

STUDY OF LONG-TERM CARE SERVICES - BACKGROUND MEMORANDUM

The Long-Term Care Committee has been assigned various responsibilities relating to long-term care services. These areas include:

- Section 10 of 2009 House Bill No. 1012, a copy of which is attached as [Appendix A](#), provides for a Legislative Management study of long-term care services in the state, including a review of the Department of Human Services' payment system and a review of the State Department of Health's survey and inspection programs and processes.
- Section 2 of 2009 House Bill No. 1263, a copy of which is attached as [Appendix B](#), provides for a Legislative Management study of how state laws and administrative rules regulate basic care and assisted living facilities. The study is to include consideration of whether the state's designations of basic care and assisted living as care categories are outmoded or inconsistent with industry categories of care and a review of the definitions used in services offered by and the licensure and registration process used in regulating basic care and assisted living facilities.

PREVIOUS LEGISLATIVE COUNCIL STUDIES 1997-98 Budget Committee on Long-Term Care

The 1997-98 Budget Committee on Long-Term Care studied a wide range of long-term care issues, including basic care rate equalization, Alzheimer's and related dementia population projects, American Indian long-term care needs, long-term care financing issues, and home and community-based services availability. Committee recommendations included:

- The repeal of basic care rate equalization (1999 Senate Bill No. 2033).
- The Department of Human Services continuation of the Alzheimer's and related dementia population pilot project (1999 Senate Bill No. 2034) and providing an exception to the case mix system to allow for the establishment of a 14-bed geropsychiatric nursing unit within an existing nursing facility (1999 Senate Bill No. 2035).
- The continuation of the moratorium on nursing facility and basic care beds through the 1999-2001 biennium and an exception to the basic care bed moratorium for the establishment of a traumatic brain-injured facility in western North Dakota (1999 Senate Bill No. 2038).

All committee recommendations were approved by the 1999 Legislative Assembly except for Senate Bill

No. 2035 relating to the exception in the case mix system.

1999-2000 Budget Committee on Health Care

The 1999-2000 Budget Committee on Health Care studied the possibility of creating an incentive package to assist rural communities and nursing facilities close or significantly reduce bed capacity and provide alternative long-term care services. The committee recommended that the 2001 Legislative Assembly consider requiring that money generated through the intergovernmental transfer process and deposited in the health care trust fund be used for projects and programs relating to the long-term care industry, including funding for projects that provide alternatives to nursing facility services and projects that reduce nursing facility bed capacity.

The 2001 Legislative Assembly, with the passage of House Bill No. 1196, provided that money in the health care trust fund may be transferred to the long-term care facility loan fund for nursing facility renovation projects and used for other programs as authorized by the Legislative Assembly.

2001-02 Budget Committee on Human Services

The 2001-02 Budget Committee on Human Services studied the long-term care needs and nursing facility payment system in North Dakota. The committee received a report from a consultant hired by the Department of Human Services to review North Dakota's nursing facility payment system which contained the following recommendations and the department's responses:

1. Evaluation of the 90 percent occupancy incentive - The consultant recommended the state continue the minimum occupancy percentage at 90 percent. The department concurred with this recommendation.
2. Evaluation of rebasing frequency - The consultant recommended the state:
 - a. Establish a maximum number of years between rebasing. The department believed this was a policy decision to be made by the Legislative Assembly. The 2005 Legislative Assembly provided that nursing home rates be rebased every four years.
 - b. Monitor and evaluate facility spending patterns during periods between rebasing that would identify:
 - (1) Significant changes in costs in excess of that estimated by the inflation index.
 - (2) Changes in the allocation of costs between direct, other direct, and indirect cost categories.

