from public assistance residents to private pay level.

Paul Kramer, staff of Long Term Care Interim Committee further explained the bill; he is not here to support or oppose the bill. Section 1 and 2 deals with managed care; allows nursing homes to negotiate a rate with managed care which would be higher than the rate provided by state. Section 3 and 4 deal with the repeal of basic equalization for basic care facilities. Section 3 does the repeal; section 4 is an emergency. Rate equalization was scheduled to take effect July 1, 1999; this bill would not be effective 'til August 1, 1999 if it did not have an emergency, so we put the emergency on to make it effective July 1, 1999, so the department doesn't have to implement a rate equalization plan for one month.

SENATOR LEE asks how this is supposed to work. Last session we talked about putting into place and now we are repealing it before it has happened. What is going to happen after July 1, 1999. Mr. KRAMER stated that theoretically by repealing this, nothing would happen; it leaves it the way it is now as it has never been implemented. SENATOR LEE continued by asked if this would permit nursing homes to charge private pay at a greater rate than those that would be

reimbursed under managed care. Answer: The first issue of the bill is the managed care - nursing homes being able to negotiate a rate above the state rate with the managed care entity. That is separate from basic rate equalization repeal. That allows nursing home to go after a market and negotiate its rates to recoup higher costs for those types of patients. Nothing will change with this bill. Nursing homes will be able to go out and negotiate higher rates for the managed care people only. Private pay and state pay are still going to be under the rate equalization, and on the other side the basic care.

SENATOR DEMERS asked if they could negotiate lower rates. No they cannot negotiate lower rates than the department. SENATOR KILZER asked the advisability of having two bills, but I can see that one event has to occur before the other one can take place. Is this the reason for one bill. No, they were just drafted in one bill; could have been two.

BARB FISCHER, Dept of Human Services, supports bill (written testimony).

SENATOR KILZER asked if charges were not based on level of care. Ms. Fischer answered that annual costs are averaged through the year over all of the residents in there. Costs can be higher in the beginning of a stay then they do after care stabilizes or the nursing staff become more familiar with a patient. Medicare rates are used by the two months; they look only at the cost in this period; the rates under equalization look at all costs and average them out.

SENATOR KILZER The reason is that Medicare doesn't pay for a very long period of time. Yes, the maximum benefit period of 100 days for Medicare. In ND most residents don't use their 100 days; once they do not need skilled nursing care they will become just a regular nursing home resident financed by their own funds or Medicaid. The care level will be recognized by an assessment process; however, the rates are different. Medicare's rates now at the highest level is

about $400 per day. Our highest rate is about $200 in the same level because ours are averaged out over a year. SENATOR DEMERS asked if we were underpaying. Ms. Fischer stated that the information was from 1997. The fiscal note implements $l.5 million to the general fund. SENATOR DEMERS asked about the very high amount. Answer: The rates include an historical cost and add an operating margin of 3% and add the incentive which is a maximum of $2.60 for those under the limit rate. Those two provisions drives the rate higher. Basic care rates are set at 80th percentile. 20% of the licensed bid are over the limit. SENATOR DEMERS commented that she would like apples compared with apples and not apples to oranges. SHELLY PETERSON, President of the ND Long Term Care Association, supports the bill with written testimony. SENATOR KILZER stated there were 3 facilities in state where private pay was higher than state pay. Yes, that is correct; one is the Terrace because of property costs being higher. Is the reason for legislation the difference between private and state pay and it appears that legislation has a positive effect and now we are asking to repeal it. Ms. Peterson stated we have never had equalization of basic rates in basic care. We have not been cost shifting; it is our goal to have reasonable rates and not charge the private pay significantly higher. Our challenge to continue with that mission is that we have adequate funding for the state so they pay their fair share for residents. SENATOR THANE stated that there was evidence there was a wide difference in private and public pay. This is a carry over from skilled care. SENATOR DEMERS asked if we could request a report back to eliminate cost shifting. That would be a good idea. We would be happy to report to you because if we can't get an increase in the Dept. of Human Services bill we may be more cautious. SENATOR LEE asked are the rates almost equal because of the threat of equalization or do we not need to raise equalization legislation.

There was no opposition; the hearing was closed on SB2033.

Discussion was resumed on 1/13/99. SENATOR FISCHER moved a DO PASS. SENATOR DEMERS seconded the bill. Roll call vote carried 6-0. SENATOR LEE will carry the bill.

FISCAL NOTE

(Return original and 13 copies)

Bill / Resolution No.: SB 2033 Amendment to:

Requested by Legislative Council Date of Request: 12/10/98

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative: This bill repeals Section 50-06-14.3 of the North Dakota Century Code which requires rate equalization for basic care facilities effective July 1, 1999. The estimated general fund savings for the 1999-2001 biennium is $1,548,303. The Department's appropriation request does not include funding to compensate basic care facilities for rate equalization.

2. State fiscal effect in dollar amounts:

	1997-1999 Biennium		1999-2001 Biennium		2001-2003 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		(1,548,303)		(2,587,029)	

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

   a. For rest of 1997-99 biennium: -0-
   b. For the 1999-01 biennium: (1,548,303)
   c. For the 2001-03 biennium: (2,587,029)

4. County, City, and School District fiscal effect in dollar amounts:

1997-1999 Biennium			1999-2001 Biennium			2001-2003 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
-0-			-0-			-0-		

If additional space is needed, attach a supplemental sheet.

Signed: Brenda M. Weisz

Typed Name: Brenda M. Weisz

Date Prepared: January 8, 1999

Department: Human Services

Phone No.: 328-2397

Date: 1/13/99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2033

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on ______
or
☐ Conference Committee

Legislative Council Amendment Number ______

Action Taken Do Pass

Motion Made By Sen Fischer Seconded By Sen DeMers

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2033: Human Services Committee (Sen. Thane, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2033 was placed on the Eleventh order on the calendar.

1999 HOUSE HUMAN SERVICES

SB 2033

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2033

House Human Services Committee

☐ Conference Committee

Hearing Date February 9, 1999

Tape Number	Side A	Side B	Meter #
1	X		10.8 - 30.3
1		X	2.3 - 5.3
Committee Clerk Signature Susann Lindteigen			

Minutes:

BARBARA FISCHER, Manager, Long Term Care and Hospital Services, Department of Human Services, testified (Testimony attached).

Rep. CAROL NIEMEIER asked for clarification on how the implementation of the rate equalization could have an adverse impact on looking at alternatives to long term care.

BARBARA FISCHER stated SB 2036 provides for basic care, assisted living, other alternatives to nursing facility care residential type services and redesigning them, putting them all in a package, and looking at that as a true alternative to nursing facility care. Basic care currently is the only entity within that package of SB 2036 that has rate setting within the department. If we continue with rate equalization, we would have to, by definition as a basic care facility, include it in there. Continue on with rate equalization and then other services that would flow through on SB 2036 would not be impacted by rate equalization. They would be able to negotiate rates or

set rates as they feel. Basic care would be the only one that would be subject to rate equalization. That could have people drop out of basic care and do something and not make that alternative available.

PAUL KRAMER, Legislative Council, Long Term Care Committee, testified I staffed this committee during the interim. This bill came out of there. The committee, after looking at the basic care rate equalization, they determined the concerns of OSHA weren't really in existence. They felt basic care rate equalization should be repealed. That is what sections 3 and 4 do. The emergency clause is so the department would not be required to implement the rate equalization program for basic care facilities on July 1, only time it appealed on August 1st. The first two sections of this bill, deal with allowing managed care organizations to negotiate rates of long term care facilities that would be in excess of rates approved by the department for medical assistance recipients. That would be accomplished by changing the definition of private pay resident to include a managed care organization as being exempt from rate equalization for long term care facilities. That summarizes the bill.

SHELLY PETERSON, President, ND Long Term Care Association, testified (Testimony attached). Basic care is 100% state dollars, at this point in time.

Rep. ROBIN WEISZ asked why would a managed care organization want to negotiate a rate when it would have to be higher than what the rate equalization is now? Please explain why that would happen? SHELLY PETERSON stated probably about six years ago, we had contacted a managed care organization in Minnesota. They were able to negotiate rates and they were interested mostly in the Grand Forks and Fargo facilities. They had patients that they felt would need long term care services and they approached the facilities to negotiate a rate. To provide, in

essence, sub acute care, ventilator care, tube feeds - very complex care. At that point in time, no facility negotiated a rate with them because we would fall under the case mixed rate and it was against the law. When we look at the cost of providing care to the types of patients that they wanted to negotiate rates were, they would sometimes double it. So none of the facilities negotiated a rate. From the managed care entity, they were very interested because what they said was generally they have to pay for these people to sit in the hospital and look for a placement. So, it was much more cost effective to negotiate rates with long term; move the people out of the acute care setting, especially if it was going to be a long term situation; pay the lesser rate than they would have in acute care; and at least meet the cost of what the facility needed to recover to provide quality care. So, its just trying to provide a more appropriate setting that was cheaper than acute care.

