Department of Human Services
Human Services Committee
Representative Chuck Damschen, Chairman
July 22, 2014

Chairman Damschen, members of the Human Services Committee, I am Julie Schwab, Director of Medical Services for the Department of Human Services (Department). I appear before you to provide information on North Dakota Medicaid transportation related payment levels and the process of requesting Medicaid transportation payments used by providers and the long-term care (LTC) study, including information relating to basic care rates and quality indicators for nursing homes.

Transportation

North Dakota Medicaid will pay for transportation services to a Medicaid-covered service with a Medicaid-enrolled provider if the service cannot be obtained free of charge and is not solely a convenience to the recipient. North Dakota Medicaid allows a non-commercial driver (not including a family member, friend or relative) or a commercial transportation provider to transport Medicaid recipients. The transportation fee schedule is updated based on legislative approved inflationary increases. See Attachment A for the North Dakota Medicaid non-emergency medical transportation fee schedule.

The initial process of requesting Medicaid payments for non-emergency medical transportation begins with enrolling as a North Dakota Medicaid provider. The request for payment must be for an active Medicaid recipient and the county social service office must approve the transportation request. If the criteria are met, a provider must complete

and submit a claim form, and the provider submits the form either electronically or on paper. An enrolled provider receives a non-emergency medical transportation manual and the Division responds to any specific questions or concerns as they arise.

Long Term Care Study

As part of the Department's 2013-15 appropriation, funding was authorized to commission a study of the LTC continuum. In July 2013, the Department contracted with Myers and Stauffer to complete the LTC study. An interim report was issued in March 2014 and included information on LTC bed capacity within the state, descriptions of the available services within the LTC continuum and cost drivers of LTC institutional services.

A final report was issued July 1, 2014. It builds upon the first report and includes additional analysis and presents findings and recommendations in the following areas:

- Five recommendations on policy considerations for state licensing requirements for basic care and assisted living
- Three recommendations on policy considerations for basic care rate setting
- Five recommendations for adding quality measures to nursing facility rate methodology
- Ten recommendations/policy considerations to help eliminate service gaps in the long term care continuum

Please refer to Attachment B, the executive summary of the North Dakota Long Term Care Study.

Recommendations on policy considerations for state licensing requirements for basic care and assisted living:

- Recommendation 1: The scope of basic care facility licensure in North Dakota is comparable to state-funded residential services in other states with respect to provider standards for participation, staffing, consumer care and service requirements, physical building specifications, state department of health inspection, survey, enforcement, and oversight. The Department should develop solutions and strategies to overcome obstacles to basic care utilization. Explore best practices in other states, including waiver expansion.
- Recommendation 2: The scope of assisted living facility licensure in North Dakota is minimal and places significant responsibility on the assisted living providers to assure that consumer service needs are being met, and that quality care is being provided. The Department should raise awareness of assisted living policy implications and identify concerns regarding oversight and interest in establishing additional standards for care and services.
- Recommendation 3: Assisted living facilities primarily serve individuals who are able to pay with private funds; they serve very few individuals who are funded through Medicaid or the SPED program. The Department should develop and implement policy changes that will expand the availability and utilization of assisted living services by elderly and disabled individuals who are Medicaid and SPED-eligible.
- Recommendation 4: Basic care facility licensure requirements focus on the provider's responsibility to assess resident care needs and provide services, while assisted living facility licensure requirements

do not. This is a distinguishing feature of a facility that is depended upon to provide services, rather than just room and board. The Department should implement regular review of Medicaid and SPED assisted living facility clients to assure ongoing health, safety and welfare.

- Recommendation 5: State-funded clients in assisted living facilities have on average higher care needs than Medicaid-funded clients in basic care facilities. While this is consistent with the Department of Human Services level of care criteria for the two settings, it is not necessarily consistent with the level and scope of services and oversight provided in the two settings. The Department should convene a broader discussion regarding the state's overall strategy for Medicaid and state-funded residential services, particularly as a means to reduce long-term nursing facility placement, and should serve as third party reviewer for assessment and services of individuals in both settings.