- (3) Changes in a facility's resident acuity. The department concurred with the recommendation and believed additional analysis would be useful in establishing benchmarks to be used by the Legislative Assembly in determining if more frequent rebasing is necessary.
- c. Change the method of calculating limits from the percentile method to a "median plus" method. The percentile method precludes a certain number of providers above the limit from receiving payments that cover all costs. The "median plus" method potentially would allow all facilities to operate at a level below the established limit. The department concurred with the recommendation and recommended the process be changed when limits are rebased. The 2005 Legislative Assembly approved using the "median plus" method.
 - d. Set limits for direct, other direct, and indirect costs at the "median plus" 20 percent, 20 percent, and 10 percent, respectively, or in proportion with these recommendations in order to achieve the greatest cost coverage for the Medicaid funding available. If the method of calculating limits was changed, the department concurred with this recommendation. The 2005 Legislative Assembly provided funding based on limits being set at "median plus" 20/20/10.
3. Evaluation of North Dakota's equalized rate policy - The consultant recommended the state:
 - a. Continue the rate equalization policy of limiting rates for private pay individuals and other nongovernmental payers in semiprivate rooms to the comparable Medicaid rate.
 - b. Limit the additional amount a nursing facility may charge for a private room to \$10 per day. The department believed the decision to limit a nursing facility's ability to charge additional amounts for private rooms was a policy decision to be made by the Legislative Assembly. The Legislative Assembly and the department have made no changes in this area.
 - c. Change the current Medicaid property cost calculation to reflect the growing number of private rooms. The rate calculation should consider the square footage separately for private rooms and semiprivate rooms on a per resident basis. The department continues to be reluctant to implement this recommendation because it would create a rate differential based on the type of accommodation that was not anticipated when equalized rates were implemented and would shift Medicaid savings to private pay residents who occupy private rooms. In addition, this change would add administrative complexities by requiring the department and providers to maintain 68 rates rather than 34 rates.
 4. Review the case mix payment system - The consultant recommended the state:
 - a. Implement a minimum data set accuracy audit program, and if errors are found, change facility payment rates and recoup overpayments. The consultant estimated annual Medicaid overpayments could be \$91,000, and the savings from the audits would provide funding for an additional staff person to conduct the audits. The department concurred with the recommendation and began to review the accuracy of the classification process, provide technical assistance, and recoup funds as appropriate. Because staff resources were limited, the department was able to visit only a few facilities. The department said it would attempt, within the resources available, to complete the number of reviews in the future.
 - b. Consider adopting the next version of the minimum data set when it becomes available from the federal government in 2004. The department said it planned to consider adopting the new version when it is available but will consult with the long-term care industry and the Legislative Assembly before making any major changes in the classification process.
- The committee received the following preliminary findings and recommendations of the long-term care needs assessment conducted by a consultant hired by the Department of Human Services:
1. North Dakota's population over age 55 is generally healthier than the national average.
 2. North Dakota's reservation population is generally much less healthy than the national average and less healthy than the remainder of the state's population.
 3. Generally, North Dakota's chronic disease rates are lower than national norms but higher among the state's elderly American Indians.
 4. Sixty-nine percent of North Dakotans age 50 and over do not plan to relocate in the next 10 years.
 5. North Dakotans living in rural frontier counties are the most committed to staying in their homes and communities.
 6. The presence of functional limitations does not impact plans to move--even those with emerging disabilities plan to stay in their homes and local communities.
 7. The number of services available declines from urban to rural to rural frontier.
 8. Availability of services is a major issue.
 9. Transportation to services is a major issue.

10. Nursing home insurance has been purchased by 25.9 percent of North Dakotans over age 50.
11. Affordable assisted living services are needed, especially in the rural and reservation communities.
12. Health promotion and wellness activities designed to prevent functional limitations are needed to allow individuals to remain independent.
13. Family and informal caregiving should be developed and integrated into a broad plan of long-term care.
14. Formal and informal caregivers should be organized into regional alliances to provide a full range of services.
15. Rural development in North Dakota should include service sector jobs.
16. North Dakota must develop a system of service delivery for home and community-based services to serve the rural elderly.
17. "Telehealth" should be explored to offer additional support for a dispersed model of services for offsite diagnosis and evaluation.
18. A special task force should be organized to address the long-term care needs of reservation populations because the number of American Indians over age 65 is increasing rapidly.
19. Long-term care workers' wages should be regularly monitored with adjustments made to maintain competitive salaries.
20. North Dakota's wages for long-term care workers are slightly less than national averages. Salaries for registered nurses are 94.1 percent of the national average, salaries for licensed practical nurses are 94.7 percent of the national average, and certified nursing assistants are 100 percent of the national average.
21. Providing benefits to all full-time workers, especially health insurance coverage, will assist with worker retention.

The committee learned the Governor issued an executive order in August 2001 establishing an Olmstead Commission to study North Dakota's compliance with requirements of the Olmstead decision. The Olmstead decision resulted from a Georgia lawsuit relating to providing adequate care to the elderly and disabled in the least restrictive environment.