<u>OPPOSITION</u>

None

Hearing closed.

Rep. ROBIN WEISZ moved DO PASS.

Rep. RALPH METCALF second the motion.

Committee Discussion.

Rep. CLARA SUE PRICE asked could they have explained Page 3 with the new language of No. 17 and better. Shelly Peterson said that's department language. Rep. CLARA SUE PRICE stated then they can't say that wasn't what they meant. In almost appears to be backwards.

ROLL CALL VOTE #4: 15 yeas, 0 nays, 0 absent

CARRIER: Rep. RALPH METCALF

Date: 2-9-99
Roll Call Vote #: 4

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2033

House Human Services Committee

☐ Subcommittee on
or
☐ Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Robin Weisz Seconded By Ralph Metcalf

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairman	X		Ralph Metcalf	X	
William R. Devlin	X		Carol A. Niemeier	X	
Pat Galvin	X		Wanda Rose	X	
Dale L. Henegar	X		Sally M. Sandvig	X	
Roxanne Jensen	X				
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter	X				
Blair Thoreson	X				

Total Yes 15 No 0
Absent 0

Floor Assignment Ralph Metcalf

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2033: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** (15 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2033 was placed on the Fourteenth order on the calendar.

1999 TESTIMONY

SB 2033

Testimony on SB 2033
Senate Human Services Committee
January 11, 1999

Chairman Thane and members of the Senate Human Services Committee, thank you for the opportunity to testify on SB 2033. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. Our Association represents basic care and nursing facility providers. I am here today to testify on their behalf.

SB 2033 has two basic purposes, both of which we support. Number one, equalization of rates for basic care, which is to go into effect on July 1, 1999 is repealed and number two this legislation gives nursing facilities the ability to negotiate rates with managed care organizations.

Basic Care

Basic care is the most cost effective type of care for individuals who need twenty four hour supervision but do not require the constant care and supervision of a licensed nurse.

There are around 40 basic care facilities in North Dakota representing approximately 1465 beds. Currently basic care is 86% occupied, caring for about 1260 residents. Based on the first three quarters of 1998, an average of 423 individuals needed basic care assistance to help pay for their care.

The top two needs of basic care residents are supervision and medication administration. Residents are admitted to basic care so they can receive constant supervision, well-balanced nutritious meals, medication as prescribed, and social activities to combat isolation and depression. Basic care delivers one of the best services at a very cost effective rate.

The average age of a basic care resident is 85 years old and usually female. The average daily cost to care for a basic care resident is $36.41, just $1.52 per hour.

We support SB 2033 which will repeal the implementation of equalization of rates. A survey by our Association indicates that "cost shifting" to private pay residents is not occurring within the industry. Very few facilities charge more to the private pay and overall rates are very economical. The Task Force on Long Term Care Planning and the Legislative Interim Budget Committee on Long Term Care both support not implementing equalization of rates for basic care.

SB 2012, the Department of Human Services appropriation bill includes the funding for basic care and there are not sufficient funds within SB 2012 to implement equalization of rates. SB 2012 will be a challenge for basic care.

SB 2012 does not include the 2% operating margin for basic care that was provided by the 1997 legislature. We will be seeking additional funding for basic care so cost shifting to private pay is not the rule but rather the exception as it is today.

Every year since equalization of rates was passed for nursing facilities we have struggled to get the system properly funded. The basic care industry doesn't wish to engage in such activity.

Nursing Facilities

The second purpose of SB 2033 is to change the statutory definition of a private pay resident. The change proposed would allow nursing facilities to negotiate rates with managed care entities. Although North Dakota has few managed care organizations affecting long term care, this will prepare us for the future.

This change will have no fiscal impact on the State since it affects only care which is paid through the managed care organizations. This will allow nursing facilities to negotiate rates for individuals needing short term, intensive care, which in the past was typically delivered in an acute care setting.

This change is supported by the Task Force on Long Term Care Planning and the Legislative Interim Budget Committee on Long Term Care.

This concludes my testimony. I would be happy to answer any questions you might have.

Shelly Peterson, President
North Dakota Long Term Care Association
120 West Thayer Avenue
Bismarck, ND 58501
(701) 222-0660

29, § 13.

Effective Date.
This section became effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13.

...urance payments by the department. Notwith... eligibility requirements for human services programs, ...rsuant to rules adopted by the department, may pay ...emiums, copayments, and deductibles for a person with ...ciency virus infection, or for any person maintaining a ...olicy covering a person with human immunodeficiency

...t of premiums, copayments, and deductibles is deter... a cost-effective alternative to the payment of future ...istance and economic assistance costs for that person;

...ment determines that the person is otherwise unable to ...cost of the premiums, copayments, and deductibles.

...h. 29, § 14; 1997, ch. section 1 of chapter 406, S.L. 1997 became effective August 1, 1997.
This section became effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13.

...t of this section by

... **Family life education program.** The department of ...all enter into an agreement with the North Dakota state ...on service for the design of a program to educate and ...ls at all points within the family life cycle. The program ...port for families and youth with research-based informa...rsonal, family, and community concerns and must contain ...ent aimed at evaluation of planned methods or programs ...amily and social problems. The program must address the ...lated topics:
... youth development.
...cation with an emphasis on parents as educators.
...evelopment.
...onal relationships.
...nteraction and family systems.
...conomics.
...rational issues.
... societal changes on the family.
...kills.
...ity networks and supports for families.

...1, ch. 509, § 2.

...me effective July 1, 1991, ...Const., Art. IV, § 13.

...apter 509, S... 1, pro-

... of legislative policy. The

the family so that the family can exercise its specific function of nurturing and protecting its members. If the family is to be nurtured and its members protected, the state must support programs that offer assistance for pregnant women and their families. Unjust social and economic structures such as poverty, sexism, and lack of adequate health care and information should be addressed. Women must have the ability to make responsible decisions concerning a pregnancy without los...

children and families is the operative principle underlying this Act."

50-06-06.11. Child care provider payments. Within the limits of federal regulations, the department of human services, at the election of the early childhood facility, shall directly pay early childhood facilities monthly under child care assistance programs administered by the department.

Source: S.L. 1993, ch. 474, § 1; 1995, ch. 462, § 1.

Effective Date.
The 1995 amendment of this section by section 1 of chapter 462, S.L. 1995 became effective August 1, 1995.

50-06-06.12. Child care provider reimbursement system. Repealed by S.L. 1995, ch. 462, § 2.

50-06-06.13. Treatment services for children with serious emotional disorders. The department shall establish in all human service regions a program to provide out-of-home treatment services for a medicaid-eligible child with a serious emotional disorder. If a child is placed in an out-of-home treatment program established under this section, the juvenile court must make a judicial determination as to whether the placement is in the best interests of the child. The department may not require a parent or legal guardian to transfer legal custody of the child in order to have the child placed in an out-of-home treatment program when the sole reason for the placement is the need to obtain services for the child's emotional or behavioral problems.

Source: S.L. 1995, ch. 300, § 2; 1997, ch. 406, § 1.

Effective Date.
The 1997 amendment of this section by section 1 of chapter 406, S.L. 1997 became effective August 1, 1997.
This section became effective August 1, 1995.

50-06-14.2. Department to establish reasonable rates. Repealed by S.L. 1993, ch. 2, § 28.

50-06-14.3. Department of human services to develop basic care facility ratesetting methodology. The department of human services shall develop a ratesetting methodology that provides for rates for all residents of basic care facilities that receive payments from the state or any political subdivision. The methodology may not provide for different rates for similarly situated residents because of the source of payment for any resident's care. The department shall consult with representatives of the basic care industry in this state in developing the ratesetting methodology. Beginning July 1, 1999, the department shall establish rates for all residents of basic care facilities that receive payments from the state or any political subdivision in accordance with the ratesetting methodology developed by the department. After June 30, 1999, no agency of the state or any p...l subdivision may make payments to a basic care facility that does ... rates at the levels established by the department.

