BUDGET COMMITTEE ON LONG-TERM CARE

The Budget Committee on Long-Term Care 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.
2. The state will need to increase its appropriation for basic care assistance if rate equalization is implemented.
3. Private pay residents will pay more under an equalized rate system.
4. Past experience with the equalization of rates for skilled nursing homes proves that it will cost the state and private pay residents more under an equalized rate system.
5. The Legislative Assembly has deferred the implementation of rate equalization the last two sessions due to a lack of funding.
6. One hundred percent of the industry supports not having the state totally control ratesetting, even though the majority of basic care facilities would profit from the equalization of rates.
7. The majority of basic care facilities do not cost shift.

The committee learned of the association's recommendation that the current basic care ratesetting methodology be changed to include a three percent operating margin and the passthrough of property costs.

The committee found that nine facilities charge less than the approved rate, 41 percent charge the approved rate, and 50 percent charge more than the approved rate. The committee learned that if the two lowest extra rates and the two highest extra rates were discarded, the average extra per day cost for a basic care resident is $2.88 or $86.40 per month.

Cost of Implementing Basic Care Rate Equalization

The committee found that only three facilities shift costs to private pay residents. All three of the facilities are combination facilities, which means each of the facilities is operated in conjunction with a nursing facility, hospital, or assisted living facility. These three facilities have a total of 38 of the state's total of 1,180 licensed beds or 3.2 percent of the total beds. The committee learned that if rate equalization were implemented as proposed, 417 private pay residents could experience an increase in their rates while 150 could experience a rate decrease.

The committee learned that if basic care rate equalization and the other proposed ratesetting changes were implemented the annual net cost increase to the state basic care assistance program would be $377,259. The total annual net cost increase to private pay residents was estimated to be $203,709.

Task Force on Long-Term Care Planning Testimony

The Governor reappointed the Task Force on Long-Term Care Planning to assist the executive and legislative branches of

government in the design of a long-term care system responsive to the needs of North Dakota's elderly in a cost-effective manner and to assist in the development of incentives to change the long-term care system into a responsive cost-effective system. The task force was cochaired by the State Health Officer and the executive director of the Department of Human Services. Membership included representatives of provider and senior-related organizations, Department of Health, Department of Human Services, North Dakota Association of Counties, and the North Dakota Long Term Care Association. The task force recommendations were the starting point for development of bill drafts by the committee. The recommendations of the task force will be addressed within each study's section of this report.

The task force concluded that rate equalization as proposed would increase, rather than decrease, private pay rates in the majority of basic care facilities. In addition, the task force concluded that current payment data demonstrates that cost-shifting is not occurring in the majority of basic care facilities.

The task force indicated that rate equalization could be detrimental to the goal of providing alternatives to nursing facility care because access may be limited if facilities currently participating in the basic care assistance program choose not to participate because of rate equalization. In addition, the expansion or conversion of services to other alternatives may be hindered because of a facility's inability to meet cash flow needs.

The task force concluded that the inclusion of the property rate in the overall limit rate is disadvantageous to newer facilities with significant debt or costs related to buildings and equipment. The committee learned that facilities that use revenues relating to operating expenses for the payment of fixed property costs may find it difficult to maintain long-term viability and will likely not be able to modify the existing facilities to provide alternative services.

The task force recommended that rate equalization for basic care facilities be repealed, that a three percent operating margin on direct care costs be implemented, and that allowable property costs be included as passthrough costs not subject to the 80th percentile limitations. The committee learned that the annual cost of the three percent operating margin is $150,000. This is $50,000 more than the $100,000 in the department's current budget for the two percent operating margin, which sunsets at the end of the 1997-99 biennium. The committee learned that the annual general fund cost of including property costs as passthrough costs is estimated to be $97,459.

Committee Recommendations

The committee determined that the previously proposed rate equalization included more than rate equalization, as it also included additional payments to basic care facilities. Rate equalization would only provide that private pay residents pay the same rate as state assistance residents. The proposed rate equalization plan included increased payment levels by providing 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.

Committee Recommendations Regarding the Alzheimer's and Related Dementia Projects

The committee recognizes that due to the delay in the implementation of the pilot projects it would be beneficial for the projects to be continued into the next biennium.