The commission was awarded a \$900,000 federal grant to develop the following five pilot projects:

1. Person-centered care, which is designed to broaden the local continuum of care provided by long-term care facilities. This project was to involve two rural and two urban nursing facilities providing a more client-driven model of care, including less restrictive alternatives or home care when appropriate.

2. Financial pooling, which is designed to allow funding to follow the client. All public and private funds available for a client will be pooled and the client given the ability to purchase services as necessary. The provider must include a health system or long-term care facility.
3. Living in place, which is designed to allow individuals to live in their homes and receive necessary personal services, modifications, and assistive technology.
4. Cultural module, which is designed to build capacity for home care among American Indians by utilizing existing training available at the United Tribes Technical College enhanced with the necessary components to enable students to provide in-home care to people with disabilities on the reservations.
5. Informational access to services, which is designed to coordinate existing resources such as the senior information line, Children's Services Coordinating Committee directories, and other resources to ensure that available services throughout the state are identified and may be accessed from one contact.

2003-04 Budget Committee on Health Care

The 2003-04 Budget Committee on Health Care studied the nursing home survey process. The committee encouraged the State Department of Health to review Life Safety Code inspection procedures and provide options, within available resources, to the 2005 Legislative Assembly for the State Department of Health to provide for any construction inspections necessary to ensure compliance with the Life Safety Code upon completion of a construction project.

2007-08 Long-Term Care Committee

The 2007-08 Long-Term Care Committee studied the long-term care system in North Dakota, including capacity, geographical boundaries for determining capacity, the need for home and community-based services, a methodology to identify areas of the state needing additional nursing home beds, access, workforce, reimbursement, and payment incentives.

Regarding capacity and geographical boundaries for determining capacity, the committee learned the number of nursing facility beds in North Dakota has been reduced from 89 beds per 1,000 elderly individuals in 1996 to 65.3 nursing facility beds per 1,000 elderly individuals in 2007. The reduction in nursing home beds per 1,000 elderly individuals has occurred because of the moratorium in place, the 2001 state bed buyout program, and an increase in elderly population. The committee also learned that demand for nursing facility beds is increasing in urban centers and decreasing in rural areas of North Dakota.

Regarding areas of the state needing additional nursing home beds, the committee learned the

Department of Human Services is in the process of developing an Aging 2020 project. The Aging 2020 project, which is to be completed in three phases over the course of three years, has two goals:

1. To identify, compile, and analyze past and current administrative data as well as census data to show the current status of programs administered by the state.
2. To produce comprehensive data documentation for state government policy and program professionals about the intergenerational dynamics of the merging issues related to eligibility programs and services delivery.

A preliminary planning document regarding the Aging 2020 project is anticipated to be available in July 2010.

Regarding workforce, the committee learned staffing is a continuing challenge for long-term care facilities. Nursing facilities are experiencing difficulties recruiting and retaining staff, especially in rural areas.

Committee recommendations included:

- Extending the moratorium on the state's licensed basic care beds and the state's licensed nursing facility beds from July 31, 2009, to July 31, 2013 (2009 Senate Bill No. 2044).
- Requiring at least a 30-day written advance notice of any transfer or discharge from a nursing home, swing-bed hospital, or basic care or assisted living facility (2009 Senate Bill No. 2045).

The 2009 Legislative Assembly amended Senate Bill No. 2044 to extend the moratorium on basic care beds and nursing facility beds from July 31, 2009, to July 31, 2011. The Legislative Assembly also passed Senate Bill No. 2045 relating to a written advance notice of any transfer or discharge from a nursing home, swing-bed hospital, or basic care or assisted living facility.

CONTINUUM OF CARE SERVICES FOR THE ELDERLY

The following is a summary of the programs that comprise North Dakota's continuum of care for the elderly:

Nursing home care - Provides facility-based residential care to individuals who, because of impaired capacity for independent living, require 24-hour-a-day medical or nursing services and personal and social services.

Basic care - Provides facility-based residential care to individuals who, because of impaired capacity for independent living, require health, social, or personal care services but not 24-hour-a-day medical or nursing services.