Source: S.L. 1993, ch. 2, § 19; 1995, ch. 34,

Effective Date.
The 1997 amendment of this section by

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE
REGARDING SENATE BILL 2033
JANUARY 11, 1999

Chairman Thane, members of the committee, I am Barbara Fischer, Manager for Long Term Care and Hospital Services with the Department of Human Services. I am here today in support of SB2033 which provides for the repeal of basic care rate equalization and changes the definition of a private pay resident as it relates to rate equalization in nursing facilities.

The amendments set forth in this bill are a result of two Long Term Care Task Force recommendations to the interim Budget Committee on Long Term Care. The recommendations were made in response to HB 1012 (1997) which directed a study of rate equalization and the current rate setting methods for basic care facilities to determine whether rate equalization should be implemented July 1, 1999 and HCR 3006 (1997) which directed a study of financial incentives necessary to encourage nursing facilities to reduce the number of licensed beds and develop alternative services and to determine the feasibility of a managed care system.

BASIC CARE RATE EQUALIZATION

Legislation was enacted in 1993 to implement rate equalization for basic care facilities beginning July 1, 1995. The Department organized a task force to review necessary changes to rate setting for basic care facilities. That task force drafted rate setting rules which would implement rate equalization for basic care facilities. Those rules have never been implemented because first, rate equalization in basic care was delayed by the 1995 and 1997 Legislative Assemblies until July 1, 1999 and second, the study was to be made to determine if rate equalization should actually be implemented.

The Long Term Care Task Force performed that study during the last interim and recommends that rate equalization for Basic Care facilities be repealed. Basic care services are considered as one of the alternatives to nursing facility care. With anticipated changes in funding streams for basic care (SB 2036) and the impetus to develop and use alternatives to nursing facility care, implementation of rate equalization could have an adverse impact and may prevent changes that accomplish the long range goals of using alternatives.

The system for setting rates for basic care facilities will in all likelihood be changed in two years if the delivery system for alternative services addressed in SB 2036 becomes a reality. The changes included in SB 2036 would make rate equalization at best, a moot issue or at worst, cause problems with the implementation of changes in the delivery system for alternative long term care services.

Rate equalization has been touted as a means of preventing cost-shifting from assistance residents to private pay residents. Study data on basic care rates indicated that "cost (revenue) shifting" to private pay residents is not occurring within the industry and that 72% of private pay residents would have increases in their rates as a result of rate equalization. The fiscal impact of the 1997 study data indicated rate equalization would increase annual payments for state-assisted residents by $377,000 and $208,000 for private pay residents.

Access to basic care facilities for assistance residents may be adversely affected if rate equalization is implemented. Facilities with low assistance to private pay ratios may opt out of the Basic Care Assistance Program (BCAP) to avoid rate equalization. Limiting access will provide fewer alternatives to nursing facility care. Currently 8 of 41 facilities are not participating in BCAP.

Rate equalization does not assure that additional payments will not be sought for services which are not part of the daily rate. For example, a facility may charge any amount for private room accommodations or for providing cable TV services in the resident's room in addition to the daily rate. Increases in charges for items and services not covered by equalized rates will add to the amounts that private pay will pay because of rate equalization and may limit options that would otherwise be available to assistance residents who have limited funds for other than basics.

Taking into consideration the negative impact rate equalization could have on developing alternatives to nursing facility care and access for care, increases in charges for noncovered services and expenses to all residents, the fiscal impact of $1.548 Million to the general fund which has not been budgeted for, and the rate increases which will occur for private pay residents, we would urge a do pass on the repeal of the basic care rate equalization provisions contained in Section 3 of the bill (Line 28, 29 page 4).

Section 4 (line 30, page 4) of the bill includes an emergency measure which is necessary to prevent implementation of rate equalization for one month if this bill passes. The effective date of SB 2033, if passed, would be August 1, 1999 and rate equalization is to be implemented July 1, 1999 causing a one month gap.

PRIVATE PAY RESIDENT DEFINITION

Sections 1 and 2 of the bill provide for an exception to rate equalization in a nursing facility for managed care organizations. This exception will allow nursing facilities to negotiate higher rates for individuals who opt for a Medicare managed care program (Medicare+Choice) rather than using the traditional Medicare fee for service.

The amendment (page 3 line 10) to the definition of a private pay resident will include managed care entities as payers who are exempt from rate equalization thus allowing nursing facilities to negotiate for higher rates for providing more expensive care to short term stay residents. This will provide an incentive for facilities to admit heavier care, short term stay individuals and should provide better access for North Dakotans to the facility of their choice.

A definition of a managed care organization has been added at line 23 on page 2. A managed care organization is defined in the Balanced Budget Act of 1997 and this definition would be the one used to identify a managed care organization which would be exempt from rate equalization.

The bill also includes a limitation on managed care rate negotiation which requires the negotiated rate to be equal to or greater than the rate established by the department for an individual with the same classification. The limitation is included in section 2 on page 3 beginning at line 26.

Cares provided to Medicare recipients typically cost more than the average costs for individuals not in a Medicare benefit period and Medicare rates typically are higher than the corresponding case mix rates.

Under the current definition, Medicare+Choice contracts are subject to rate equalization because once an individual chooses the Medicare managed care option, Medicare no longer has rate setting authority for the services provided by the managed care entity or its network of providers. Since the current definition precludes any third party payer from negotiating or establishing rates unless the payer is a governmental entity, nursing facilities cannot negotiate rates for the increased costs associated with individuals who have chosen not to be covered

under traditional fee for service plans.

The definition change would allow nursing facilities to negotiate rates with managed care organizations. The ability to negotiate for short stays is an important incentive which has no fiscal impact on state funds or private pay residents but has a significant impact on a facility's revenue potential because these individuals tend to have high resource utilization and the case mix rate which is based on longer average lengths of stay may not adequately compensate for the cost of care provided.

The definition fiscally impacts only the costs which must be paid by a managed care organization. There is no impact on private pay residents since individuals enrolling in managed care, have already paid a premium, which is not specifically based on the individual's care needs, to the managed care organization. Facilities may not become part of a provider network if they are unable to negotiate for the higher costs of care thereby limiting access to a population most in need of nursing facility care on a short term basis. In addition, if a facility does not have the ability to negotiate for the higher costs of care associated with short term stays, a facility may not admit these residents. The resident then is adversely affected because access to a facility of his choosing will be limited and may not even occur.

I'd be happy to answer any questions you may have.

BUDGET COMMITTEE ON LONG-TERM CARE

The [illegible] was assigned five studies. Section 32 of House Bill No. 1012 directed a study of basic care rate equalization, including the cost impacts to the state and private pay residents. House Concurrent Resolution No. 3003 provided for the monitoring of the implementation of the projects developed by the Department of Human Services related to the conversion of existing nursing facility or basic care capacity for use by the Alzheimer's and related dementia population and the implementation of an expanded case management system for elderly persons and disabled persons. House Concurrent Resolution No. 3004 directed a study of the means of expanding home and community-based services availability, options for training additional qualified service providers, the adequacy of geropsychiatric services, and the feasibility of combining service reimbursement payment sources to allow payments to flow to a broadened array of elderly and disabled service options. House Concurrent Resolution No. 3005 directed a study of American Indian long-term care needs and access to appropriate services and the functional relationship between state service units and the American Indian reservation service systems. House Concurrent Resolution No. 3006 directed a study of long-term care financing issues to determine the changes necessary to develop alternative services and the feasibility of a managed care system for long-term care services.

Committee members were Senators Aaron Krauter (Chairman), Bill L. Bowman, Evan E. Lips, Harvey Sand, and Russell T. Thane and Representatives Grant C. Brown, Mike Callahan, Ron Carlisle, James O. Coats, Jeff W. Delzer, Gereld F. Gerntholz, Shirley Meyer, and Lynn J. Thompson. Representative Bill Oban was chairman of the committee until his death in July 1998.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 1998. The Council accepted the report for submission to the 56th Legislative Assembly.

STUDY OF BASIC CARE RATE EQUALIZATION

Section 32 of 1997 House Bill No. 1012 directed a study of basic care rate equalization, including the cost impacts to the state and private pay residents.

Background

Rate equalization is seen as a means of preventing cost-shifting from public assistance residents to private pay residents. House Bill No. 1002 (1993) provided for a basic care assistance program. Included in the bill was a provision that the Department of Human Services develop a basic care facility ratesetting methodology for all residents of basic care facilities. The ratesetting methodology was to be effective July 1, 1995, and not allow different rates for similarly situated residents because of the source of payment for the resident's care. In addition, the ratesetting methodology was not to allow the state or any political subdivision to make payments to basic care facilities that did not set rates at the levels established by the department.

