2011 HOUSE HUMAN SERVICES

HB 1323

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1323
1/24/11
13255

☐ Conference Committee

Committee Clerk Signature Meredith Trachsel

Explanation or reason for introduction of bill/resolution:

A BILL for an Act relating to payments for nursing homes in smaller communities; and to provide an appropriation.

Minutes: You may make reference to "attached testimony."

Chairman Weisz: The committee was called to order. Roll was called and a quorum was declared. We'll open the hearing on HB 1323, and the clerk will read the title.

Shelly Peterson, President, North Dakota Long Term Care Association: See attached testimony 1.

Chairman Weisz: I assume your intent is that every rural facility receive $1 at the minimum, regardless.

Peterson: No.

Chairman Weisz: Assuming they're not receiving other incentives.

Peterson: Yes. If they are currently not getting the efficiency incentive, then they would get the rural incentive. The sense is, it's very difficult for small rural facilities that have a small number of beds to get the efficiency incentive because of their numbers.

Chairman Weisz: But your language says they have to already be receiving an efficiency incentive.

Peterson: That is not accurate. When we had the bill drafted, they looked at other components of the payment system, and they said that was the best way. Maybe it should be drafted another way, because of the language in the current statute. On the first read through, it doesn't make sense, but I was told this was the correct way to do it. Our intent is they would be eligible for it.

Rep. Porter: How do you stop a facility from not going after the incentive? If they're getting it now but it's a hassle to get, and this money is just laying there, wouldn't they be better off going for this?

Peterson: No. You're still better off, in the payment system, to go after the full incentive. $2.60 per resident per day is better than $1.00.

Rep. Porter: Why wouldn't we then look at refining the incentives? The facilities that are out there getting the maximum incentive range in bed size from 24 to 86. Why wouldn't we leave it on the table and find out why the facilities not getting it, aren't?

Peterson: You are correct. In our December membership meeting, we passed a motion that we need to study why some are getting the incentive and some aren't. We have a preliminary report on the initial data findings tomorrow.

Chairman Weisz: Could you get us some of that information from your meeting tomorrow?

Peterson: I don't think so, because I just started looking at the data last night, and it doesn't appear to have any answers right now, we need to study it much more in depth.

Chairman Weisz: Further questions from the committee? Anyone else to support 1323?

Rocky Zastoupil, President and CEO, St. Aloisius Medical Center (Harvey): We're struggling in rural ND from several things – finding adequate employees, the census, and financially. The census is an issue that can help define the situation of why we have disparity amongst efficiency incentives. My facility has been running 83% occupancy this last year. We normally run in the 90s. With that happening, my cost per day goes up, and the opportunity for an efficiency incentive drops considerably. We still have employees, facilities, and utilities to maintain, regardless of if I have 10 residents or 100. We did a study that made us determine that the average cost for the top 10 cities in the state is $2.30, and the rest of the state is $1.30. That's partly where the dollar amount we're asking for came from. Economically, in most of our facilities in our cities we're the largest or second largest employer. We're vital to our communities. It's not large dollar amounts that we're requesting in this bill, but it can make a difference for us.

Chairman Weisz: Looking at the chart, it shows Harvey is currently maxing out its incentive, but you're anticipating you won't be, with a drop in bed utilization?

Zastoupil: Very possibly. I have a unique situation, in that I am one of 7-14 colocative facilities in the state, meaning there is a hospital attached. With the census dropping, that would create problems for me. As I've watched the average census in the state, I think it's averaged 90-92% the entire year. The census in the state is declining while the generation that is in the nursing home is starting to pass on.

Rep. Porter: Under your scenario, why wouldn't we lower from 90 to 88 to 85% the efficiency rating of occupancy over the course of the year to allow a facility to deactivate a bed into a state pool and then maybe buy it back if they need to, rather than incentivize declining population inside of a rural facility?

Zastoupil: You run into two situations there. As in any community, we're proud of where we live and we want to maintain our entity and our community as long as we can.

Secondly, we actually have a bill, HB 1325, which will address the bed layaway program, which would allow us four years to determine our appropriate bed size. At this point, to avoid being imputed, we have to remove the beds, in a permanent solution to possibly a temporary problem. It's causing management to make some decisions that normally we wouldn't make.

Rep. Porter: I'm taking it one step further, by saying the state would buy that bed and put it into a state pool, and it would be off your records. If you needed it back later, you would buy it back.

Zastoupil: That's an interesting analysis. We try to look at any method we can. We thought the four year bed layaway program would give us enough time to make that decision, but that's an option that could definitely be considered.

Rep. Porter: Wouldn't that in itself allow a facility that may be at an 85% occupancy the means to get back into the current incentive program without taking any drastic steps?