The committee recommends Senate Bill No. 2034 to authorize the Department of Human Services to continue the approved Alzheimer's and related dementia population pilot projects into the 1999-2001 biennium. The bill also requires the department to monitor and report on the progress of the pilot projects. The report is to be submitted to the Legislative Council by June 30, 2000, and contain conclusions and recommendations regarding the future of the pilot projects. In addition, the committee accepted the task force's recommendations that:

1. The Department of Human Services allow other entities the opportunity to develop alternative residential services for

Alzheimer's and related dementia populations or other populations that meet quality and financial standards established by the department.
2. The funding for these projects comes from existing appropriations for the Medicaid home and community-based services waiver or the expanded SPED program. The number of projects will be limited by the number of available home and community-based services waiver slots approved by the federal government, the cost neutrality requirement contained in the home and community-based services waiver, and the total appropriation for the expanded SPED program.

Expanded Case Management System Background

The 1997 Legislative Assembly (Section 21 of House Bill No. 1012) provided legislative intent that the Department of Human Services may establish pilot projects for expanded long-term care case management. Expanded case management is to assist functionally impaired adults in accessing the necessary services needed to maintain the appropriate level of independence in the least restrictive setting at the lowest possible cost. The pilot projects were to be financed within available department resources. The resolution providing for the implementation of an expanded case management system stated that:

1. An expanded case management system allows individuals in need of long-term care to access services through a single point of entry providing "one-stop" accessibility for those individuals and their families.
2. It is in the people's best interest to develop an expanded case management system because case management for older adults and persons with disabilities in this state is currently provided to a limited number of individuals through a variety of private and public agencies resulting in confusion for many individuals and their families.

National studies have concluded that case management is a key component in the assessment of client needs, assisting clients in accessing needed services provided by a multitude of agencies and providers, and ensuring that services and funding are targeted to individuals most in need of assistance.

Pilot Projects

Two expanded case management pilot projects were established by the Department of Human Services, one in an urban county (Burleigh) and the other in a rural county area (Benson, Eddy, Ramsey, and Towner Counties).

The operative start date for the Burleigh County expanded case management pilot project was December 1, 1997. The committee learned that the urban pilot project wanted to demonstrate the value of electronic exchange of information. The committee found that a significant portion of the pilot project will be to coordinate the efforts of the several entities providing services or information to senior citizens and their families. The committee learned that the overall goal of the Burleigh County pilot project is to delay or prevent nursing facility placement. An additional goal of the pilot project is the implementation of a comprehensive computerized data base assessment tool. The committee learned that through the first three months of the pilot project, 24 referrals had been received.

The operative start date for the Benson, Eddy, Ramsey, and Towner Counties expanded case management pilot project was January 6, 1998. The committee learned that the rural pilot project had received 20 referrals and that five of the 20 referrals were currently receiving expanded case management services.

Task Force on Long-Term Care Planning Testimony

The task force concluded that the pilot projects needed to be continued into the 1999-2001 biennium in order to evaluate the effectiveness of the expanded case management systems. The task force recommended that the Department of Human Services continue to monitor the progress of the pilot projects and prepare a report on the results of the projects no later than June 30, 2000. The task force recommendation included that the continued funding of the projects come from within the department's budget.

Committee Recommendations Regarding the Expanded Case Management Pilot Projects

The committee recognized that due to the delay in the implementation of the pilot projects it would be beneficial for the projects to be continued into the next biennium so the results can be properly documented. The committee expressed its support for the continuation of 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

	1993	1994	1995	1996
Medicaid waiver	429	366	313	298
SPED program	1,691	1,758	1,482	1,449
Expanded SPED program*			269	396
TBI waiver			9	11
*Expanded SPED payments began in November 1994.				

The committee learned that approximately 8.6 percent of the SPED and expanded SPED services are provided to American Indian clients, while American Indians account for approximately 4.3 percent of the state's population. The committee also learned that there are an estimated 6,357 individuals needing assistance with two or more activities of daily living who are not currently being served by a program or funding source provided through the Aging Services Division of the Department of Human Services.