The basic care rate equalization ratesetting methodology developed by the department included:

1. Paying direct care costs up to a limit established at the 90th percentile;
2. Paying indirect care costs up to a limit established at the 75th percentile;
3. Including property costs as a passthrough with no limitations;
4. Allowing a three percent operating margin;
5. Allowing an efficiency incentive for facilities with indirect care rates below the limit; and
6. Allowing for annual inflation adjustments.

The ratesetting methodology has never been implemented because the 1995 and 1997 Legislative Assemblies delayed the implementation of basic care rate equalization. The current statutory provisions call for rate equalization to be implemented July 1, 1999.

Funding

The committee learned that the funding for the basic care program has changed from 50/50 state/county to 70/30 state/county effective January 1, 1995, and then to 100/0 state/county on January 1, 1998. The following table shows the basic care program funding, by funding source, for the 1995-97 and 1997-99 bienniums:

Source of Funds	1995-97 Biennium	1997-99 Biennium
State general fund	$3,457,249	$5,681,435
Other	112,509	52,716
County	1,449,972	429,905
Total	$5,019,730	$6,164,056

The committee was informed that approximately $100,000 was included in the 1997-99 biennium budget for the provision of a two percent operating margin for basic care facilities. The provision for the two percent operating margin expires June 30, 1999, and is not a permanent part of the ratesetting methodology.

North Dakota Long Term Care Association Testimony

The committee was informed of the Long Term Care Association - Basic Care Committee's opposition to basic care rate equalization. The association's opposition was based on the following seven reasons:

1. Equalization of rates will not cost less.

for an operating margin and the passthrough of property costs. Rate equalization itself would not mandate higher rates for private pay individuals, but when combined with the other proposed changes, both private pay rates and public assistance rates would increase.

The committee recognized that cost shifting is not a major problem in basic care facilities. The committee also determined that if rate equalization for basic care facilities was implemented as proposed, 417 private pay residents could experience a net annual increase in their rates of $203,709. The committee also determined that if basic care rate equalization and the other proposed ratesetting changes were to be implemented the annual net cost increase to the state basic care assistance program would be $377,259.

The committee recommends Senate Bill No. 2033 to repeal basic care rate equalization. In addition, the committee accepted the task force's recommendations to:

1. Include an operating margin of three percent of direct care costs, subject to an 80th percentile limitation, in the rates established for basic care assistance recipients; and
2. Include property costs as passthrough costs, not subject to limitations, in the rates established for basic care assistance recipients.

MONITORING THE IMPLEMENTATION OF ALZHEIMER'S AND RELATED DEMENTIA POPULATION PROJECTS AND AN EXPANDED CASE MANAGEMENT SYSTEM

House Concurrent Resolution No. 3003 provided for the monitoring of the implementation of the projects developed by the Department of Human Services related to the conversion of existing nursing facility or basic care capacity for use by the Alzheimer's and related dementia population and the implementation of an expanded case management system for elderly persons and disabled persons.

Alzheimer's and Related Dementia Projects

Background

The 1997 Legislative Assembly (Section 12 of House Bill No. 1012) directed the Department of Human Services to establish pilot projects for Alzheimer's and related dementia populations in order to explore the financial and service viability of converting existing long-term care facility bed capacity to a specific service environment targeting the Alzheimer's and related dementia populations. The pilot projects were to be part of an effort to examine how long-term care services are delivered in North Dakota and to make recommendations that will result in the elderly and disabled of the state receiving the most appropriate and cost-effective services necessary to meet their long-term care needs.

It was determined that the funding for the pilot projects could come from funds already contained in the Department of Human Services long-term care budget. The existing funding was determined to be sufficient to pay for the pilot projects because the pilot projects were to use converted nursing facility or basic care beds. In addition, the individuals entering the pilot projects would be individuals who would have otherwise entered a nursing or basic care facility. Three possible payment sources were identified as funding sources for the pilot projects. The payment sources included the expanded service payments for elderly and disabled (SPED) program, Medicaid waiver program, and private pay.

Pilot Projects

The Department of Human Services was able to establish a 14-bed pilot project at the Baptist Home of Kenmare. The committee learned that the proposed budget of the pilot project provided for $12.11 per day for room and board and $67.26 per day for residential care services. The committee found this to be cost-effective when compared to average nursing facility costs of $85.41 per day for 1998, a difference of approximately $6.04 per day. This provides a savings of approximately $2,200 per resident per year when compared to nursing facility care. While meeting in Kenmare the committee toured the Alzheimer's pilot project unit at the Baptist Home of Kenmare.

The committee learned that the Good Samaritan Society is also planning to develop two pilot projects by converting nursing facility beds into Alzheimer's and related dementia population units at Lisbon and Arthur. It is anticipated that these projects will not be operational until sometime in 1999.

Task Force on Long-Term Care Planning Testimony

The Task Force on Long-Term Care Planning concluded that due to delays in the startup of the pilot projects it was not possible to fully evaluate the effectiveness of the pilot projects during the current biennium. Because of the delayed implementation of the pilot projects, the task force recommended that the three projects be extended beyond the current biennium in order to determine if this concept is financially viable and is an appropriate setting for the delivery of services. The task force also recommended that the department monitor the progress of the pilot projects and report to the Legislative Council, on the progress of the pilot projects, by June 30, 2000.

The task force also recommended that the Department of Human Services allow other entities the opportunity to develop alternative services for Alzheimer's and related dementia populations and that funding for these projects come from existing appropriations for the Medicaid home and community-based waiver or the expanded SPED program.

the expanded case management system pilot projects into the 1999-2001 biennium. The committee also accepted the task force's recommendation to have the Department of Human Services continue monitoring the progress of the pilot projects and prepare a report on the results no later than June 30, 2000, and that the continued funding of these projects come from within the Department of Human Services budget.

STUDY OF HOME AND COMMUNITY-BASED SERVICES AVAILABILITY, PROVIDER TRAINING, GEROPSYCHIATRIC SERVICES, AND COMBINING PAYMENT SOURCES

House Concurrent Resolution No. 3004 directed a study of the means of expanding home and community-based services availability, options for training additional qualified service providers, the adequacy of geropsychiatric services, and the feasibility of combining service reimbursement payment sources to allow payments to flow to a broadened array of elderly and disabled service options.

Background

The limited availability of qualified service providers in rural areas requires the rural elderly and disabled to choose between relocating to access services or going without necessary services. In addition, training opportunities are limited and potential providers may lack the skills necessary to meet required competency standards. Expanding the training of qualified service providers could enhance the availability and improve the quality of home and community-based services. In addition, the combining of service reimbursement payment sources could provide increased flexibility and portability of service payments to allow payments to flow to a broadened array of service options for the elderly and disabled.

Findings

The committee learned that due to the changing demographics of the state, meeting the future service needs of older North Dakotans will provide a significant challenge. The task force's report indicated that the number of individuals age 65 and older is projected to increase from 93,000 to 166,000 by the year 2025. The committee was informed that higher service expectations, the growth of alternative living arrangements, and the shift from institutional settings of health and long-term care to less restrictive community-based settings is driving the need to have qualified individuals available to provide adequate care. The committee learned that under the qualified service provider system individuals are independent contractors, and in order to maintain this independent contractor status, the Department of Human Services cannot train the individuals. Instead the department has established standards requiring competency in specific areas of service delivery.

The committee learned that North Dakota's rural counties have generally maintained federal health professional shortage area designation for psychiatric services. According to national studies, it has been estimated that up to 60 percent of mental health care for residents of rural areas is rendered by a primary care provider. The committee found that based on information contained in the nursing facility minimum data set the 1997 incidence rate of bipolar or manic depressive disorder in North Dakota nursing facilities was about 1.1 percent, compared to the National Institute of Mental Health's observed rate of one percent in the United States adult population.

Funding and Utilization

The committee received information on the funding and utilization of the Medicaid waiver, SPED program, expanded SPED program, and the traumatic brain-injured (TBI) waiver. Medicaid waiver services are provided in lieu of nursing home placement for eligible elderly and disabled. Recipients must be Medicaid-eligible and in need of the level of care provided in a nursing home. Service payments for elderly and disabled and expanded SPED services are provided in home and community-based settings to functionally impaired elderly persons and disabled persons to avoid institutionalization. Services provided include family home care, homemaker service, home health aid, respite care, case management, nonmedical transportation, chore service, adult foster care, adult day care, and personal care. Traumatic brain-injured waiver services are provided in lieu of nursing home placement to Medicaid-elibigle recipients in need of the level of care provided in a nursing home.