Zastoupil: You also run into another problem, having to do with the limits and the costs that you're spending. Even if you take away the imputive penalty, your costs per day will still be rising, because of your census. It wouldn't entirely solve that situation.

Chairman Weisz: Further questions from the committee? Anyone else here in support?

Karen Gabbert, Administrator, St. Gerard's Community Nursing Home (Hankinson): See attached testimony 2.

Chairman Weisz: Questions from the committee? Rep. Kreidt, thanks for joining us.

Rep. Gary Kreidt, District 33, Bill Sponsor: This bill is to help communities with less than 2500 individuals having problems generating additional cash. This would allow those not getting the $2.60 incentive to be able to obtain some of that money for their budget. The appropriation for this would come out of the health care trust fund, and the amount needed would be about $400,000. The health care trust fund went into effect a number of years ago, and it was the differential between Medicare and Medicaid dollars. There was about $98 million in federal money that came into the state of ND. That money was used to help nursing homes, basic care facilities, increase salaries, do remodeling, purchase equipment, etc. The money dried up. Part of the money that went out was in loans, so there is a repayment factor, interest and principal, that does come back into the state and it goes into the health care trust fund. It generates about $1.3 million, perpetual. Last session, we used some of it to enhance salaries for basic care and nursing home employees; however, there was an amendment passed last session that the money can only be used for health care facilities in the state of ND. There would be no general fund dollars used in this incentive, and I hope the committee acts in favor of this bill.

Chairman Weisz: Any questions? Anyone else here in support of HB 1323?

Sister Mary Louise, Assistant Administrator, St. Gerard's Community Nursing Home (Hankinson): I am here in full support of HB 1323. I concur with the testimony already

presented this morning. I say that our commitment to the mission of serving the elderly in rural facilities is unwavering. I believe in the value and the need of providing such services to the elderly in rural communities where they have spent, many of them, their entire lives, and are being cared for by those that they have known and those they love. The wife of one of our residents recently expressed her deep gratitude that he could receive care close to their home, as it would be a problem to visit him if he were out of town. I could share many comments and accounts illustrating the same point. Rural facilities are definitely a blessing and are needed. They benefit many individuals and families, and provide employment, in our case over 70 full time and part time employees. The entire community is impacted by our presence. We definitely make a difference. I ask you to please support HB 1323.

Chairman Weisz: Any questions from the committee? Anyone else here in support?

LeeAnn Theil, Administrator, Medicaid Payment and Reimbursement Services, Medical Services Division, Department of Human Services: See attached testimony 3.

Chairman Weisz: Can you expand a little more about needing legislature guidance on the use of non-federal funds for costs exceeding the UPL?

Thiel: According to federal regulations, we cannot set the nursing home rates higher than what Medicare would reasonably pay. We would need guidance on how to make up the difference between the cost-based rate, for example $200, and the UPL, for example $190, what you want us to do to make up the other $10.

Chairman Weisz: Further questions from the committee? Further testimony in support of HB 1323? Anyone here in opposition to HB 1323? Seeing none, we'll close the hearing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1323
1/26/11
13467

☐ Conference Committee

Committee Clerk Signature Meredith Frankhouse

Explanation or reason for introduction of bill/resolution:

A BILL for an Act relating to payments for nursing homes in smaller communities; and to provide an appropriation.

Minutes: You may make reference to "attached testimony."

Chairman Weisz: The way the bill is written, if you're not currently getting an incentive agreement, you wouldn't get this one either. That's not their intent, their intent was that every nursing home that's in a 2500 or less community would get the dollar incentive but not be able to exceed the $2.60 if they're getting additional incentives. I had a conversation with them last night, and there is concern that the language doesn't say that. If we send it out as is, we need to fix that part. I have problems with this, because the whole incentive program was created to get facilities to be more efficient, but now here's an incentive payment just because you exist. Now you're just messing with the incentive payments.

Rep. Schmidt: I have a note asking if it's possible to lower the efficiency from 90% to 80%. What would that mean, if we did that?

Chairman Weisz: It would have some effect on their incentive payment. There's more than just that occupancy rate that determines their incentive payment. There's the other bill that has a moratorium, that in a sense has more direct effect, because they get penalized if they're under 90%. But that's not the only criteria, so it is a possibility to get an incentive even if occupancy is under 90%, if they're really good in all the other categories.

Rep. Kilichowski: Under this bill, was it in discussion to set basic beds aside?

Chairman Weisz: Sort of both, but the main discussion on that was on the other bill. If you did lower that to 85%, it will have some effect on this. It's part of the formula. What are the committee's leanings on this?

Rep. Damschen: I feel I'm in a dilemma because I agree this is counter-effective to the incentive, yet I've got a small nursing home in my district that would like to see this passed.