Recommendations on policy considerations for basic care rate setting:

- Recommendation 6: The Department should phase-in an occupancy limit to the BCAP reimbursement methodology over a period of five years beginning with a 50% occupancy limit and increasing the percentage annually to 60%, 70%, 75% and finally 80%. This would provide greater consistency across the Medicaid program reimbursement systems as the nursing facility program already has an occupancy requirement. This would also encourage BCAP providers to become more efficient and look for alternative purposes for their unused bed capacity. The occupancy limit should be reevaluated each year based on more current census statistics.

- Recommendation 7: The Department should adopt a median plus methodology for calculating its cost center limits. The Direct Care cost center limit should be set at 125% of the median cost determined on assistance days in order to produce a relatively budget neutral outcome. The Indirect Care cost center limit should be set at 120% of the median cost determined on assistance days in order to also produce a relatively budget neutral outcome. Moving to a median plus methodology will strengthen the reimbursement system by creating a limit calculation that does not automatically limit a set number of providers. Tying the calculation to assistance days so that cost data from the most significant BCAP participants has the most influence.
- Recommendation 8: The Department should adopt policies that would include nearly all providers in the cost arrays. For providers that fail to submit a cost report on time and for providers that are not required to file a cost report due to a change of ownership, historical cost data should still be included in the cost array. In both cases older cost report data should be included in lieu of a new cost report and an appropriate inflation factor should be applied to this cost data so that it is trended to the same point as other costs included in the arrays.

Recommendations for adding quality measures to nursing facility rate methodology:

- Recommendation 9: Consider creating a Pay for Performance (P4P) including indicators for falls with injury, moderate to severe pain, increase need for help with ADLs and depressive symptoms.
- Recommendation 10: Incorporate some review of survey results to ensure consistency with other regulatory efforts.

- Recommendation 11: Implement a P4P measure tied to satisfaction only after a satisfaction survey process has operated for a few cycles.
- Recommendation 12: Limit P4P criteria and improvement as well as achievement.
- Recommendation 13: Audit/review provider submitted P4P documentation.

Recommendations and policy considerations to help eliminate service gaps in the long term care continuum:

- Recommendation 14: Review the website and current program materials, identify needed changes, additions and enhancements, and develop a strategy and timeline for implementation.
- Recommendation 15: Expand the services that can be performed through Options Counseling, as well as work with participating hospitals to educate discharge planners.
- Recommendation 16: Implement initial, annual, and when changes occur level of care reviews for nursing facility residents according to the same criteria applied for individuals who are on the HCBS Waiver Program.
- Recommendation 17: Evaluate issues and problems and develop a comprehensive strategy to improve accessibility and availability of services, particularly for elderly Medicaid individuals with behavioral health problems.
- Recommendation 18: Engage workforce development experts to create a statewide strategy for addressing workforce issues.

- Recommendation 19: Identify and resolve any policy and process issues that present obstacles; develop a proactive and concerted strategy to develop additional transportation providers.
- Recommendation 20: Further develop, expand, and foster the Medicaid 1915(c) waiver, personal care, and other services needed to promote the ability of seniors to maintain their own homes and to age in place.
- Recommendation 21: Expand minimum data set (MDS) reviews for nursing facility residents.
- Recommendation 22: Evaluate whether the number and scope of home and community based services (HCBS) reviews that are currently being performed are sufficient or whether additional staffing resources are needed.
- Recommendation 23: Consider implementing consumer interviews and satisfaction reviews.

The LTC final report is available on the Department's website at: http://www.nd.gov/dhs/info/pubs/docs/medicaid/ltc-interim-report-final.pdf

This concludes my testimony and I would address any questions that you may have.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