The following tables show the funding for each program for the 1995-97 and 1997-99 bienniums and the number of unduplicated recipients for fiscal years 1993 through 1996:

	Medicaid Waiver	SPED	Expanded SPED	TBI Waiver
1995-97 biennium appropriation	$4,243,740	$7,370,437	$1,423,266	$1,745,826
Actual 1995-97 expenditures	$4,296,156	$6,576,195	$1,249,041	$532,658
1997-99 biennium appropriation	$5,671,608	$8,886,923	$1,522,417	$1,778,356
1997-99 biennium increase from 1995-97 actual expenditures	$1,375,452	$2,310,728	$273,376	$1,245,698

geropsychiatric services at the hospital is $1,146,685 per biennium.

The committee found that if a geropsychiatric unit were to be established outside the State Hospital and if a nursing home were to be subsidized to cover the additional cost of the geropsychiatric unit, the additional cost would be approximately $602,020 per biennium. This would leave a general fund savings of $544,665 per biennium when compared to the State Hospital's costs of $1,146,685. The committee found that through the use of Medicaid funds the state could save an additional $422,000, for a total savings of $966,665.

The task force recommended a study of the expansion of psychiatric and geropsychiatric training for general practice and family practice physicians at the University of North Dakota School of Medicine and Health Sciences. In addition, the task force recommended that an exception to the case mix system of nursing home reimbursement be provided to allow for the establishment of a 14-bed geropsychiatric nursing unit within an existing nursing facility. Additional task force recommendations relating to geropsychiatric services included expanding continuing education opportunities in psychiatric and geropsychiatric care for rural primary care providers, expanding networking models for the provision of services to the elderly, integrating the human service centers and the State Hospital into telemedicine networks to provide enhanced access to psychiatric and geropsychiatric services in rural areas, and contracting with an existing nursing facility for the establishment of a 14-bed geropsychiatric nursing unit.

Task Force on Long-Term Care Planning Testimony

The task force addressed each of the components of the study separately. In addition, the task force provided the committee with conclusions and recommendations regarding the adult protective services program. The task force provided the committee with the following conclusions and recommendations.

Home and Community-Based Services Availability

The task force concluded that the elderly and disabled receive services through a variety of public, private, formal (human service centers, county social services, SPED, expanded SPED, etc.), and informal (hospitals, nursing homes, neighbors, churches, relatives, service organizations, etc.) service networks in the state. In addition, it was determined that in order to plan for future service needs, a solid understanding of the state's current service delivery system must be developed. The task force concluded that the formal service network should supplement, not replace, the informal network and that future service development should be based on changing demographics and service needs. The task force recommended that the Department of Human Services contract with a public or private entity to conduct the necessary assessment to determine the extent of the future service delivery needs.

Training of In-Home Care Providers

The task force concluded that the service delivery of certified nurse assistants and qualified service providers is similar. However, the formal training available for certified nurse assistants is not suited for qualified service providers because the training is focused on an institutional setting. It was determined that because many qualified service providers provide care only to a specific individual, qualified service providers need training that focuses on care provided in the home setting. In addition, the cost of such training must be taken into consideration as most potential qualified service providers have limited resources available to invest in training.

The task force recommended that the Department of Human Services coordinate with the State Board for Vocational and Technical Education for the establishment of a statewide model curriculum for in-home care certification and competency and that the task force investigate the impact of a formalized in-home care training program on service availability and quality service delivery. The task force also recommended that competitive reimbursement rates be established.

Funding Sources

Currently the fiscal and administrative responsibility for long-term care services is split within the Department of Human Services among the Medicaid program, Aging Services Division, and Economic Assistance. The committee was informed that in a survey of other states conducted by the task force, of which 29 states responded, 17 states split responsibilities for long-term care services between the Medicaid program and other agencies. The other 12 states have either consolidated all long-term care activities with the Medicaid program (five states), aging services agency (six states), or are in the process of consolidating all long-term care activities in one division (one state). The survey also disclosed that states with consolidated operations listed more advantages, such as better control over budgeting and management of issues, better service delivery coordination, eliminating duplicative administrative structures, information sharing, and streamlining decisionmaking, than the states with split responsibilities.

The task force concluded that some advantages were possible by combining all long-term care activities in one division. However, the task force did not make any recommendations regarding the restructuring of the department's programs due to the Budget Committee on Human Services study of the Department of Human Services.

solution is not to mandate the statutorily created program without also providing the necessary funding. The committee considered, but did not recommend, a bill that would have removed any language from NDCC Chapter 50-25.2 that provided that the vulnerable adult protective services program was only to be implemented if a legislative appropriation was provided. The bill was not recommended because the committee thought it forced future Legislative Assemblies into funding the program or removing it from the statutes. The committee thought the best alternative was to leave the statutes as currently written because if funding is provided the current statute does not hinder the implementation of the program, and if funding is not provided, it does not put the department or county social service agencies at jeopardy of lawsuits.

Adult Family Foster Care

The committee considered, but did not recommend, a bill that would have changed the definition of adult family foster care. The bill would have allowed an individual to provide care to more than four persons and would have removed the requirement that the services be provided in an occupied private residence. The committee did not recommend the bill because it would have made adult family foster care very similar to basic care.

STUDY OF AMERICAN INDIAN LONG-TERM CARE NEEDS AND ACCESS TO APPROPRIATE SERVICES

House Concurrent Resolution No. 3005 directed a study of American Indian long-term care needs and access to appropriate services and the functional relationship between state service units and the American Indian reservation service systems.

Background

The 1995-96 interim Budget Committee on Home and Community Care identified the following reasons for a study of American Indian long-term care needs and access to appropriate services:

1. Because of the wide variances in the long-term care service inventory, distribution, and alternatives within the North Dakota American Indian service areas and reservations, ranging from a nontribe owned and operated nursing facility to unlicensed facilities and home-based care.
2. Because the coordination and application of various American Indian long-term care programs and service components are directed by tribal policy and organizational structure.
3. Because of the possibility of developing specifically targeted service programs for residents of reservations and case management to coordinate the care arrangement and delivery.
4. Because the noninstitutional care components appear to be available on reservations, but service arrangement and delivery may not be adequately coordinated and case management services for elderly reservation residents, if available, could result in a significant increase in the effectiveness of service delivery for that population.

State/Tribal Summit

The committee met in October 1997 with members of the Budget Committee on Human Services and the Welfare Reform Committee to receive input from tribal members and to discuss tribal long-term care issues.

Findings

The committee learned that there are four nursing facilities located on or near Indian reservations. The following table shows the name and location of each facility, the capacity, the percentage of staff that is American Indian, and the percentage of residents that is American Indian:

		Percentage American Indian	
Facility - Location	Capacity	Staff	Residents
Dunseith Community Nursing Home, Dunseith	54	75	60
Presentation Care Center, Rolette	48	45	46
New Town Good Samaritan Center, New Town	59	50	25
Rockview Good Samaritan Center, Parshall	56	31	6

Program Funding

The committee learned that there are no American Indian specific long-term care programs. The committee reviewed the funding of the various long-term care programs for the 1995-97 and 1997-99 bienniums:

Service	General Fund	Other Funds	Total
1995-97 Biennium			
Nursing home care	$59,684,221	$158,129,801	$217,814,022
Basic care	$3,457,249	$1,562,481	$5,019,730
Medicaid waiver	$1,318,818	$2,924,922	$4,243,740
SPED	$7,131,840	$375,360	$7,507,200
Expanded SPED	$1,423,266		$1,423,266
TBI waiver	$542,828	$1,202,998	$1,745,826
1997-99 Biennium			
Nursing home care	$62,801,890	$181,777,775	$244,579,665
Basic care	$5,681,435	$482,621	$6,164,056
Medicaid waiver	$1,375,652	$3,213,880	$4,589,532
SPED	$8,442,577	$444,346	$8,886,923
Expanded SPED	$1,522,417		$1,522,417
TBI waiver	$456,004	$1,322,352	$1,778,356

Program Utilization

The committee learned that during federal fiscal year 1996, a total of 175 American Indians received nursing facility services through the Medicaid program, totaling $2.8 million. The 175 recipients represented three

Other Testimony

The committee received a report from the Department of Human Services on the status of long-term care services in North Dakota. The report indicated that the appropriation for nursing facility services for the 1997-99 biennium is $244.6 million, or 50 percent of the $486.6 million budgeted for traditional medical services, excluding institutional and home and community-based services for the developmentally disabled. The report also indicated that the total appropriation for alternative services is $24 million or 8.9 percent of the appropriation for long-term care services.