Medicaid waiver for the aged and disabled - Provides in-home and community-based care to individuals who otherwise would require nursing home

care and who are Medicaid-eligible. Services available include:

- Adult day care.
- Adult foster care.
- Adult/traumatic brain-injured (TBI) residential.
- Chore.
- Emergency response system.
- Environmental modification.
- Case management.
- Homemaker.
- Transportation (nonmedical).
- Respite care.
- Specialized equipment/supplies.
- Supported employment.
- Transitional care.
- Nurse management.
- Attendant care service.

Service payments for elderly and disabled (SPED) - Provides in-home and community-based care to individuals who are impaired in at least four activities of daily living (examples include toileting, transferring, eating, etc.) or at least five instrumental activities of daily living (examples include meal preparation, housework, laundry, medication assistance, etc.). Services available include:

- Adult day care.
- Adult foster care.
- Chore.
- Emergency response system.
- Environmental modification.
- Family home care.
- Case management.
- Homemaker.
- Respite care.
- Personal care.

Personal care services - Provides in-home care to individuals who are impaired in at least one activity of daily living (examples include toileting, transferring, eating, etc.) or at least three of the four following instrumental activities of daily living--meal preparation, housework, laundry, and medication assistance. The individual must be Medicaid-eligible to receive personal care services. These services include assistance with bathing, dressing, toileting, transferring, eating, mobility, and incontinence care and also assistance with meal preparation, housework, laundry, and medication assistance.

Expanded SPED - Provides in-home and community-based care to individuals who are not severely impaired in activities of daily living (examples include toileting, transferring, eating, etc.) but who are impaired in at least three of the four activities of daily living--meal preparation, housework, laundry, and medication assistance--or who have health, welfare, or safety needs, including requiring supervision or a structured environment. This program is an alternative to basic care. The individual must be Medicaid-eligible to receive services under this program. Services include:

- Adult day care.
- Adult foster care.
- Chore.
- Emergency response system.
- Environmental modification.
- Family home care.
- Case management.
- Homemaker.
- Respite care.

[Appendix C](#) is a Department of Human Services document comparing selected long-term care programs.

LONG-TERM CARE SERVICES FUNDING

The following schedule presents the 2009-11 legislative appropriations for long-term care-related services and the average number of clients that are anticipated to be served during the biennium based on the appropriations:

Program/Service	Budgeted Numbers to Serve	General Fund	Federal Funds	Other Funds	Total
Nursing facilities	3,323	\$132,415,339	\$286,519,675	\$6,926,264 ¹	\$425,861,278
Basic care facilities	455	8,219,552	7,514,011	2,380,362 ²	18,113,925
TBI waiver	27	707,879	1,451,929		2,159,808
Aged and disabled waiver	322	2,427,300	4,976,908		7,404,208
Technology dependent waiver	3	174,557	358,051		532,608
Children's medically fragile waiver	11	376,213	771,631		1,147,844
Program of all-inclusive care for elderly	76	2,427,882	4,965,829		7,393,711
Personal care option	671	8,214,016	16,830,583		25,044,599
Targeted case management	458	641,694	1,316,202		1,957,896
SPED	1,597	16,620,560		874,767 ³	17,495,327
Expanded SPED	129	726,578			726,578
Dementia care services		1,200,000			1,200,000
Assisted living rent subsidy pilot project				200,000 ⁴	200,000
Community of care program		120,000			120,000
Total	7,072	\$174,271,570	\$324,704,819	\$10,381,393	\$509,357,782

¹This amount consists of \$4,124,506 from the health care trust fund and \$2,801,758 of contingent Bank of North Dakota loan proceeds.

²This amount consists of \$96,000 of estate collections and \$2,284,362 of retained funds.

³County funds.

⁴Health care trust fund.

The 2009 Legislative Assembly provided funding to:

- Allow for a 6 percent inflationary increase in the second year of the 2009-11 biennium for rebased services (hospitals, physicians, chiropractors, and ambulances) and dentists and a 6 percent per year inflationary increase for all other providers.
- Provide a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities, except for administrators and contract nursing.
- Increase nursing facility bed limits in the formula for nursing home payments.
- Provide a \$1 per hour increase for qualified service providers.
- Revise the SPED fee schedule based on the actual cost-of-living adjustment through January 2008 and an estimated cost-of-living adjustment for January 2009 to allow individuals with higher incomes to receive SPED services without paying a fee.