SUPPLEMENTAL MEDICAID BILLING INSTRUCTIONS AND FEES

NON-EMERGENCY TRANSPORTATION PROVIDERS

EFFECTIVE July 1, 2013

Procedure Codes to be used Block 24D of Claim Form

CODE	DESCRIPTION	BASE RATES ALLOWED	FEE SCHEUDLE
A0080	Non-emergency transportation, not medically equipped, passenger vehicle, *per mile (non-commercial/volunteer)*	N/A	$ 0.56/mile
A0100	Non-emergency transportation: taxi	2*	$ 21.40
A0110	Non-emergency transportation: bus, train, intra or inter-state common carrier	N/A	Ticket Price
A0120	Non-emergency transportation: mini-bus *(recipient is ambulatory)*	2*	$ 14.27 + $0.67/mi
A0130 **S0209**	Non-emergency transportation: wheelchair van *(recipient is transported in a wheelchair)* Non-emergency transportation: wheelchair van; mileage *per mile* (greater than 15 miles)	2* N/A	$ 14.27 + $2.03/mi
A0140	Non-emergency transportation and air travel (private or commercial) intra- or inter-state	N/A	Ticket Price
T2005 **S0215**	Non-emergency transportation: stretcher van Non-emergency transportation: stretcher van mileage, *per mile*	2 N/A	$ 77.03 + $2.03/mi

Providers will be reimbursed the lesser of the North Dakota Medicaid fee schedule or the provider's usual and customary charge.

*A typical transport involves one base rate per way. There are minimal exceptions to the base rates allowed; for clarification on additional base rates for A0100, A0120 and A0130, contact Cindy Sheldon at 1.800.755.2604.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

I. Executive Summary

A profile of the older population reveals that North Dakota is demographically an "old" state today. In 2012, North Dakota ranked 12th in the nation for the proportion of the population 65+ and had the second highest proportion of persons 85 and older [NDSU, 2013]. In addition, high proportions of persons 65 years and older continue to live in their own homes and often in relatively remote areas. Of those in need of services and who are on Medicaid, some receive community-based residential care in basic care facilities or community-based care through the state's 1915 (c) Medicaid Waiver Program, but most receive long-term care in nursing facilities.

North Dakota is committed to finding solutions to meet the needs of its elderly citizens and has conducted a number of studies in the past ten years and participated in a number of long-term care rebalancing initiatives. The Department of Human Services has been actively working with key stakeholders across the state to address and identify challenges.

In 2013, the North Dakota Department of Human Services engaged Myers and Stauffer LC to assist in evaluating additional options available to continue efforts to appropriately, effectively, and creatively meet the needs of current and future cohorts of elders and disabled individuals in need of long-term care. The study consisted of developing two reports, the focus of which is on the evaluation and development of findings and recommendations needed to complete an assessment of North Dakota's current and future long-term care service delivery system.

The final report builds upon the first report and includes additional analysis and presents findings and the following recommendations for North Dakota's long-term care service delivery system:

- Five (5) recommendations on policy considerations for state licensing requirements for basic care and assisted living
- Three (3) recommendations on policy considerations for basic care rate setting
- Five (5) recommendations for adding quality measures to nursing facility rate methodology
- Ten (10) recommendations/policy considerations to help eliminate service gaps in the long-term care continuum

Based on numerous exchanges with state staff and stakeholder groups, the recommendations have two primary goals: to build on North Dakota's existing, very solid framework of long term care services and programs; and to enhance areas in which gaps or weaknesses have been identified.

Basic Care/Assisted Living Licensing Requirements

Low income individuals who are aged and/or disabled in North Dakota may be eligible to receive community-based residential care through the Medicaid state plan in two licensed settings: basic care facility and assisted living facility. Funding is also available to support services provided in assisted living to individuals who are not Medicaid-eligible through one of two state-funded programs, Service Payments for the Elderly and Disabled (SPED).

Basic care facilities offer a residential long-term care service option within North Dakota's LTC continuum that includes a separate payment for room and board. They are regulated within a licensure category that is lower than the care provided by nursing facilities but higher than independent living. They are licensed through the State Department of Health and are funded through Medicaid, through state programs administered by the Department of Human Services, and by privately-paying residents. North Dakota's licensure requirements for basic care facilities are fairly comprehensive when compared with similar residential care settings in other states (which are commonly referred to as residential care facilities, boarding homes, and housing with services establishments).

