Testimony
Health Services Committee
Wednesday, September 26, 2012; 11:15 a.m.
North Dakota Department of Health

Good morning, Madam Chair and members of the Health Services Committee. My name is Darleen Bartz, Ph.D., Chief of the Health Resources Section, North Dakota Department of Health. I am here at the request of Chairman Lee to provide comments regarding the need for additional Basic Care beds in our state and whether the Committee should ask the State Health Council to consider developing an incentive plan for moving basic care beds similar to the one for skilled care beds.

The purpose of the moratorium on the expansion of basic care bed capacity in North Dakota Century Code 23-09.3-01.1 was to limit the expansion of basic care beds in our state. The moratorium has been reviewed by the legislature every two years and has been supported by the industry. The provisions in the moratorium also include several options by which beds can be added to the state's licensed basic care bed capacity. Those options include:

- A nursing facility converts nursing facility beds to basic care;
- An entity licenses bed capacity transferred as basic care bed capacity;
- Basic care beds are transferred from one basic care facility to another basic care facility;
- An entity converts skilled beds placed in layaway to basic care and licenses basic care beds in their facility or transfers to another facility; or
- An entity demonstrates to the North Dakota Department of Health (NDDoH) and the North Dakota Department of Human Services (DHS) that basic care services are not readily available within a designated area of the state or that existing basic care beds within a 50-mile [80.47-kilometer] radius have been occupied at 90 percent or more for the previous 12 months.

Over the past few years, we have seen several nursing facilities convert nursing facility beds to basic care beds and open small 5 to 6 bed basic care facilities. We have had nursing facilities convert skilled nursing facility beds to basic care and transfer the basic care beds to another basic care facility or entity to license as basic care beds. We currently have 107 nursing facility beds that are in the layaway program that could be converted to basic care and licensed by the facility or transferred to another facility. We also have 16 basic care beds on hold for entities

waiting to be licensed. The basic care beds that are on hold, or the skilled nursing facility beds in layaway, can also be transferred to other basic care facilities. When visiting with Shelly Peterson, North Dakota Long Term Care Association President, she has indicated there is the potential for several basic care beds to be available for transfer either now or in the near future.

When working with the State Health Council this spring to look at needs related to basic care facility beds, the State Health Council made the determination to stay with 15 beds per 1,000 individuals age 65 and older. However, the census data this was based on was updated to the 2010 census projections for North Dakota – from 97,771 to 110,235 individuals age 65 and older. This resulted in an increase in the number of basic care beds needed for North Dakota from 1,467 beds to 1,653, an increase of 186 basic care beds. We currently have 1,812 basic care beds licensed in North Dakota.

Based on the need identified for basic care beds in 2009, it was identified there were 256 licensed basic care beds above the projected need of 15 beds per 1,000 individuals age 65 and older. With the adjustments made in the census data reviewed by the State Health Council in 2012 and the changes which have occurred in licensed basic care beds on an ongoing basis, the state continues to be over the projected need by 159 beds. The number of basic care beds needed was determined to be sufficient based on the basic care occupancy rates reported throughout the state in September 2011, which showed an 82 percent occupancy rate over the past 12 months, or an average bed vacancy rate of 327 beds throughout the state.

We recognize that the number of basic care beds needed varies in each region, as do the occupancy rates. In 2012, we have had four entities request the Department of Health and Department of Human Services review their applications for new/additional basic care beds based on demonstrated need. Of the four applications reviewed, one was approved in Human Service Region VIII for 10 basic care beds. Human Service Region VIII had an identified need for 10 additional basic care beds based on the population age 65 and older, and had an average basic care bed occupancy rate within a 50-mile radius over the past 12 months of 92 percent, meeting both of the criteria to be considered when adding basic care beds to the area.

Another entity who applied for eight basic care beds in Human Service Region VII ended with a different outcome. Human Service Region VII was identified to be 13.14 beds over the projected need and to have an average occupancy rate in a 50-

mile radius over the past 12 months of 89 percent. This translated into an average of 33 vacant basic care beds in a 50-mile radius over the past 12 months. The need for basic care beds in this region had increased with the updated census projections by 41.54 beds. However, there had also been an increase in the beds available in the past couple years with two new basic care facilities opening, one with 17 beds and one with 18 beds, and a third facility increasing their capacity by 19 beds for a total increase since 2009 of 54 beds. When this application was denied in April 2012, this provider was able to transfer three basic care beds to their facility from another basic care facility and increase their licensed basic care bed capacity to 20, resulting in an increase in basic care bed capacity in region VII since 2009 of 57 beds.

The question was asked if the current system for transfer of basic care beds seems to be working, or if the State Health Council should consider developing a plan with incentives for transfer of basic care beds. In my experience, the current system does work effectively consistent with the direction provided by the legislature. While not every facility or entity that applies to the NDDoH and DHS for additional beds is approved based on the criteria, the legislature has provided several other options that can be pursued for the transfer of basic care beds. As stated earlier, the department is seeing several transfers of basic care beds occurring every month, so the options are being actively used.

As the licensing agency, the Department of Health does not get involved with the financial transactions that may occur between facilities when transferring beds. However, we do believe the option for facilities to reach agreement regarding the transfer of beds does create an incentive for facilities to transfer beds they do not need. Also, if an additional incentive program is desired by the legislature, we believe that the NDDoH is not the entity to do so. The incentive program for the transfer of nursing facility beds was managed by the Department of Human Services and used the intergovernmental transfer funds. To my knowledge, this option is no longer available and nursing facilities are successfully working together to transfer beds consistent with the options provided by the legislature.

This concludes my testimony. I would be happy to respond to any questions you may have.