Home and Community-Based Services Costs

The committee reviewed information on the average cost of home and community-based services. The committee learned that effective May 1, 1997, the department established maximum rate for agency qualified service providers was increased from $12.84 to $14 per hour and the maximum rate for self-employed qualified service providers was increased from $9.72 to $10.52 per hour. The following table shows the average cost for the delivery of home and community-based services, based on the prior maximum hourly rates of $12.84 for agencies and $9.72 for self-employed providers:

Homemaker service	$10.35 per hour
Home health aide	$11.20 per hour
Personal/attendant care	$43.05 per day/$8.43 per hour
Respite care	$8.48 per hour
Adult day care	$30.21 per day
Emergency response	$18.53 per month
Adult family foster care	$32.54 per day

The committee found that the 1995-97 biennium average monthly cost per client was $846 for services funded through the Medicaid waiver for the aged and disabled, $288 for services funded through the SPED program, and $268 for services funded through the expanded SPED program.

Adult Family Foster Care

Because the committee had been assigned a study relating to home and community-based services, the issue of adult family foster care came within its assigned study area. Therefore, the committee received information relating to locating adult family foster care facilities in something other than a private residence and providing services to more than four adults.

Adult Protective Services

As a result of the committee's study relating to home and community-based services the committee reviewed the current statutory provisions relating to the provision of adult protective services. The committee received a staff report on the background and history of 1989 House Bill No. 1058, which established the vulnerable adult protective services program. In addition, the staff provided the committee with statistics and funding information on the adult protective services programs in Minnesota, South Dakota, and Montana. The committee also received a staff report indicating that an agency may not be relieved from potential liability because a specific appropriation was not provided for a statutorily mandated program

The committee learned that due to the 1989 referrals the adult protective services program funding was eliminated. Because the funding was eliminated and has never been restored, the program has never been implemented. The committee learned that North Dakota is the only state without a funded adult protective services program.

The Task Force on Long-Term Care Planning concluded that as the state expands service availability through home and community-based services, a system needs to be developed to respond to the concerns of inadequate care, abuse, and exploitation. The task force concluded that early intervention provides the best opportunity for long-term cost savings. The task force recommended the removal of all language from North Dakota Century Code (NDCC) Chapter 50-25.2 providing that the vulnerable adult protective services program only be implemented if a legislative appropriation is provided.

Geropsychiatric Services

The task force concluded that a small population of elderly and disabled and severely mentally ill reside at the State Hospital. This population has consistently failed to thrive in community placements. The task force concluded that the creation of a geropsychiatric nursing unit within an existing nursing facility will provide a more appropriate and cost-effective service setting for these individuals. However, the establishment of such a unit would require professional support from the State Hospital and a waiver from the reimbursement limits under the case mix system.

The committee received a report on the cost of establishing a separate geropsychiatric unit outside the State Hospital. The committee learned that the cost to treat these individuals at the State Hospital is approximately $275 per day. The report indicated that closing the unit at the State Hospital would allow the hospital to reduce approximately 26 full-time equivalent positions. The general fund appropriation currently needed to provide 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.

Committee Recommendations Home and Community-Based Services Availability

The committee recognized the need for a thorough understanding of the current service delivery system in order to develop the proper service delivery system to meet the future needs of the state. The committee accepted the task force's recommendation that the Aging Services Division of the Department of Human Services, through a request for proposal, contract with a public or private agency or organization for an assessment to determine the extent of the current and future service delivery systems for North Dakotans age 60 and older and for persons with physical disabilities age 18 through 59 in North Dakota. A request for proposal has been drafted by the department. This will require a budgetary commitment from the department either in part, or as a whole, if outside financial participation is not secured.

Training of In-Home Care Providers

The committee recognized that expanded training for qualified service providers could enhance the availability of and improve the quality of home and community-based services in rural areas. The committee accepted the task force's recommendations that:

1. 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, including:
    a. The exploration of statewide funding options through welfare-to-work program and Work Force 2000.
    b. Expanding the availability of the customized training network within the State Board for Vocational and Technical Education to make programs available regionally throughout the state.
    c. Monitoring the development of the pilot project for training of in-home care providers in Benson County.
2. The Task Force on Long-Term Care Planning investigate the impact of a formalized in-home care training program on service availability and quality service delivery.
3. In order to attract and retain in-home care providers, competitive reimbursement rates must be established, and in order to establish these rates, a market analysis should be commissioned to determine the financial resources needed to support an in-home care provider system.