The committee received a staff report on the various levels of long-term care. The report provided definitions, a comparison of services, a comparison of funding sources, and the licensure requirements for acute care, swing beds, subacute care, congregate housing, assisted living, basic care, and nursing homes. The committee also received a staff report on senior mill levy match funding. The report provided information on the 1996, 1997, and 1998 disbursements to counties and cities for the senior citizens' mill levy match program.

The committee also received reports on subacute care, Medcenter One's proposal for a long-term care hospital in Mandan, the possibility of the federal government changing the Medicaid program to a block grant, and the Medicaid eligibility determination process.

Task Force on Long-Term Care Planning Testimony

The Task Force on Long-Term Care Planning addressed each of the components of the study separately. The task force provided the committee with the following conclusions and recommendations.

Long-Term Care Financing and Incentives

The task force concluded that the current payment system lacks the incentives needed to encourage providers to deliver alternative services or to reduce licensed capacity. The task force also concluded that changes are needed to the current ratesetting structure. The changes should provide additional revenues to some facilities, which would enable those facilities to offer additional services and develop alternative services. The task force recommended the creation of an incentive and disincentive for facilities with high or low case mixes. Facilities with a high case mix average (1.6199) would have their rates calculated using direct care and other direct care limits increased by 2.5 percent. Facilities with a low case mix average (1.4244) would have their rates calculated using direct care and other direct care limits decreased by 2.5 percent. The impact of this recommendation would be an estimated cost savings of $50,000 per biennium, $35,000 of which would be federal funds and $15,000 of which would be state funds.

The task force concluded that providing an exception to the 90 percent occupancy limit would encourage facilities to delicense beds when a decreased occupancy is sustained. As compared to the current system that promotes admitting residents so that rates will not be adversely impacted by the 90 percent occupancy limitation. The task force recommended waiving the 90 percent occupancy limitation for facilities delicensing beds before the beginning of, or during, a rate year in which the limitation would apply.

The task force concluded that short-term stays generate higher per day costs than long-term stays. Because of this the task force recommended an incentive for facilities with low annual average lengths of stay. The incentive would provide facilities with an increase in their daily rate for direct care, other direct care, and indirect care, subject to limitations. The incentive would be one percent for facilities with an average length of stay under 201 days, two percent for facilities with an average length of stay under 181 days, and three percent for facilities with an average length of stay under 161 days. It is anticipated that this incentive will encourage facilities to consider alternatives to nursing facility care upon initial admission, as well as encourage facilities to provide necessary short-term care and then discharge individuals to appropriate alternative settings.

The task force concluded that because the current statute precludes any third-party payer from negotiating or establishing higher rates for higher cost services, the definition of private pay resident needs to be changed. By changing the definition of private pay resident to include managed care entities as payers exempt from rate equalization, it will allow facilities to negotiate for the higher costs associated with short stays and encourage facilities to accept this type of resident and become a part of a managed care provider network. The task force recommended that the definition of private pay resident be amended to include managed care entities as payers exempt from rate equalization.

The task force concluded that incentives and other forms of assistance should be available to enable facilities to make the transition toward closing or to providing institutional services to fewer residents. Because facilities in rural communities are experiencing decreased occupancy and staffing problems, they usually lack the needed resources to develop alternative types of care. Because of this situation the task force recommended a study of the possibility of the state providing an incentive package to assist rural communities and nursing facilities close or significantly reduce bed capacity and provide alternative long-term care services within the community.

The task force concluded that senior mill levy funding is used for a variety of services designed to assist senior citizens maintain independence, including home-delivered meals, transportation, outreach assistance, congregate dining, and health-related services. Because these funds are used to serve an at-risk population in the

group of individuals receives necessary and appropriate care near their home and families.

The task force concluded that although the current funding sources and administrative policies prevent nursing facilities from providing services at a level of care below that of their license as a nursing facility, it would be desirable in certain instances to allow an individual that does not meet the level of care criteria required for placement in a nursing facility to be allowed to stay in a nursing facility. The task force recommends giving nursing facilities the option to continue to provide services to residents no longer meeting the level of care criteria required for placement in a nursing facility.

Swing-Bed Facilities

The task force concluded that there is very little data and no standard measurement process available to determine the quality of care and services provided by swing-bed hospitals. In addition, most of the swing-bed residents have similar conditions to those individuals residing in nursing facilities. Because of the number of individuals occupying swing beds for more than six months, the task force concluded that some hospitals have gone beyond the original intent of the swing-bed program. The task force recommended a study of the swing-bed facilities' role in the future of long-term care services.

Committee Recommendations

Long-Term Care Financing and Incentives

The committee recognized the need for changes in the current payment system in order to encourage the development of alternative services. The committee determined that in order for a rural community to reduce bed capacity and develop alternative services, an incentive package is needed to provide assistance to the community. The committee also recognized the need for the senior mill levy match funding as a part of the long-term care continuum. The committee recommends Senate Bill No. 2033 to change the definition of a private pay resident to include managed care entities as payers exempt from rate equalization, Senate Concurrent Resolution No. 4004 to provide for a Legislative Council study of an incentives package to assist rural communities and nursing facilities to close or significantly reduce bed capacity and provide alternative long-term care services, and House Concurrent Resolution No. 3003 to provide for a Legislative Council study to determine if the mill levy match program could be expanded to enhance home and community-based services availability.

In addition, the committee accepted the task force recommendations to:

1. Waive the 90 percent occupancy limitation for facilities delicensing beds before the beginning of, or during, a rate year in which the limitation would apply.
2. Provide an increase up to three percent of direct care, other direct care, and indirect care rates (subject to limits) for facilities with an annual average length of stay of 200 or fewer days per occupied bed.
3. Continue to provide funding for the senior mill levy match.
4. Discontinue feasibility studies of managed care of long-term care clients until North Dakota has gained experience in managed care for the population at large, alternatives to institutional long-term care have been more fully developed, and the pilot projects for expanded case management of long-term care clients have been concluded.

The committee did not accept the task force recommendation to increase limit rates by 2.5 percent for nursing facilities with high case mix averages and decrease limit rates by 2.5 percent for facilities with low case mix averages.

The committee also recommends that the Department of Human Services be encouraged to rebase the long-term care payment reimbursement system and to develop a regular rebasing schedule for the long-term care payment reimbursement system.

Alternative Services

The committee recognized that the current delivery system for alternative long-term care services is not meeting the needs of the elderly and disabled. The committee determined that there was very little difference between the definition of a basic care facility and an assisted living facility. The committee determined that separate definitions were not needed for basic care and assisted living and therefore, recommends Senate Bill No. 2036 to repeal basic care and assisted living and create an adult residential care facility classification. The bill directs the Department of Human Services and the State Department of Health to develop a recommendation for consideration by the 57th Legislative Assembly describing appropriate methods and means for the inspection and regulation of adult residential care facilities that respect the residents' choices of care providers. The recommendation is to include a proposed budget and any necessary implementing legislation and necessary appropriation. The bill contains an effective date of July 1, 2001, in order to allow for the development of the new rules, policies, and procedures.

The bill provides for:

1. A repeal of existing law regarding the definition of assisted living facilities and the definition, regulatory oversight, and payment requirements for basic care facilities.
2. A new category of residential facility that will include facilities formerly classified as basic care facilities or assisted living facilities to include facilities that provide 24-hour health,

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
REGARDING SENATE BILL 2033
FEBRUARY 9, 1999

Chairman Price, members of the committee, I am Barbara Fischer, Manager for Long Term Care and Hospital Services with the Department of Human Services. I am here today in support of SB2033 which provides for the repeal of basic care rate equalization and changes the definition of a private pay resident as it relates to rate equalization in nursing facilities.

The amendments set forth in this bill are a result of two Long Term Care Task Force recommendations to the interim Budget Committee on Long Term Care. The recommendations were made in response to HB 1012 (1997) which directed a study of rate equalization and the current rate setting methods for basic care facilities to determine whether rate equalization should be implemented July 1, 1999 and HCR 3006 (1997) which directed a study of financial incentives necessary to encourage nursing facilities to reduce the number of licensed beds and develop alternative services and to determine the feasibility of a managed care system.