Assisted living facilities offer a residential, apartment-like setting, with no payment from the state for room and board. Assisted living is considered another long-term care service option for the elderly but with much fewer regulatory requirements. Assisted living facilities in North Dakota are licensed by both the State Department of Human Services and the State Department of Health and are occupied largely by privately-paying residents. Licensure requirements for assisted living facilities in North Dakota are fairly minimal when compared to the scope and breadth of assisted living requirements in many other states. Specifically, among the more basic requirements, most states now include licensure standards that require 24 hour on-site staffing, address resident care planning and assessments, and specify resident criteria regarding who is and is not appropriate to receive services in an assisted living setting.

Although North Dakota's basic care and assist living facilities have licensure requirements, the scope and breadth are quite different between the settings. North Dakota's basic care licensure requirements are fairly comprehensive in terms of resident criteria, services, staffing, and other regulatory requirements and are similar to residential care facility licensure requirements in other states. In contrast, North Dakota's assisted living facility licensure requirements are comparatively less than basic care and also less than assisted living licensure requirements in many other states.

Although residents in assisted living facilities are generally expected to be more independent and have fewer care needs than residents in basic care facilities, current resident assessment data collected for North Dakota Medicaid and SPED clients in both settings indicate that those clients in the assisted living facilities have considerably higher ADL scores and therefore higher needs than their basic care counterparts.

The following recommendations specific to basic care and assisted living licensure were identified:

- Recommendation 1: The scope of basic care facility licensure in North Dakota is comparable to state-funded residential services in other states with respect to provider standards for participation, staffing, consumer care and service requirements, physical building specifications, state department of health inspection, survey, enforcement, and oversight. The Department should develop solutions and strategies to overcome obstacles to basic care utilization. Explore best practices in other states, including waiver expansion.
- Recommendation 2: The scope of assisted living facility licensure in North Dakota is minimal and places significant responsibility on the assisted living providers to assure that consumer service

needs are being met, and that quality care is being provided. The Department should raise awareness of assisted living policy implications and identify concerns regarding oversight and interest in establishing additional standards for care and services.

- Recommendation 3: Assisted living facilities primarily serve individuals who are able to pay with private funds; they serve very few individuals who are funded through Medicaid or the SPED program. The Department should develop and implement policy changes that will expand the availability and utilization of assisted living services by elderly and disabled individuals who are Medicaid and SPED-eligible.
- Recommendation 4: Basic care facility licensure requirements focus on the provider's responsibility to assess resident care needs and provide services, while assisted living facility licensure requirements do not. This is a distinguishing feature of a facility that is depended upon to provide services, rather than just room and board. The Department should implement regular review of Medicaid and SPED assisted living facility clients to assure ongoing health, safety and welfare.
- Recommendation 5: State-funded clients in assisted living facilities have on average higher care needs than Medicaid-funded clients in basic care facilities. While this is consistent with the Department of Human Services level of care criteria for the two settings, it is not necessarily consistent with the level and scope of services and oversight provided in the two settings. The Department should convene a broader discussion regarding the state's overall strategy for Medicaid and state-funded residential services, particularly as a means to reduce long-term nursing facility placement, and should serve as third party reviewer for assessment and services of individuals in both settings.

LONG-TERM CARE CAPACITY ANALYSIS

Long-term care "capacity" represents the ability of a state or community to provide the support and assistance needed by individuals who, because of physical, cognitive or mental limitations, require assistance from others to meet the activities of daily living necessary for basic health and well-being. It is generally accepted that the term "capacity" includes a range of options for assistance that adequately and cost-effectively meets the needs of people while also addressing user's preferences for how and where services are provided. The range of services includes: nursing home care for those with the highest levels of impairment; residential options for those with somewhat less impairment in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (e.g., group homes, basic care, assisted living); and in-home services for those who may have a wide range of ADL and IADL impairments, but choose to remain in their own homes. At a minimum, capacity includes the availability of providers in the necessary numbers and with the needed training to provide the service, the monetary resources to provide the amounts of service needed; and the accessibility of the service to those in need. In other words, adequate capacity means that the service is adequately dispersed geographically and is affordable for those who need it.

Capacity analysis showed that long-term care beds appear to be adequate in relation to number and distribution across the state. North Dakota has 80 nursing facilities with 6,029 certified beds, 68 basic

care facilities with 1,785 certified beds, and 73 assisted living facilities with 2,672 living units. There is little indication that any region of the state has a serious shortage of long-term care beds, even though the occupancy rates in nursing homes in North Dakota are much higher than the national average (93 percent versus 81.2 percent).