Geropsychiatric Services

The committee recognized the need for geropsychiatric services and training in rural areas. The committee also recognized the need for a study of the possibility of expanding the psychiatric and geropsychiatric training provided to general practice and family practice physicians at the University of North Dakota School of Medicine and Health Sciences. The committee determined that it would be beneficial to establish a geropsychiatric nursing unit at an existing nursing facility and close the geropsychiatric unit at the State Hospital.

The committee recommends House Concurrent Resolution No. 3001 to provide for a Legislative Council 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 committee recommends Senate Bill No. 2035 to provide for an exception to the case mix system of nursing home reimbursement to allow for the establishment of one 14-bed geropsychiatric nursing unit within an existing nursing facility. In addition, the committee accepted the task force's recommendations providing:

1. That the State Department of Health and the Department of Human Services work to expand continuing education opportunities in psychiatric and geropsychiatric care for rural North Dakota primary care providers in cooperation with the state's medical, psychiatric, and nursing associations.
2. For the expansion of networking models for the provision of services to the elderly, including geropsychiatric services to all human service centers. A formally organized, collaborative approach to elder services, including a psychiatric component, should be present in each human service center. Services should include consultation and care planning in nursing facilities and the home and community-based services system.
3. That the human service centers and the State Hospital be integrated into telemedicine networks to provide enhanced access in rural North Dakota to psychiatric and geropsychiatric services from tertiary medical centers and the State Hospital.
4. That the Department of Human Services contract with an existing nursing facility for the establishment of a 14-bed geropsychiatric nursing unit. This unit should be created within existing licensed capacity and would continue to be licensed as nursing facility beds.

Funding Sources

The committee accepted the task force's recommendation to not consider any restructuring of the Department of Human Services due to the Budget Committee on Human Services study of the Department of Human Services.

Protection of Vulnerable Adults

The committee recognized that although a need may exist for an adult protective services program the 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:

1995-97 Biennium			
Service	**General Fund**	**Other Funds**	**Total**
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 percent of the total number of individuals receiving services during that period and the $2.8 million represented two percent of the nursing facility expenditures during the same time period. The following table shows the number of American Indians in nursing facilities during federal fiscal years 1993 through 1996:

Federal Fiscal Year	Number of American Indians in Nursing Facilities
1993	148
1994	167
1995	147
1996	175

Task Force on Long-Term Care Planning Testimony

The task force indicated that it was unable to establish a committee comprised of representatives of each reservation and non-American Indians to study the American Indian long-term care needs. The task force recommended that the study of American Indian long-term care needs be continued during the next interim.

Committee Recommendations

The committee recognized the need for the continuance of the study of American Indian long-term care needs. In addition, the committee recognized that the opportunity exists for significant improvements relating to the possibilities of coordination of state, county, and local service units and tribal or reservation service delivery and case management. Because of these observations the committee recommends House Concurrent Resolution No. 3002 to provide for a Legislative Council study of American Indian long-term care and case management needs, access to appropriate services, and the functional relationship between state service units and the North Dakota American Indian reservation service systems. The resolution calls for the creation of a separate working group on each reservation to carry out the provisions of the study.

STUDY OF LONG-TERM CARE FINANCING ISSUES TO DEVELOP ALTERNATIVE SERVICES AND THE FEASIBILITY OF A MANAGED CARE SYSTEM

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.

Background

Approximately 25 percent of all individuals in nursing facilities are categorized in the two lowest case mix classifications, which indicates that many of these individuals could likely receive the needed level of care in a home or community-based setting at an average cost that is lower than nursing facility costs. The current long-term care payment system is in need of a review to determine if some categories of nursing home residents could receive services in alternative, less costly settings. A managed care program for long-term care services may result in the development of alternative care in a cost-efficient manner. In addition, a review is needed of any financial, regulatory, or other impediments that may exist and prevent the development of alternative services to long-term care.

The funding trends of nursing facility services from fiscal years 1959 through 1996 show that the Department of Human Services nursing facilities funding has increased from $703,872 in fiscal year 1959 to $106,991,191 in fiscal year 1996. The 1997-99 biennium budget for nursing facility services is $244.6 million, a $28 million increase from the 1995-97 funding level of $216.6 million. Based on this rate of growth, assuming no other program changes, the nursing facility services budget will exceed $350 million by the 2003-05 biennium.