HEALTH CARE TRUST FUND/LONG-TERM CARE FACILITY LOAN FUND

The health care trust fund was established by the 1999 Legislative Assembly (Senate Bill No. 2168) for providing nursing facility alternative loans or grants. House Bill No. 1196 (2001) provided that money in the fund may be transferred to the long-term care facility loan fund for nursing facility renovation projects and used for other programs as authorized by the Legislative Assembly. Money was generated for the health care trust fund as a result of the Department of Human Services making government nursing facility funding pool payments to two government nursing facilities--McVille and Dunseith. Payments were made based on the average amount Medicare rates exceeded Medicaid rates for all nursing care facilities in the state multiplied by the total of all Medicaid resident days of all nursing homes. Federal Medicaid funds were available for these payments and required a state match. Payments were made to the two government nursing facilities and were subsequently returned to the state, less a \$50,000 transaction fee retained by each of the two government nursing

facilities. Once returned to the state, the state's matching share was returned to its source, and the federal funds were deposited in the health care trust fund. Money in the fund is invested by the State Investment Board and any investment earnings are retained in the fund. The federal government has eliminated this intergovernmental transfer program. As a result, North Dakota's final intergovernmental transfer payment was received in July 2004.

North Dakota received a total of \$98.2 million under this program from 2000 to 2004. Of the total, \$11.3 million was used for long-term care facility loans and the remainder for other programs and purposes. [Appendix D](#) is the current analysis of the health care trust fund which indicates a projected June 30, 2011, fund balance of \$25,607.

Under North Dakota Century Code (NDCC) Chapter 50-30, subject to legislative appropriations, money may be transferred from the health care trust fund to the long-term care facility loan fund for the purpose of making loans, as approved by the Department of Human Services, for renovation projects. Each loan is limited to \$1 million or 90 percent of the project cost, whichever is less. Under the program, 23 loans have been approved totaling \$11.4 million. As of June 2009, \$8.9 million of outstanding loans remains. Of the approved loans, 3 were for assisted living facilities, 17 for nursing home facilities, 1 for a basic care facility, and 2 for combination nursing, assisted living, and basic care facilities.

NURSING HOME FACILITIES

Survey Process

Nursing homes that provide services under Medicare or Medicaid must be certified as meeting certain federal minimum requirements established by Congress. Certification is achieved through routine facility surveys performed by the states under contract with the Centers for Medicare and Medicaid Services. In North Dakota the State Department of Health is the agency responsible for conducting nursing home surveys. The state conducts the inspections of each nursing home on an average of once a year (9-month to 15-month intervals); however, inspection may occur more frequently if the nursing home is performing poorly. There are two types of surveys conducted--health and Life Safety Code surveys.

1. Health surveys - The health survey team consists of two to six trained inspectors, including at least one registered nurse. The established nursing home survey protocol includes interviewing a sample of residents and family members about the resident's life within the nursing home, interviews with caregivers and administrative staff, and reviews of clinical records. Title 42 of the Code of Federal Regulations, Part 483, provides detailed federal regulatory standards that long-term care facilities must meet.

These standards address areas of service provided by the nursing home, including:

- a. Administration - How well the nursing home is administered and managed, including ensuring that staff is properly trained and licensed to perform the tasks assigned.
 - b. Quality of care - How well the facility provides services and ensures that residents receive adequate supervision and assistance. The residents are to receive the necessary care and services to maintain and, when possible, improve functional ability.
 - c. Residents' rights - How well the facility ensures the rights of residents are respected, recognized, and upheld. This includes allowing the freedom of choice to make independent decisions, safeguarding the resident's property and money, providing privacy in communication, providing freedom from abuse or mistreatment, and providing reasonable accommodation of individual needs.
 - d. Dietary services - How well the resident meals are prepared and served. Food must be stored, prepared, and served under sanitary conditions. The meals must meet nutritional needs of the residents and be appetizing.
 - e. Other services - The availability of medical, pharmacy, and specialized rehabilitation services.
2. Life Safety Code surveys - The Life Safety Code, pursuant to the National Fire Protection Association Standard 101, sets minimum building design, construction, operation, and maintenance requirements necessary to protect building occupants from dangers caused by fire, smoke, and toxic fumes. The Life Safety Code also provides prompt escape requirements for new and existing buildings. Section 483.70 of Title 42 of the Code of Federal Regulations requires nursing home facilities to meet the provisions of the Life Safety Code. Surveyors employed by the State Department of Health conduct onsite surveys of nursing home facilities under agreement with the Centers for Medicare and Medicaid Services within six months of the health survey.