North Dakota appears to have adequate capacity in nursing and basic care facilities to address the institutional care needs well into the future, particularly if attention is shifted to a broader range of community-based and in-home options. While pockets of need for nursing facility or basic care may occur, shifting of resources rather than adding resources in these levels of care is advisable. Given the anticipated flattening in the numbers of older adults needing long-term care for the next several years, North Dakota has a window of opportunity to plan, implement and evaluate options for long-term care that have proven in other states to be more cost-effective and provide both greater autonomy and choice for consumers.

Occupancy Incentive in Basic Care Rate-Setting

There are reasons for adding a minimum occupancy requirement to the basic care assistance program (BCAP) reimbursement methodology, but there are also issues that must be given careful consideration before such a change is implemented. Adding an occupancy requirement could encourage greater efficiency among BCAP providers. It could also motivate some providers to repurpose unused basic care facility beds. However, because of the number of facilities with low occupancy rates and policies that allow providers to convert nursing facility beds to basic care beds, the impact of an occupancy limit could be very significant. If an occupancy limit was added, these factors should be considered and implementation might need to be phased in over a period of a few years.

Adding a minimum occupancy limit to the BCAP reimbursement methodology would have a fiscal impact but that could be lessened if the limit was phased in over time. There are merits for including such a limit in the system.

- Recommendation 6: The Department should phase-in an occupancy limit to the BCAP reimbursement methodology over a period of five years beginning with a 50% occupancy limit and increasing the percentage annually to 60%, 70%, 75% and finally 80%. This would provide greater consistency across the Medicaid program reimbursement systems as the nursing facility program already has an occupancy requirement. This would also encourage BCAP providers to become more efficient and look for alternative purposes for their unused bed capacity. The occupancy limit should be reevaluated each year based on more current census statistics.

Direct Care and Indirect Care Cost Center Limitation Process in Basic Care Rate Setting

The basic care rate methodology is based on historical cost reports for each provider, with a per diem rate composed of the following components and add-ons: property; room and board; direct care; indirect care; and operating margin. To encourage efficiency, limits are set for the per diem reimbursement for Direct Care and Indirect Care. These limits are reset annually based on an array of

the cost data from participating basic care facilities. The current BCAP limit methodology uses the 80th percentile facility, based on beds, to determine the limit.

Concern over the drop in the limits between FY 2012-2013 and FY 2013-2014 prompted a review and consideration of a possible revision of the limit methodology.

Although some of the modeling options did eliminate the decline in the Direct Care limit, they did not completely eliminate up and down fluctuations in the limits. After additional review it appears that the decrease in the limits that occurred for FY 2013-2014 is influenced more by the number of homes that were not included in the limit calculation array.

There are several options that could be considered to help avoid the chance that a limit would decrease when costs are actually rising.

- Move to rebasing the limit less frequently and apply an inflationary factor during interim years. This is similar to the methodology used to determine the limits for nursing facility rates.
- Use an average per diem cost as the basis for the limit. This methodology is usually avoided since the limit can be severely influenced by very high or very low outlier costs. This could however be mitigated somewhat by removing outliers from the calculation, although determining the criteria for eliminating outliers might prove difficult.
- Include all providers in the array even if their current cost data is missing. An inflation factor could be applied to old cost data to compensate somewhat for the outdated information.

Through the cost center limitation analysis other methodologies were evaluated. These included variations on the current percentile methodology and options for a median plus methodology. A factor in setting the cost center limits is the data used as the basis for the percentile or median. This determination could be made using beds, facilities, total resident days, or assistance days.

A median plus methodology was determined to be the most positive way to encourage efficiency. Budget neutral cost center limits can be set using a median plus methodology and would strengthen the BCAP reimbursement system.