BASIC CARE RATE EQUALIZATION

Legislation was enacted in 1993 to implement rate equalization for basic care facilities beginning July 1, 1995. The Department organized a task force to review necessary changes to rate setting for basic care facilities. That task force drafted rate setting rules which would implement rate equalization for basic care facilities. Those rules have never been implemented because first, rate equalization in basic care was delayed by the 1995 and 1997 Legislative Assemblies until July 1, 1999 and second, the study was to be made to determine if rate equalization should actually be implemented.

The Long Term Care Task Force performed that study during the last interim and recommends that rate equalization for Basic Care facilities be repealed. Basic care services are considered as one of the alternatives to nursing facility care. With anticipated changes in funding streams for basic care (SB 2036) and the impetus to develop and use alternatives to nursing facility care, implementation of rate equalization could have an adverse impact and may prevent changes that accomplish the long range goals of using alternatives.

The system for setting rates for basic care facilities will in all likelihood be changed in two years if the delivery system for alternative services addressed in SB 2036 becomes a reality. The changes included in SB 2036 would make rate equalization at best, a moot issue or at worst, cause problems with the implementation of changes in the delivery system for alternative long term care services.

Rate equalization has been touted as a means of preventing cost-shifting from assistance residents to private pay residents. Study data on basic care rates indicated that "cost (revenue) shifting" to private pay residents is not occurring within the industry and that 72% of private pay residents would have increases in their rates as a result of rate equalization. The fiscal impact of the 1997 study data indicated rate equalization would increase annual payments for state-assisted residents by $377,000 and $208,000 for private pay residents. The 1997 study data and a short explanation of how to read the table is attached.

Access to basic care facilities for assistance residents may be adversely affected if rate equalization is implemented. Facilities with low assistance to private pay ratios may opt out of the Basic Care Assistance Program (BCAP) to avoid rate equalization. Limiting access will provide fewer alternatives to nursing facility care. Currently 8 of 41 facilities are not participating in BCAP.

Rate equalization does not assure that additional payments will not be sought for services which are not part of the daily rate. For example, a facility may charge any amount for private room accommodations or for providing cable TV services in the resident's room in addition to the daily rate. Increases in charges for items and services not covered by equalized rates will add to the amounts that private pay will pay because of rate equalization and may limit options that would otherwise be available to assistance residents who have limited funds for other than basics.

Taking into consideration the negative impact rate equalization could have on developing alternatives to nursing facility care and access for care, increases in charges for noncovered services and expenses to all residents, the fiscal impact of $1.548 Million to the general fund which has not been budgeted for, and the rate increases which will occur for private pay residents, we would urge a do pass on the repeal of the basic care rate equalization provisions contained in Section 3 of the bill (Line 28, 29 page 4).

Section 4 (line 30, page 4) of the bill includes an emergency measure which is necessary to prevent implementation of rate equalization for one month if this bill passes. The effective date of SB 2033, if passed, would be August 1, 1999 and rate equalization is to be implemented July 1, 1999 causing a one month gap.

PRIVATE PAY RESIDENT DEFINITION

Sections 1 and 2 of the bill provide for an exception to rate equalization in a nursing facility for managed care organizations. This exception will allow nursing facilities to negotiate higher rates for individuals who opt for a Medicare managed care program (Medicare+Choice) rather than using the traditional Medicare fee for service.

The amendment (page 3 line 10) to the definition of a private pay resident will include managed care entities as payers who are exempt from rate equalization thus allowing nursing facilities to negotiate for higher rates for providing more expensive care to short term stay residents. This will provide an incentive for facilities to admit heavier care, short term stay individuals and should provide better access for North Dakotans to the facility of their choice.

A definition of a managed care organization has been added at line 23 on page 2. A managed care organization is defined in the Balanced Budget Act of 1997 and this definition would be the one used to identify a managed care organization which would be exempt from rate equalization.

The bill also includes a limitation on managed care rate negotiation which requires the negotiated rate to be equal to or greater than the rate established by the department for an individual with the same classification. The limitation is included in section 2 on page 3 beginning at line 26.

Cares provided to Medicare recipients typically cost more than the average costs for individuals not in a Medicare benefit period and Medicare rates typically are higher than the corresponding case mix rates.

Under the current definition, Medicare+Choice contracts are subject to rate equalization because once an individual chooses the Medicare managed care option, Medicare no longer has rate setting authority for the services provided by the managed care entity or its network of providers. Since the current definition precludes any third party payer from negotiating or establishing rates unless the payer is a governmental entity, nursing facilities cannot negotiate rates for the increased costs associated with individuals who have chosen not to be covered

under traditional fee for service plans.

The definition change would allow nursing facilities to negotiate rates with managed care organizations. The ability to negotiate for short stays is an important incentive which has no fiscal impact on state funds or private pay residents but has a significant impact on a facility's revenue potential because these individuals tend to have high resource utilization and the case mix rate which is based on longer average lengths of stay may not adequately compensate for the cost of care provided.

The definition fiscally impacts only the costs which must be paid by a managed care organization. There is no impact on private pay residents since individuals enrolling in managed care, have already paid a premium, which is not specifically based on the individual's care needs, to the managed care organization. Facilities may not become part of a provider network if they are unable to negotiate for the higher costs of care thereby limiting access to a population most in need of nursing facility care on a short term basis. In addition, if a facility does not have the ability to negotiate for the higher costs of care associated with short term stays, a facility may not admit these residents. The resident then is adversely affected because access to a facility of his choosing will be limited and may not even occur.

I'd be happy to answer any questions you may have.

Rate Equalization 1997 Data

Comparison of 1997 Revenues to Revenues Generated under Rate Equalization

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
					Effect on BCAP Rates			Effect on Private Pay revenues for Change to Rate Equalization							
	Total	80th Perc Total Rate	Total W/RE	Difference	BCAP Increase	Decrease	Rate Difference per NDLTC	PP Rates Equal to BCAP		PP Rate < RE Incr & Rates >Cost	PP Rate > RE Incr & Rates >Cost	PP Rate > RE Incr but PP Rates <Cost	PP Rates > RE Inc & Rate<Cost	Private Pay Total	Total Effect BCAP +PP
Baptist Home of Kenmare	$36.37	$36.63	$36.88	0.25	1,666		$0.22			249				249	1,914
Baptist Home, Bismarck	$52.47	$40.93	$50.68	9.75	16,855		$17.07						(13,977)	(13,977)	2,879
Bethel 4 Acres Home	$26.31	$26.60	$29.35	2.75	24,166		$0.00	4,814						4,814	28,980
Bethel Lutheran	$45.89	$40.93	$45.61	4.68	11,724		$16.43						(20,663)	(20,663)	(8,939)
Borg Memorial Home	$36.59	$36.95	$39.76	2.81	15,901		$0.00	22,152						22,152	38,052
Chateau for Senior Citizens	$36.21	$36.57	$39.40	2.83	14,098		$3.85				(4,929)			(4,929)	9,169
Dakota Hills Home	$35.30	$35.63	$38.39	2.76	14,772		$0.00	6,613						6,613	21,385
Edgewood Vista	$42.57	$40.93	$44.63	3.70	21,108		$0.01			14,657				14,657	35,765
Edmore Memorial Rest Home	$24.31	$24.56	$27.29	2.73	8,846		$0.44			26,364				26,364	35,210
Evergreen Inn - Dickinson	$32.75	$32.87	$35.53	2.66	7,728		$1.65			14,303				14,303	22,031
Evergreen Place - Ellendale	$41.53	$40.93	$43.22	2.29	6,225		$2.07			551				551	6,776
Gackle Care Centers, Inc.	$39.33	$39.69	$42.55	2.86	22,716		$4.31				(8,424)			(8,424)	14,292
Golden Years Living Center	$29.18	$29.48	$32.23	2.75	7,063		$4.52				(7,147)			(7,147)	(84)
Good Shepherd Home	$43.66	$40.87	$43.02	2.15	1,214		$4.13						(3,528)	(3,528)	(2,314)
Harold Haaland Home	$32.11	$32.39	$35.13	2.74	28,683		$0.00	44,446						44,446	73,130
Odd Fellows Home	$36.86	$37.16	$36.01	(1.15)		(1,370)	$0.00		(10,114)					(10,114)	(11,483)
Karrington Commons	$35.31	$35.53	$37.95	2.42	30,094		$0.00	31,086						31,086	61,180
Kensington - Williston	$31.59	$31.73	$34.40	2.67	26,854		$0.00	36,515						36,515	63,369
Leach Home	$40.57	$40.93	$40.69	(0.24)		(520)	$0.00		(2,890)					(2,890)	(3,410)
Maddock Memorial Home	$30.86	$31.11	$33.83	2.72	9,923		$0.00	14,258						14,258	24,180
Manor of St. Joseph	$33.61	$33.91	$35.51	1.60	6,381		$0.00	12,094						12,094	18,475
Noonan Good Samaritan Center	$39.92	$40.26	$38.97	(1.29)		(6,224)	$0.74				(11,332)			(11,332)	(17,556)
Fischer's Basic Care	$34.85	$35.21	$38.09	2.88	4,661		$0.95			2,784				2,784	7,445
Sr. Suites at Sakakawea	$50.65	$40.93	$45.38	4.45	9,380		$0.00	31,109						31,109	40,489
Prairie Home	$60.12	$40.93	$43.92	2.99	3,885		$0.00	3,682						3,682	7,567
Redwood Village	$35.27	$35.55	$36.19	0.64	6,277		$1.00				(931)			(931)	5,346
Rock of Ages	$35.79	$36.14	$38.92	2.78	22,444		$0.85			19,663				19,663	42,107
Sheridan Memorial Home	$22.62	$22.79	$25.48	2.69	4,783		$0.00	19,529						19,529	24,312
St. Anne's Guest Home	$36.26	$36.56	$36.76	0.20	1,953		$0.00	1,980						1,980	3,933
St. Francis Residence	$57.38	$40.93	$45.70	4.77	1,744		$0.00	15,526						15,526	17,270
St. Catherine's Living Center	$41.92	$40.80	$44.15	3.35	4,836		$5.20				(5,408)			(5,408)	(572)
The Terrace	$67.01	$40.93	$56.58	15.65	49,393		$21.07					(29,325)		(29,325)	20,067
Total					$385,373	($8,114)		$243,805	($13,004)	$78,570	($38,171)	($29,325)	($38,167)	$203,708	$580,967