When an inspection team finds that a nursing home does not meet a specific regulation, it issues a deficiency citation. Surveyors are to assign a scope and severity rating for each deficiency. The number of residents affected or scope of each deficiency is based on the following:

1. Isolated - This deficiency affects one or the fewest number of residents, staff, or occurrences.

2. Pattern - This deficiency affects more than a limited number of residents, staff, or occurrences.
3. Widespread - This deficiency is found to be widespread through the facility or has the potential to affect a large portion or all the residents.

The potential level of harm or severity of each deficiency is based on:

1. Potential for minimal harm - This deficiency has the potential for causing no more than minor negative impact on the resident. An example is a nursing home's failure to post a statement of deficiencies.
2. Minimal harm or potential for actual harm - This deficiency results in minimal discomfort to the resident or has the potential to negatively affect the resident's ability to achieve his or her highest functional status. An example is observing staff not washing hands properly between resident treatments.
3. Actual harm - This deficiency results in a negative outcome that has negatively affected the resident's ability to achieve his or her highest functional status. An example is restraining an active or vocal resident, despite lack of medical symptoms for doing so, resulting in the resident being withdrawn.
4. Immediate jeopardy - This deficiency has caused or is likely to cause serious injury, impairment, or death to a resident of the nursing home. Immediate corrective action is necessary when this deficiency is identified. An example is finding a resident with dementia wandering outside the nursing home property due to an insufficient or nonworking monitoring system.

Depending on the nature of the problem, the Centers for Medicare and Medicaid Services is permitted to take various actions against the nursing home, including fines, denying payment, or assigning a temporary manager. If problems are not corrected, the Centers for Medicare and Medicaid Services may terminate its agreement with the nursing home. As a result, the nursing home would no longer be certified to provide services to Medicare and Medicaid beneficiaries.

Demonstration Project

During the 2007-09 biennium, the State Department of Health implemented a demonstration project to provide a life safety survey process for basic care and long-term care facilities to assess, voluntarily, a construction project, a renovation project, or a construction and renovation project costing more than \$3 million.

Senate Bill No. 2046 (2009) requires the State Department of Health to conduct surveys during construction or renovation projects of health facilities licensed by the State Department of Health. The 2009 Legislative Assembly provided funding of

\$346,530, of which \$232,174 was from the general fund, and authorized two new full-time equivalent positions to the State Department of Health for conducting these surveys.

Licensing Requirements

North Dakota Administrative Code (NDAC) Section 33-07-03.2-03, as authorized by NDCC Sections 23-01-03 and 28-32-02, requires that nursing home facilities must obtain a license from the State Department of Health to operate in North Dakota. An application for an initial license will not be accepted until the State Department of Health conducts an inspection of the nursing home facility and the facility is found to be in compliance with NDAC Chapters 33-07-03.2 and 33-07-04.2. The State Department of Health will issue renewal licenses to facilities if they are found to be in compliance with the licensing requirements, as determined by periodic unannounced onsite health and Life Safety Code surveys conducted by the department.

Renewal licenses expire on December 31 of each year. The annual license fee, pursuant to NDCC Section 23-16-03, for nursing home facilities not owned by the state or its political subdivisions is \$10 for each bed. This amount was increased from \$7, effective July 1, 2003.

North Dakota Administrative Code Chapters 33-07-03.2 and 33-07-04.2 detail the state nursing home licensing requirements which relate to quality of care provided, including administration, physical environment, equipment, and services. Long-term care facilities are not subject to federal survey requirements if they do not participate in the Medicaid or Medicare program; however, all facilities must meet the licensing rules.

North Dakota Administrative Code Section 33-07-03.2-04, as authorized by NDCC Sections 23-01-03 and 28-32-02, provides that state nursing home requirements may be waived from licensure requirements by the State Department of Health for a specified period in specific instances, provided such a waiver does not adversely affect the health and safety of the residents and would not result in unreasonable hardship upon the facility. A waiver may not exceed a period of one year and shall expire on December 31 of the year issued. The need for a continuation of a waiver is reviewed at the time of renewal of licensure. Nursing facilities may obtain a waiver by submitting a written proposal to the director, Division of Health Facilities, State Department of Health.