Chairman Weisz: If the committee thinks the smaller, more rural nursing homes are facing an additional problem over the urban, nothing stops us from doing something. Should they

be treated separately from larger ones? Appropriations will argue that out, if they need an inflator or an adjusted bump. I have problems with this method of incentive, though.

Rep. Porter: When you look at the complicated method of setting these charges in the first place, this really is an end run around what we as a state set for the indirect care cost, and what we as a state set for an incentive system. If a rural nursing home uses this dollar as their save-all and it's a band-aid approach to what the problem may be, then we need to look at the incentive program or the indirect care limit per day. I think it's wrong to start picking at an established rate system. This whole thing comes on the department's budget, which is in the Senate, and the whole arguments of if the numbers are set right for the industry are all set through appropriations and that budgeting process. For us to start nibbling pieces here and there takes the whole rate system and flips it upside down. If the incentive program was set up with the industry, with the Department of Human Services, and with the Appropriations Committee, to keep the indirect costs down, then throwing a dollar out there without any kind of program is saying that the incentive program was set up wrong. We'd be better off reworking the incentive program, if the bar is set too high, or increasing the direct care line item in the department's budget.

Chairman Weisz: I agree with you, but I think the rural nursing homes are becoming real concerned since we've had this shift from a shortage of beds to an excess, that they no longer have a marketable bed. In the past they didn't care as much; now that utilizations are dropping they are afraid of the future and they think this is a way to shore up their budgets.

Rep. Damschen: I agree, that concern is real, but on the other hand, it doesn't seem sensible to have a complicated rate setting system and incentive, and then say, woops!, you're not getting enough. A different method would be more practical.

Chairman Weisz: You do have to wonder why some homes can't get any incentive payment at all. Is it things they can control, or things beyond their control?

Rep. Louser: I agree with the last two statements, this system was set up as an incentive system, and when you start changing the inputs, clearly the outputs are going to change dramatically. This seems to be a $400,000 appropriation they feel they should get because they're not getting it from the health care trust fund anymore.

Chairman Weisz: It probably isn't related to the health care trust fund in that sense, but you're right that they are looking for another $400,000 on top of their appropriation through the department. I have real troubles with the vehicle they're trying to use. We can have a motion if no one is looking at any changes to the bill.

Rep. Porter: I move Do Not Pass.

Rep. Hofstad: Second.

Chairman Weisz: We have a motion and a second. Further discussion?

Rep. Devlin: I oppose the motion, but I agree with Rep. Porter that maybe a different approach needs to be made to the payment system. I do think there is validity to the point that these smaller facilities have trouble making the efficiencies of those in the big cities because they just don't have the number of beds to spread them across.

Rep. Holman: We have another bill, 1325 I think, that deals with parking your unused beds for awhile. Don't these two kind of blend together? That allows them changes, too, to their benefit. Are we talking about some of the same types of issues?

Chairman Weisz: Yes and no. HB 1325 they want to build a bank of beds from the standpoint of giving them time to figure out what they want to do with probably lower occupancy rate. It gives them some flexibility in case these are just short term down trends. Are they related, yes. It is still separate because that wouldn't affect their incentive or anything else to be more efficient.

Rep. Kilichowski: I echo what Rep. Devlin said. I think this gives the little ones a bit more of a chance and some breathing room. I'm going to oppose this, too.

Rep. Porter: To be statistically sound, it doesn't seem there is any correlation between size and efficiency. We have examples in ND. It really is all about how they run their facility and how efficient they are. It has nothing to do with size, or rural, or losing beds. The argument that this is to save the rural facilities is false, because there are rural facilities that are meeting, and maxing out, the efficiency incentive. This is nothing but an end run around biting the bullet and being efficient.

Chairman Weisz: Any further discussion or comments?

Rep. Damschen: I just want to repeat that I am sensitive to that issue, too, that there are homes doing most things right but still running short of money, but I'm going to support the motion because I think it is counter to our other funding.

Rep. Hofstad: I'm afraid that this is a problem where we're not addressing the right issues. This is a very complicated formula, and to just add a little bit of money on top of these nursing homes in trouble is not the answer. It would be wiser to address the core issues and adjust the formula to fix those problems.

Chairman Weisz: Any further comment? Seeing none, the clerk will call the roll for a Do Not Pass on HB 1323. Motion carries 7-6. Rep. Porter will carry the bill.

Date: 1-26-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1323

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN		✓
VICE-CHAIR PIETSCH		✓	REP. HOLMAN		✓
REP. ANDERSON	✓		REP. KILICHOWSKI		✓
REP. DAMSCHEN	✓				
REP. DEVLIN		✓			
REP. HOFSTAD	✓				
REP. LOUSER	✓				
REP. PAUR	✓				
REP. PORTER	✓				
REP. SCHMIDT		✓			

Total (Yes) 7 No 6

Absent _____

Floor Assignment Rep. PORTER

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

DNP
motion
carried

REPORT OF STANDING COMMITTEE

HB 1323: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (7 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1323 was placed on the Eleventh order on the calendar.