North Dakota Long Term Care Association Testimony

The Long Term Care Association expressed its support for the recommendations of the task force, with the exception of the recommendation relating to the incentive for high case mix facilities and the disincentive for low case mix facilities. The association also informed the committee of the need to rebase the long-term care payment reimbursement system. The current

system is based on 1992 costs. The committee found that the annual inflation adjustments have not kept up with actual cost increases. The committee learned that the estimated cost to rebase the system is $7 million, of which $4.9 million would be federal funds and $2.1 million would be state funds. The $7 million is based on the 56 percent Medicaid occupancy, and when taking private pay residents into account, the total impact to long-term care facilities is approximately $12 to $13 million.

Traumatic Brain-Injured Facility

The committee learned that there is a two- to four- year wait for admission to the state's only traumatic brain-injured facility. Traumatic brain-injured individuals currently receiving services in long-term care facilities are unable to move to a less restrictive setting because of the lack of alternative residential services. The committee found that a traumatic brain-injured facility in western North Dakota would fill the gap between a nursing facility and total independence. The committee found that the average traumatic brain-injured waiver services cost about $2,200 per month as compared to the cost of traumatic brain-injured services being provided in long-term care facilities which is approximately $7,300 per month.

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 least restrictive setting and were considered by the task force to be an integral part of the continuum of care, the task force recommended a Legislative Council study and continued funding for the program. The study would consider the possibility of expanding the program as a means of enhancing home and community-based services availability.

The task force concluded that managed care for long-term care is very limited nationwide and that North Dakota is relatively inexperienced with managed care. The task force recommended that feasibility studies of managed care for long-term care be discontinued until North Dakota has gained experience with managed care in medical and hospital environments. In addition, an effective case management system needs to be developed and alternatives to nursing facility care should be developed or expanded prior to further consideration of managed care for long-term care.

Alternative Services

The task force concluded that the current delivery system for alternative long-term care services does not address the ongoing needs of the elderly and disabled in a coordinated, consumer-friendly manner and that current regulatory and payment policies limit the options available to individuals in need of long-term care services. The task force concluded that housing options should be considered separately from the service needs of an individual. The system should first determine the type of services that will be necessary to maintain each elderly or disabled person and at the same time a determination would be made as to what funding source could be used to provide the service. The client would choose the living arrangement based on cost and care consideration factors and the services would then be provided and paid for based on the needs of each client and the funding source for which the client is eligible. The task force recommended that legislation be passed directing the Department of Human Services and the State Department of Health to develop the rules, policies, and procedures necessary to implement the proposed changes in the current delivery system for alternative long-term care services with an effective date of July 1, 2001. Some of the changes contained in the recommendation are as follows:

1. Repeal existing laws regarding the definition of assisted living facilities and the definition, regulatory oversight, and payment requirements for basic care facilities.
2. Define 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, social, or personal care services to five or more individuals who are not related by blood or marriage to the owners or operators.

Targeted Case Management

The task force concluded that states that have successfully increased the use of home and community-based services and reduced the number of high-functioning individuals entering nursing facilities have all established a strong case management system, including a mandatory assessment to establish the services necessary to maintain each individual and identify potential

alternatives to entering a nursing facility. In order to establish the importance of case management and to complement the two current enhanced case management projects, the task force concluded that action should be taken to ensure that Medicaid-eligible individuals at risk of entering nursing facilities be required to obtain case management services, including a preadmission assessment of needs, before individuals and families decide how to access long-term care services. The task force concluded that the funding for this could come from the Medicaid program targeted case management optional service. The task force estimated the cost to be approximately $980,000 per biennium, based on 1,400 individuals receiving services. Of the $980,000 total, $294,000 would be state general fund money. It was estimated that about 40 percent of the individuals would ordinarily receive case management under SPED or expanded SPED. Based on this assumption, the general fund impact would be reduced by $274,000, to $20,000. The task force recommended the implementation of a targeted case management program, that any Medicaid-eligible individual obtain a preadmission assessment prior to entering a nursing facility, and that the results of the targeted case management program be monitored to determine if the program should be extended to all individuals.