Breakdown of Increase due to Rate Equalization*	BCAP	Private	Total
Property	97,459	38,357	135,816
Operating Margin	25,099	18,978	44,077
Incentive	265,673	257,718	523,391
Direct Rate	(50,218)	(27,218)	(77,436)
Indirect Rate	39,246	21,538	60,784
Private Pay Rate		(105,663)	(105,663)
	$377,259	$203,709	$580,968

* Property costs are passed through under rate equalization and not subject to any limitation. Property costs under current system are included in the total rate which is subject to limitation.

Operating Margin - Current system allows for a 2% operating margin of the direct rate up to the 80th percentile. Rate Equalization operating margin is 3% of the direct rate up to the 90th percentile limit.

Incentive - No incentive is paid under the current system. Under rate equalization, the difference between the limit rate and the actual indirect rate times 70% up to a maximum of $2.60 is included as an incentive payment for facilities with an indirect rate below the 75th percentile limit.

Direct Rate - Under the current system the direct rate is part of the total rate which is limited to the 80th percentile. Under rate equalization the direct rate component is limited to the 90th percentile of the direct rates and is not effected by the other rate categories.

Indirect Rate - Under the current system the indirect rate is part of the total rate which is limited to the 80th percentile. Under rate equalization the indirect rate is limited to the 75th percentile indirect rate and is not effected by the other rate categories.

Private Pay Rate - This is the difference between the existing private pay rate differential less any increases in the rate resulting from the above listed components and the rate that would be the maximum the facility could charge under rate equalization.

ATTACHMENT A

EXPLANATION OF 1997 STUDY ON BASIC CARE RATE EQUALIZATION

A - "Total" the facility's actual rate based on allowable historical costs plus inflation divided by census.

B - "80th Perc Total Rate" - the facility's basic care rate using the current rate setting methods.

C - "Total W/RE" - What the facility's rate would be for all residents if rate equalization goes into effect

D - "Difference" The increase/decrease for the change from the current rate setting methods to rate equalization. Column C minus Column B.

E - "BCAP Increase" The Basic Care Assistance Program's dollar effect of the increase in rates. Column D times the number of basic care days (not shown).

F - "Decrease" The Basic Care Assistance Program's dollar effect of the decrease in rates. Column D times the number of basic care days (not shown).

G - "Rate Difference per NDLTC" The difference between the current BCAP rate (Column B) and the Private Pay rate.

H - "PP Rates Equal to BCAP" The increased dollar effect rate equalization will have on private pay residents who now pay the same rate as BCAP residents. Calculated by subtracting Column G from Column D and multiplying times the number of private pay days. 13 facilities.

I - "PP Rates Equal to BCAP" The decreased dollar effect rate equalization will have on private pay residents who now pay the same rate as BCAP residents. Calculated by subtracting Column G from Column D and multiplying times the number of private pay days. 2 facilities.

J - "PP Rate <RE Incr & Rates>Cost" The increase private pay residents will have to pay under rate equalization because the current rate which is greater than the BCAP rate is still less than the rate under rate equalization. Column D minus Column G times resident days. 7 facilities.

K - "PP Rate >RE Incr & Rates>Cost" The decrease private pay residents will have to pay under rate equalization because the current private pay rate which is greater than the actual rate is still more than the rate under rate equalization. Column D minus Column G times resident days. 6 facilities.

L - "PP Rate >RE Incr but PP Rates <Cost" The decrease private pay residents will have because of rate equalization. The rates private pay residents are currently paying do not cover the actual cost of care (Column A minus Columns B plus G). 1 facility

M - "PP Rates >RE Inc & Rate<Cost" The private pay rate exceeds the actual cost, the increase due to rate equalization and the facility's rates are limited. These facilities are the only ones that could be considered to cost shift since the private pay rate differential is greater than the difference between the actual rate (column A) and the BCAP rate (Column B). 3 facilities.

N- "Private Pay Total" the total effect on private pay residents.

O - "Total Effect BCAP+PP" The total impact rate equalization has on all residents.

The Box shown below columns L through O shows what components of the rates increased or decreased to get to the net increase of $580,968.

410 Private residents will have increases and 157 will have decreases. 388 BCAP residents will have increases and 22 will have decreases.

Testimony on SB 2033
House Human Services Committee
February 9, 1999

Chairman Price and members of the House Human Services Committee, thank you for the opportunity to testify on SB 2033. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. Our Association represents basic care and nursing facility providers. I am here today to testify on their behalf.

SB 2033 has two basic purposes, both of which we support. Number one, equalization of rates for basic care, which is to go into effect on July 1, 1999 is repealed and number two this legislation gives nursing facilities the ability to negotiate rates with managed care organizations.

Basic Care

Basic care is the most cost effective type of care for individuals who need twenty four hour supervision but do not require the constant care and supervision of a licensed nurse.

There are approximately 40 basic care facilities in North Dakota representing approximately 1465 beds. Currently basic care is 86% occupied, caring for about 1260 residents. In 1998, an average of 456 individuals needed basic care assistance to help pay for their care.

The top two needs of basic care residents are supervision and medication administration. Residents are admitted to basic care so they can receive constant supervision, well-balanced nutritious meals, medication as prescribed, and social activities to combat isolation and depression. Basic care delivers one of the best services at a very cost effective rate.

The average age of a basic care resident is 85 years old and usually female. The average daily cost to care for a basic care resident is $36.41, just $1.52 per hour.

We support SB 2033 which will repeal the implementation of equalization of rates. A survey by our Association indicates that "cost shifting" to private pay residents is not occurring within the industry. Very few facilities charge more to the private pay and overall rates are very economical. The Task Force on Long Term Care Planning and the Legislative Interim Budget Committee on Long Term Care both support not implementing equalization of rates for basic care.

SB 2012, the Department of Human Services appropriation bill includes the funding for basic care and there are not sufficient funds within SB 2012 to implement equalization of rates.

Every year since equalization of rates was passed for nursing facilities we have struggled to get the system properly funded. The basic care industry doesn't wish to engage in such activity.

Nursing Facilities

The second purpose of SB 2033 is to change the statutory definition of a private pay resident. The change proposed would allow nursing facilities to negotiate rates with managed care entities. Although North Dakota has few managed care organizations affecting long term care, this will prepare us for the future.

This change will have no fiscal impact on the State since it affects only care which is paid through the managed care organizations. This will allow nursing facilities to negotiate rates for individuals needing short term, intensive care, which in the past was typically delivered in an acute care setting.

This change is supported by the Task Force on Long Term Care Planning and the Legislative Interim Budget Committee on Long Term Care.

This concludes my testimony. I would be happy to answer any questions you might have.

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