2011 TESTIMONY

HB 1323

#1

Testimony on HB 1323
House Human Services Committee
January 24, 2011

Good Morning Chairman Weisz and members of the House Human Services Committee. My name is Shelly Peterson representing the North Dakota Long Term Care Association. Our Association represents assisted living facilities, basic care facilities and nursing facilities in North Dakota. I am here today to ask for your support of HB 1323.

HB 1323 is designed to enhance the current nursing facility payment system by providing a small payment to nursing facilities located in communities of less than 2,500 in population, to help them sustain essential nursing facility care. The nursing facilities who meet this criteria would be eligible for a "rural access payment" of $1.00 per resident per day, not to exceed a combined efficiency/rural payment of $2.60 per resident per day. To best explain how the rural access payment would work, I have two attachments I would like you to review.

Attachment A—Nursing Facility Payment System

Attachment B—Rural Access Payments

Some rural nursing facilities are really struggling and are asking for your help to remain a vital part of their community. Ninety-three percent of nursing facilities are non-profit, community owned or church affiliated. They are caring for some of our most frail residents who are no longer able to care for themselves. Residents generally are female and range in age from 18 to 106 years old, with the average age being 84. Most need help with dressing, eating, transferring, walking and making decisions. They have complex medical needs and require assistance throughout the day.

Nursing facilities are a vital part of the community and in rural North Dakota the major employer. The direct and secondary impact of the long term care facilities on the state's economy has reached nearly $1 billion dollars ($972.9 million).

Long term care facilities directly employ approximately 14,500 individuals, with secondary employment at 10,329 for a total of 24,826 individuals. These facilities care for over 16,000 North Dakotan annually, with over 10,649 being cared for in a nursing facility setting (assisted living facility—3,371 and basic care facility—2,040 individuals). Nursing facilities advance the health and well-being of people and communities throughout the state in many ways: physical, emotionally, spiritually and economically.

Over the years, long term care facilities have fulfilled a mission of enhancing the dignity, independence and quality of life for long term care residents and their loved ones. They stand ready to serve 24-hours a day, seven days a week.

They provide assistance during some of the most trying times in life. They offer quality care to all people regardless of their social or financial status. They are significant to the residents they care for, to their community and to the State of North Dakota.

The rural access payment helps rural facilities remain a part of their community. This in combination with the current vital components of the nursing facility payment system will help them sustain their business and service.

In 1987, the legislature passed equalization of rates for nursing facilities. This means the state determines the payment system for nursing facilities and it is against the law to charge more. The only way to increase payment or change the payment system is to seek legislative approval. We ask for your support and approval to provide a rural access payment.

In conclusion thank you for considering HB 1323. We urge your support. I would be happy to address questions.

Shelly Peterson, President
North Dakota Long Term Care Association
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Cell (701) 220-1992 • www.ndltca.org • E-mail: shelly@ndltca.org

NURSING FACILITY PAYMENT SYSTEM

MINIMUM DATA SET FOR PAYMENT

The state adopted the Minimum Data Set (MDS) for its payment system on January 1, 1999. The MDS provides a wide array of information regarding the health status of each resident. The payment system has thirty-four facility specific rates. Each resident is evaluated at least quarterly and the intensity of their needs determines their rate classification.

EQUALIZATION OF RATES

The legislature implemented equalization of rates between Medicaid residents and self pay residents for nursing facilities in 1990. Equalization of rates requires all residents be charged the same rate for comparable services. Minnesota and North Dakota are the only states in the nation with equalization of rates. Nursing facilities are the only providers/private business subjected to an equalized rate system in the State of North Dakota.

RATE CALCULATIONS

The determination of rates is the sum of **four components**: direct care, other direct care, indirect care and property. Today's limits are calculated based on the **June 30, 2006 cost report** inflated forward to 2011. The 2009 legislature allowed rates and limits to be increased by 6% in 2010 and 2011.

Limits (the maximum that will be paid) are set for the direct care, other direct care and indirect care components by utilizing the **2006** cost report of all Medicaid nursing facilities, arraying the facilities from least expensive to most expensive, selecting the facility at mid-point (median facility) and then adding either 10% or 20% to the cost of that median facility. The **direct care** and **other direct care** limit is established by adding **20%** to the cost of that median facility. The **indirect care** limit is established by adding **10%** to the cost of that median facility. The limits are then inflated annually by the legislative approved inflation factor. In addition, an adjustment was made to the limits in 2011 to recognize the increases for the salary enhancements approved in the 2009 session.