- Recommendation 7: The Department should adopt a median plus methodology for calculating its cost center limits. The Direct Care cost center limit should be set at 125% of the median cost determined on assistance days in order to produce a relatively budget neutral outcome. The Indirect Care cost center limit should be set at 120% of the median cost determined on assistance days in order to also produce a relatively budget neutral outcome. Moving to a median plus methodology will strengthen the reimbursement system by creating a limit calculation that does not automatically limit a set number of providers. Tying the calculation to assistance days so that cost data from the most significant BCAP participants has the most influence on the limit will also improve the system.

In trying to develop a methodology that would avoid drops in limits despite increasing costs the analysis showed that changing the limit calculation methodology alone will not likely eliminate this. This issue is

caused more by the data included in the cost arrays and to correct it policies need to be adopted to avoid large fluctuations in the cost array size.

- Recommendation 8: The Department should adopt policies that would include nearly all providers in the cost arrays. For providers that fail to submit a cost report on time and for providers that are not required to file a cost report due to a change of ownership, historical cost data should still be included in the cost array. In both cases older cost report data should be included in lieu of a new cost report and an appropriate inflation factor should be applied to this cost data so that it is trended to the same point as other costs included in the arrays.

Regardless of the methodology selected, there are ways to adjust the parameters to bring the limits close to their existing levels, although doing so requires considerations that go beyond simple fiscal analysis. While there are advantages and disadvantages to any system, a median plus methodology provides an opportunity for every facility to be reimbursed their costs, which is not the case with a limit set from a percentile. Furthermore, the options for the basis that is used to select the limit from each cost array also provide advantages and disadvantages. When using beds or facilities as the basis, the data used to select the limit is readily available and does not rely on facility reporting. However, using resident days or assistance days as the basis focuses the limit selection on the facilities that provide the majority of care. Selecting the limit based on assistance specifically weights the limit selection towards those homes that provide the greatest amount of services to the BCAP program.

Adding Quality Measures to Nursing Facility Rate Methodology

The quality of nursing home care has been a concern of the general public, policy makers, and the nursing home industry for decades. Governments traditionally approached the problem through the regulatory process with fines or sanctions imposed on facilities that deliver poor care.

Nursing home quality has been studied extensively with numerous recommendations for quality improvement (Wunderlich & Kohler, 2001). Recently, Medicare and several state Medicaid programs have adopted pay for performance (P4P) models that reward nursing facilities for better quality by linking payment to performance on standardized quality measures. Providers delivering the best care or showing the most improvement receive the highest incentive payment. The newer quality-based reimbursement systems emphasize high quality, not just problem avoidance. They reward collaborative and supportive programs that engage providers in the quality process.

States have been experimenting with nursing home P4P programs for almost 30 years. A new generation of nursing home P4P programs has emerged in the last 12 years owing to renewed interest among policy makers in measuring and rewarding better nursing home quality of care. Since then, at least 11 states have implemented nursing home P4P programs (Arling, Job, & Cooke, 2009; Werner, Tamara Konetzka, & Liang, 2009). These new systems have benefited from improved quality measures and a stronger evidence base for improving nursing home quality (Castle & Ferguson, 2010).

The foundation of any P4P system is a valid and reliable set of performance measures that cover relevant dimensions of care quality and other areas of performance. Measures fall into general areas of structure (organizational resources and inputs), process (care practices and treatments), and outcomes (impacts on health, function and quality of life). Most of the states have some measures that look at quality of care, quality of life, survey status, satisfaction and the implementation of culture change. Issues considered in the development of a P4P system include the sources of data, difficulty in obtaining the needed data, and processing and evaluating the data. Based on analysis of North Dakota's nursing facility rate-setting methodology and provider characteristics, the following recommendations are presented for consideration:

- Recommendation 9: Consider creating a P4P including indicators for falls with injury, moderate to severe pain, increase need for help with ADLs and depressive symptoms.
- Recommendation 10: Incorporate some review of survey results to ensure consistency with other regulatory efforts.
- Recommendation 11: Implement a P4P measure tied to satisfaction only after a satisfaction survey process has operated for a few cycles.
- Recommendation 12: Limit P4P criteria and improvement as well as achievement.
- Recommendation 13: Audit/review provider submitted P4P documentation.