Moratorium on Nursing Facility and Basic Care Beds

The task force goal is to reduce the number of beds per thousand population age 65 and older from approximately 75 beds to 60 beds by the year 2002. The national average is 50 nursing facility beds per thousand population age 65 and older. The task force concluded that many high-functioning residents are admitted to nursing facilities in the metropolitan areas of the state. These individuals could be served in alternative settings thereby freeing up needed beds for those with greater care needs. Because of this, the task force concluded that there were enough long-term care beds and recommended that the moratorium be continued for another biennium. The task force also recommended that until the proposed changes to the basic care system are implemented in 2001, the basic care bed moratorium be continued, with one exception. The one exception is for a traumatic brain-injured facility in western North Dakota. The task force recommended that an exception to the basic care bed moratorium be granted for the creation of one traumatic brain-injured facility in western North Dakota. The facility would help ensure that this special 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, social, or personal care services to five or more individuals who are not related by blood or marriage to the owners or operators.
3. The development of rules, policies, and procedures that will establish minimum standards for the delivery of personal care services to individuals residing in residential facilities.
4. The development of payment rules, policies, and procedures that will allow program payments to follow eligible clients irrespective of the housing option chosen. The payment process should vary based on the needs of each individual and may be developed on a regional or statewide basis and need not be tied directly to costs incurred by individual providers of service. It should also include subsidized housing as necessary for recipients of basic care assistance not to exceed defined limits and individuals receiving home and community-based services if cost-effective.

Case Management

The committee recognized that in order to increase the use of home and community-based services and reduce the number of high-functioning individuals entering nursing facilities a strong case management system is needed. In addition, the committee recognized the importance of a mandatory assessment to establish the services necessary to maintain each individual and identify potential alternatives to entering a nursing facility. The committee recommends Senate Bill No. 2037 to provide for the implementation of a targeted case management program. The bill also provides that any Medicaid-eligible individual obtain a preadmission assessment to determine the type of services necessary to maintain that individual. The bill provides that the assessment may not be used as a condition of admission to the facility. The bill provides an appropriation of $980,000, of which $294,000 is from the general fund and $686,000 is from federal and other funds to the Department of Human Services for the provision of targeted case management services. The bill also provides that the department is to monitor the results of the targeted case management program to determine if the program should be extended to all individuals.

Moratorium on Nursing Facility and Basic Care Beds

The committee recognized the need to continue the moratorium on nursing facility and basic care beds. The committee also recognized the need for a traumatic brain-injured facility in the western part of the state. The committee recommends Senate Bill No. 2038 to continue the current moratorium on nursing facility and basic care beds through the 1999-2001 biennium. The bill also provides an exception to the basic care bed moratorium for the establishment of a traumatic brain-injured facility in western

North Dakota. In addition, the committee accepted the task force recommendation that the Department of Human Services change current funding and administrative policies to allow nursing facilities to provide and receive payment from the department for other services up to the level of the license of a skilled nursing facility.

The committee was informed by the Department of Human Services that it was able to implement procedures for the payment of basic care services in a nursing facility. The department issued guidelines and procedures to nursing facilities on August 20, 1998. The policies are intended to assist residents who have been residing in a nursing facility and no longer meet the level of care criteria necessary to have Medicaid pay for the nursing facility services. Because the policy is not intended to allow nursing facilities to admit basic care individuals, it includes a requirement that the individual must have been in the facility for at least six months before payment can be made under the basic care assistance program.

Swing-Bed Facilities

The committee recognized the importance of determining the role of swing beds in the future of long-term care services in the state. The committee recommends House Concurrent Resolution No. 3004 to provide for a Legislative Council study of the swing-bed process to determine if changes are necessary in the current requirements for providing services to swing-bed residents, including the need for a standard assessment process and whether any limits, such as length of stay or number of available swing beds, should be implemented.

LONG-TERM CARE FACILITY TOURS

While meeting in Devils Lake the committee toured the Academy Village complex, the Senior Citizen Center, Heartland Care Center, and the Odd Fellows Basic Care Home. At one of the meetings held in Bismarck the committee met at and toured The Terrace and St. Vincent's Care Center. While meeting in Kenmare the committee toured the Kenmare Community Hospital swing-bed and skilled care units and the Baptist Home of Kenmare assisted living units, basic care facility, and Alzheimer's pilot project unit.

BUDGET TOURS

While meeting in Devils Lake, the committee conducted a budget tour of the School for the Deaf, Lake Region Human Service Center, and UND-Lake Region. On the tours, the committee heard of needs for capital improvements and any problems the agencies may be encountering during the interim. The tour group minutes are available in the Legislative Council office and will be submitted in report form to the Appropriations Committees during the 1999 Legislative Assembly.