Direct Care Rate. Costs in the Direct Care Category include: nursing and therapy salaries and benefits, OTC drugs, minor medical equipment and medical supplies. On January 1, 2011 the direct care limit was set at $127.76 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities over the limit are spending at least $1,056,229 in nursing that will never be recouped.

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Other Direct Care. Costs in the Other Direct Care Category include: food, laundry, social service salaries, activity salaries and supplies. On January 1, 2011 the other direct care limit was set at $23.95 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities exceeding the limit are spending at least $206,937 in costs that will never be recouped.

Indirect Care. Costs in the Indirect Care Category include: Administration, pharmacy, chaplin, housekeeping salaries, dietary salaries, housekeeping and dietary supplies, medical records, insurance, and plant operations. On January 1, 2011 the indirect limit was set at $60.60 per day. Nineteen nursing facilities currently exceed this limit. The nineteen nursing facilities exceeding the limit are spending at least $1,799,029 in indirect care expenses. These costs will never be recouped.

Property rate includes depreciation, interest expense, property taxes, lease and rental costs, start-up costs and reasonable and allowable legal expenses. The average property rate is $14.34 per resident per day, with a range of $3.39 to $52.40.

Occupancy Limitation – In the June 30, 2010 cost reporting period, twenty-two nursing facilities reported twelve month occupancy averages at less than 90%. Together they incur $1,726,047 in penalty costs because they operate under 90% occupancy.

Incentives - A reward is provided to nursing facilities that are under the limit in indirect care. The incentive is calculated for each facility based upon their indirect costs compared to the indirect limit. Facilities are able to receive 70 cents for every dollar they are below the limit up to a maximum of $2.60 per resident day. In 2011, fifty-five nursing facilities received an incentive, with the average per day incentive at $2.10. Of the fifty-five nursing facilities receiving an incentive, they ranged from $0.07 to $2.60 per resident per day.

Operating Margin - All nursing facilities receive an operating margin of three percent based on their historical direct care costs and other direct care costs (up to limits). The operating margin provides needed cash flow to cover up-front salary adjustments, replacement of needed equipment, unforeseen expenses, and dollars to implement ever increasing regulations. The operating margin covers the gap between the cost report and the effective date of rates (this can be up to 18 months). In 2011, the average operating margin is $3.59 per resident per day.

Inflation - Rates are adjusted for inflation annually. Inflation is a rise in price levels that are generally beyond the control of long term care facilities. Examples of price level increases include the 9.7% increase in health insurance and significant increases in fuel. To attract and retain adequate staff, nursing facilities need to offer salary and benefit packages that reward people. Approximately 75% of a nursing facility's budget is dedicated to personnel costs. Adequate inflation adjustments are critical for salary and benefits so nursing facilities can compete in the market place. Turnover of certified nurse assistants, the largest pool of employees was 62% in 2010.

Annual inflationary adjustments are set every legislative session.

Rebasing – A limit is establish on the maximum that will be paid in each cost category. The 2011 limits are based upon the June 30, 2006 cost report inflated forward to 2011. The next time limits will be rebased is January 1, 2013 using the June 30, 2010 cost report.

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Testimony on HB 1323
House Human Services Committee