A P4P program should address a broad range of quality issues. A good P4P program will communicate performance to the consumers and to the providers. The state may have to help equip providers with methods and tools to improve their performance. Financial incentives should encourage providers to invest in better care and motivate providers at all levels of care to improve their performance. The financial incentive should be predictable and achievable. The P4P program should be part of a comprehensive approach to quality improvement.

Eliminating Service Gaps

North Dakota should consider changes in addition to licensure that can similarly and positively assist in rebalancing efforts, such as: reviewing program and service criteria in all long-term care settings to identify changes needed to expand flexibility and improve availability and accessibility of services; developing an assisted living service option within the existing 1915 (c) waiver program, and/or developing a section 1115 demonstration waiver or another Medicaid 1915 (c) waiver program that is targeted to individuals in assisted living facilities (both programs can provide the flexibility needed to build and customize an assisted living program for North Dakota's Medicaid waiver population).

The interim report completed for the long-term care study included the identification of several high-level gaps which are systemic and have significant implications on long-term care service availability, accessibility, quality, processes, and/or rebalancing. Ten additional recommendations are identified:

- Review the website and current program materials, identify needed changes, additions and enhancements, and develop a strategy and timeline for implementation.

- Expand the services that can be performed through Options Counseling, as well as work with participating hospitals to educate discharge planners.
- Implement initial, annual, and when changes occur level of care reviews for nursing facility residents according to the same criteria applied for individuals who are on the HCBS Waiver Program.
- Evaluate issues and problems and develop a comprehensive strategy to improve accessibility and availability of services, particularly for elderly Medicaid individuals with behavioral health problems.
- Engage workforce development experts to create a statewide strategy for addressing workforce issues.
- Identify and resolve any policy and process issues that present obstacles; develop a proactive and concerted strategy to develop additional transportation providers.
- Further develop, expand, and foster the Medicaid 1915(c) waiver, personal care, and other services needed to promote the ability of seniors to maintain their own homes and to age in place.
- Expand minimum data set (MDS) reviews for nursing facility residents.
- Evaluate whether the number and scope of home and community based services (HCBS) reviews that are currently being performed are sufficient or whether additional staffing resources are needed.
- Consider implementing consumer interviews and satisfaction reviews.

North Dakota has in place a solid foundation of the core elements needed to support a comprehensive approach to providing long-term care services to its poor elderly and disabled populations. These include: Medicaid State Plan Personal Care Services, a Medicaid 1915(c) Home and Community Based Services Waiver Program, residential services (basic care and assisted living), Program of All-Inclusive Care for the Elderly (PACE), Money Follows the Person program, and two state-funded programs, Service Payments for the Elderly and Disabled (SPED) program, and Expanded Service Payments for the Elderly and Disabled (Ex-SPED) program. Long-term care institutional and residential care capacity in North Dakota is distributed geographically and generally adequate to meet demand, although assisted living services are provided primarily to privately paying individuals and limited in terms of minimal licensure standards, and workforce and other infrastructure issues disproportionally impact the oil boom counties on the western part of the state.

North Dakota's long-term care continuum continues to include an unusually heavy emphasis on nursing facility care as the primary provider of services, which is contrary to the national movement by states and the Centers for Medicare and Medicaid Services (CMS) to shift the balance away from institutional forms of care toward less expensive and more desirable community-based care. This heavy reliance on nursing facility care is also inconsistent with the very high number of North Dakota's elderly persons who maintain good health and maintain their own homes in the community. North Dakota's residents are healthier and maintain their own homes longer than their cohorts in other states, which means that North Dakota's elderly have a correspondingly lower need for long-term care services, a lower need for subsidized room and board, and the state's long-term care expenditures are lower overall. But when North Dakota's elderly and disabled citizens can no longer maintain their own homes, most go directly into a nursing home for their care, rather than an alternative community or residential setting. It is

therefore in the state's best interest to proactively invest additional resources to further develop its non-institutional resources (HCBS, basic care, and assisted living) that promote the ability of the elderly and disabled to "age in place" and be served for as long as possible in their own home or another community residential setting. Therefore, the state should develop an overall long-term care strategy that includes significant emphasis on diversion policies and processes, such as the PACE Program and those targeted to hospital discharge planning for persons at risk of long-term care institutionalization.