[redacted]D ON RATES SET BEGINNING JANUARY 1, 2011

	NH No.	Provider Name	Provider No.	City	Census	Licensed Beds	2010 Incentive	2011 Incentive	Under 2500 Population (RAP)	Fiscal Impact	Population
61	2709	Aneta Parkview Health Center	30322	Aneta	13,634	39	$0.97	$0.50	$1.00	$13,634	1-500
62	2809	Arthur Good Samaritan Center	30058	Arthur	11,413	42	$0.00	$2.60	$0.00	$0	1-500
63	1709	Nelson County Health System Care Cente	30384	Mcville	13,834	39	$2.32	$2.60	$0.00	$0	1-500
###	6609	Osnabrock Good Samaritan Center	30117	Osnabrock	6,892	24	$1.73	$2.60	$0.00	$0	1-500
6	0109	Ashley Medical Center	30188	Ashley	15,884	44	$0.00	$2.60	$0.00	$0	501-2500
7	3009	Bottineau Good Samaritan Center	30118	Bottineau	25,344	75	$0.00	$0.00	$1.00	$25,344	501-2500
8	3109	Southwest Healthcare Services	30403	Bowman	22,939	66	$0.00	$0.00	$1.00	$22,939	501-2500
9	0409	Towner County Medical Center	30379	Cando	13,925	41	$0.00	$0.00	$1.00	$13,925	501-2500
10	0609	Golden Acres Manor Nursing Home	30008	Carrington	21,356	60	$2.60	$2.60	$0.00	$0	501-2500
11	3209	Wedgewood Manor	30194	Cavalier	16,296	50	$2.60	$0.00	$1.00	$16,296	501-2500
12	0709	Cooperstown Medical Center	30095	Cooperstown	17,272	48	$1.39	$2.60	$0.00	$0	501-2500
13	3309	Crosby Good Samaritan Center	30122	Crosby	14,336	42	$0.00	$0.00	$1.00	$14,336	501-2500
14	3709	Dunseith Community Nursing Home	30052	Dunseith	10,320	35	$0.00	$0.00	$1.00	$10,320	501-2500
15	0909	Jacobson Memorial Hospital Care Center	30077	Elgin	9,006	25	$1.34	$0.00	$1.00	$9,006	501-2500
16	3809	Prince of Peace Care Center	30012	Ellendale	16,949	53	$0.00	$0.99	$1.00	$16,949	501-2500
17	3909	Maryhill Manor	30108	Enderlin	19,057	54	$1.83	$2.29	$0.31	$5,908	501-2500
18	4509	Four Seasons Health Care Center, Inc.	30406	Forman	11,180	32	$2.60	$2.60	$0.00	$0	501-2500
19	4609	Benedictine Living Center of Garrison	30247	Garrison	18,117	52	$2.00	$2.60	$0.00	$0	501-2500
20	1009	Garrison Memorial Hospital Nursing Home	30134	Garrison	9,490	28	$1.41	$0.00	$1.00	$9,490	501-2500
21	1109	Marian Manor Healthcare Center	30067	Glen Ullin	30,792	86	$2.60	$2.60	$0.00	$0	501-2500
22	1309	St. Gerard's Community Nursing Home	30163	Hankinson	11,822	37	$0.00	$0.86	$1.00	$11,822	501-2500
23	8409	St. Aloisius Medical Center	30129	Harvey	35,833	106	$2.60	$2.60	$0.00	$0	501-2500
24	1409	Tri County Health Center	30018	Hatton	14,116	42	$0.00	$0.00	$1.00	$14,116	501-2500
[redacted]	9309	Western Horizons Living Center	30477	Hettinger	17,331	54	$1.51	$0.00	$1.00	$17,331	501-2500
[redacted]	3609	Hillsboro Medical Center	30019	Hillsboro	12,872	36	$0.00	$0.00	$1.00	$12,872	501-2500
[redacted]	8909	Hill Top Home of Comfort, Inc.	30271	Killdeer	17,561	50	$0.00	$0.00	$1.00	$17,561	501-2500
28	5009	Lakota Good Samaritan Nursing Home	30097	Lakota	16,953	49	$2.60	$2.60	$0.00	$0	501-2500
29	5109	St. Rose Care Center	30119	LaMoure	12,627	40	$1.95	$2.60	$0.00	$0	501-2500
30	5209	Maple Manor Care Center	30083	Langdon	21,567	63	$2.60	$2.60	$0.00	$0	501-2500
31	5309	Larimore Good Samaritan Center	30113	Larimore	15,186	45	$0.00	$0.00	$1.00	$15,186	501-2500
32	9009	North Dakota Veterans Home	30293	Lisbon	13,751	38	$0.00	$0.00	$1.00	$13,751	501-2500
33	8209	Parkside Lutheran Home	30109	Lisbon	14,348	40	$0.00	$0.70	$1.00	$14,348	501-2500
34	5609	Luther Memorial Home	30024	Mayville	33,088	99	$2.60	$2.60	$0.00	$0	501-2500
35	5809	North Central Good Samaritan Center	30173	Mohall	20,038	59	$2.60	$2.60	$0.00	$0	501-2500
36	5909	Mott Good Samaritan Nursing Center	30142	Mott	16,201	45	$2.60	$2.60	$0.00	$0	501-2500
37	6009	Napoleon Care Center	30114	Napoleon	15,261	44	$2.19	$1.63	$0.97	$14,803	501-2500
38	6109	Lutheran Home of the Good Shepherd	30029	New Rockford	26,289	80	$2.60	$2.60	$0.00	$0	501-2500
39	6209	Elm Crest Manor	30116	New Salem	22,851	68	$2.60	$2.36	$0.24	$5,484	501-2500
40	6409	Northwood Deaconess Health Center	30031	Northwood	19,670	61	$0.00	$0.00	$1.00	$19,670	501-2500
41	6509	Oakes Manor Good Samaritan Center	30124	Oakes	33,294	102	$2.60	$2.60	$0.00	$0	501-2500
42	6709	Park River Good Samaritan Center	30154	Park River	21,582	68	$2.60	$2.60	$0.00	$0	501-2500
43	6809	Rock View Good Samaritan Center	30155	Parshall	8,785	30	$0.00	$0.00	$1.00	$8,785	501-2500
44	9409	Richardton Health Center	30487	Richardton	5,901	18	$0.00	$0.00	$1.00	$5,901	501-2500
45	8309	Presentation Medical Center	30466	Rolette	11,844	38	$2.60	$0.00	$1.00	$11,844	501-2500
46	6909	Mountrail Bethel Home	30032	Stanley	19,776	57	$0.00	$0.00	$1.00	$19,776	501-2500
47	2309	Strasburg Care Center	30033	Strasburg	19,253	60	$2.60	$2.60	$0.00	$0	501-2500
48	2409	Tioga Medical Center	30176	Tioga	10,806	30	$2.60	$1.94	$0.66	$7,132	501-2500
49	2509	Prairieview Home-Medcenter One	30053	Underwood	20,573	60	$2.60	$2.60	$0.00	$0	501-2500
50	7109	Souris Valley Care Center	30216	Velva	17,167	50	$1.12	$2.29	$0.31	$5,322	501-2500
51	7309	Pembilier Nursing Center	30035	Walhalla	9,245	32	$2.60	$2.60	$0.00	$0	501-2500
52	7409	McKenzie County Healthcare System	30449	Watford City	16,174	47	$0.00	$0.00	$1.00	$16,174	501-2500
53	2609	Wishek Home for the Aged	30039	Wishek	21,616	70	$0.00	$0.41	$1.00	$21,616	501-2500
58	7909	Knife River Care Center	30002	Beulah	30,651	86	$0.00	$0.00			2501-5000
59	4709	Lutheran Sunset Home	30016	Grafton	34,579	104	$1.22	$0.60			2501-5000
[redacted]	3009	Heart of America Medical Center	30135	Rugby	27,039	80	$0.00	$0.00			2501-5000
[redacted]	3409	Devils Lake Good Samaritan Center	30115	Devils Lake	19,026	62	$1.16	$0.41			5001-10000
[redacted]	809	Heartland Care Center	30010	Devils Lake	25,840	74	$0.00	$0.96			5001-10000
[redacted]	7009	Sheyenne Care Center	30073	Valley City	61,741	138	$2.60	$2.60			5001-10000

[redacted]D ON RATES SET BEGINNING JANUARY 1, 2011

	NH No.	Provider Name	Provider No.	City	Census	Licensed Beds	2010 Incentive	2011 Incentive	Under 2500 Population (RAP)	Fiscal Impact	Population
57	7209	St. Catherine's Living Center	30034	Wahpeton	32,692	100	$2.60	$1.85			5001-10000
###	2909	Baptist Home	30003	Bismarck	49,694	141	$2.60	$0.79			10001+
		Good Samaritan Society—Bismarck		Bismarck	0	48					10001+
1	0309	Medcenter One St. Vincent's Care Center	30005	Bismarck	36,670	101	$2.60	$2.60			10001+
2	0209	Missouri Slope Lutheran Care Center, Inc.	30004	Bismarck	90,685	250	$1.93	$1.48			10001+
		St. Gabriel's Community		Bismarck		72					10001+
1	3509	St. Benedict's Health Center	30237	Dickinson	56,314	164	$2.60	$2.60			10001+
2	3609	St. Luke's Home	30011	Dickinson	30,100	84	$1.83	$2.60			10001+
3	4009	Bethany Home	30060	Fargo	65,796	172	$1.32	$0.65			10001+
	####	Bethany on 42nd	30492	Fargo	8,419	78		$0.00			10001+
1	4209	Elim Home	30051	Fargo	45,258	128	$2.60	$1.15			10001+
2	9109	Manorcare of Fargo ND, LLC	30478	Fargo	34,348	131	$2.60	$2.60			10001+
3	4309	Rosewood on Broadway	30015	Fargo	40,040	111	$1.86	$2.32			10001+
4	4409	Villa Maria Healthcare	30086	Fargo	47,906	140	$0.00	$0.07			10001+
5	8709	Valley Eldercare Center	30017	Grand Forks	60,049	176	$2.60	$2.60			10001+
6	8809	Woodside Village	30201	Grand Forks	42,558	118	$2.60	$2.60			10001+
7	4809	Ave Maria Village	30020	Jamestown	36,222	100	$2.60	$2.60			10001+
8	4909	Hi-Acres Manor Nursing Center	30021	Jamestown	49,583	142	$2.60	$2.60			10001+
9	2209	MCO Mandan Care Center Off Collins	30106	Mandan	18,007	50	$0.99	$0.00			10001+
10	5509	Medcenter One Care Center	30288	Mandan	46,516	128	$2.60	$2.60			10001+
11	9209	Manor Care of Minot ND, LLC	30479	Minot	36,514	114	$2.60	$2.60			10001+
12	2009	Trinity Home	30028	Minot	93,799	292	$2.60	$2.60			10001+
		Sheyenne Crossing Care Center		West Fargo		64					10001+
[redacted]	7609	Bethel Lutheran Home	30038	Williston	58,945	168	$2.60	$2.60			10001+
		Total								$411,641	

HB 1323
Jan. 24, 2011
Attachment 2

Hello Chairman Weisz and Members of the House Human Services Committee,

The following is the testimony that I gave this morning at the Hearing for HB 1323:

Good Morning Chairman Weisz and members of the House Human Services Committee. My name is Karen Gabbert, Administrator of St. Gerard's Community Nursing Home, Independent Living, Child Care and Kinder Kollege in Hankinson, ND.

As you know, an incentive is built into the rate system that is intended to encourage facilities to keep expenses under indirect limits. This incentive can be up to $2.60 per day. For small facilities, this is very difficult as the expenses are divided among fewer residents. This is evident in the facts that follow. Of the 82 facilities in North Dakota, there are 46 rural facilities (population 2,500 or less). That is 56% of us. Of those 46 facilities, 22 received less than a $1.00 incentive. Stated another way, 48% of rural facilities did not even receive one dollar incentive.

Facilities in communities with a population of over 2,500 constitute 44% of us. Of those facilities, only 5 of them or 14% received an incentive of less than $1. Clearly, there is a need for what we are asking which is that nursing homes in small rural communities get a little extra boost by receiving a $1.00 rural access payment. It is for the good of all rural nursing homes and it does not take anything away from those that do achieve a large or full incentive.

One more point I would like to make is that this is nothing new. The incentive is already in place. It just allows our rural North Dakota facilities to share in it.

I urge you to support HB1323.

Thank you very much.

Karen Gabbert, Administrator
St. Gerard's Community Nursing Home
PO Box 448
Hankinson, ND 58041-0448
Phone: 701.242.7891
E-mail: stgerard@rrt.net

#3

Testimony
House Bill 1323 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 24, 2011

Chairman Weisz, members of the Human Services Committee, I am LeeAnn Thiel, Administrator of Medicaid Payment and Reimbursement Services of the Medical Services Division for the Department of Human Services.

I am here today to provide information on House Bill 1323, about the estimated cost increase and the Medicaid Upper Payment Limit.

Section 2 of House Bill 1323 provides for an appropriation from the health care trust fund. The estimated impact to the Medicaid program if the health care trust fund is not used for the changes proposed in House Bill 1323 would be $332,465 of which $148,280 is general funds. The estimated impact to costs for private pay individuals is $284,997. Both estimates are for 18 months as nursing facility rates would be affected beginning January 1, 2012.

The federal Medicaid regulations contain a requirement that Medicaid payments to institutional providers, including nursing facilities, in the aggregate, cannot exceed what Medicare would pay, in the aggregate, for the same care. This is known as the Upper Payment Limit (UPL). The Upper Payment Limit must be calculated yearly for each type of facility: private; state-government owned, and non-state government owned. Historically, the gap between the Medicaid payments and the Upper Payment Limit has been large enough, where this has not been an issue or something the Department needed to bring to your attention. However, the increases

provided by the 2009 Legislature, have resulted in North Dakota approaching the Upper Payment Limit for the private facilities, and actually, for 2011, exceeding the Upper Payment Limit for the non-state government owned facilities. The proposed increase to the Medicaid payments for nursing facilities in House Bill 1323 will directly impact the UPL for all three types of nursing facilities because an incentive payment is not an allowable cost under Medicare reasonable cost principles. If this bill and/or the cumulative impact of legislation passed during the 2011 Legislative Assembly results in the UPL being exceeded for one or more of the facility types, the Department will need to reduce the Medicaid rates to comply the Upper Payment Limit. Subsequently, because of equalized rates, the rates for the private pay would be reduced as well. If the Department were to reduce rates, we would need guidance from the Legislature about the use of non-federal funds to pay for the portion of costs associated with approved nursing facility rate increases, which exceed the UPL.

Finally, if the intent of this new section is that the rural nursing incentive payment be based on resident days, clarifying language should be added similar to N.D.C.C. 50-24.4-10(5). Attached to my testimony is the century code reference.

I would be happy to answer any questions that you may have.

ND Century Code 50-24.4-10(5)

The efficiency incentives to be established by the department pursuant to subsection 3 for a facility with an actual rate below the limit rate for indirect care costs must include the lesser of two dollars and sixty cents per resident day or the amount determined by multiplying seventy percent times the difference between the actual rate, exclusive of inflation rates, and the limit rate, exclusive of current inflation rates. The efficiency incentive must be included as a part of the indirect care cost rate.