Payment System

North Dakota's nursing facility payment system has been in place since 1990 and requires equalized rates, which means nursing facilities may not charge private pay residents a higher rate than individuals whose care is paid for under the Medicaid program. Nursing facilities may, however, charge higher rates for private occupancy rooms.

The North Dakota nursing facility payment system consists of 34 classifications. Classifications are based on the resident assessment instrument (minimum data set) required in all nursing facilities. The rates for each classification vary by facility based on each facility's historical costs. Residents in higher classifications pay more than residents in lower classifications at the same facility.

Facility rates change annually on January 1 and may change throughout the year due to audits or special circumstances. Revenue received by a facility changes throughout the year based on the classifications of the residents receiving services. Each resident is reviewed within 14 days of admission or reentry from a hospital and every three months subsequently. A resident's classification may change only at the scheduled three-month interval or if hospitalization occurs. The facility is required to give a 30-day written notice to its residents whenever the facility's rates change. If an individual's classification changes, no notice is required, and the rate is retroactive to the effective date of the classification.

BASIC CARE FACILITIES

North Dakota Century Code Section 23-09.3-01 defines a basic care facility as a residence that provides room and board to five or more individuals who are not related by blood or marriage to the owner or manager of the residence and who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular 24-hour-a-day medical or nursing services.

Licensure

North Dakota Century Code Sections 23-09.3-05 and 23-09.3-05.1 provide that no person, institution, organization, limited liability company, or public or private corporation may keep, operate, conduct, or manage a basic care facility without holding a valid license issued by the State Department of Health. A basic care facility is to apply annually to the department for a license and pay the annual license fee of \$10 per bed.

Standards and Survey Process

North Dakota Century Code Section 23-09.3-04 provides that the State Department of Health is to establish standards for basic care facilities. The department is to inspect all places and grant annual licenses to basic care facilities. The department is to implement a survey process for basic care facilities. As part of the survey process, the department is to develop, in consultation with basic care facilities, and implement a two-tiered system of identifying areas of noncompliance with the health portions of the survey.

Payment System

North Dakota's basic care facilities payment system has been in place since 2003. Rates are

established for personal care and room and board. The personal care rate includes resident care services and supplies and laundry, dietary, and housekeeping salaries. The room and board rate is for semiprivate accommodations and includes all other costs, such as health care professional services, property, food, utilities, and other plant costs. Basic care facilities may charge higher rates for private occupancy rooms. The personal care costs are included under the Medicaid program, and the room and board costs are paid entirely from state funds.

Facility rates change annually on July 1 and may change throughout the year due to audits or special circumstances. Rates are facility-specific and are based on historical costs of the facility. Basic care facilities must charge private pay individuals a rate that is equal to or greater than the rate charged for individuals whose care is paid for under the Medicaid program.

NURSING CARE AND BASIC CARE BED MORATORIUM

Senate Bill No. 2044 (2009) continues through July 31, 2011, the moratorium on the expansion of nursing facility bed capacity above the state's gross licensed capacity of 6,236 beds. The provisions allow, not more than once in a 12-month period, a nursing facility to convert licensed nursing facility bed capacity to basic care bed capacity and a basic care facility to convert basic care bed capacity back to nursing facility bed capacity. Senate Bill No. 2044 also continues through July 31, 2011, the moratorium on basic care bed capacity. The bill provides that except for a nursing facility that is converting nursing facility bed capacity to basic care or unless the applicant demonstrates to the State Department of Health and the Department of Human Services that a need for additional basic care bed capacity exists, the department may not issue a license for additional basic care bed capacity above the state's gross licensed capacity of 1,619 beds.

North Dakota Century Code Section 23-16-01.1 allows nursing facilities to transfer beds from one facility to another and Section 23-09.3-01.1 allows basic care facilities to transfer beds from one facility to another. Under both sections, the facility receiving the beds has 48 months in which to license the beds. As of July 31, 2009, 228 nursing home beds have been transferred and are awaiting licensure, and 37 basic care beds have been transferred and are awaiting licensure. These amounts are in addition to the licensed bed capacity referred to above.

ASSISTED LIVING

North Dakota Century Code Section 50-32-01 defines an assisted living facility as a building or structure containing a series of at least five living units operated as one entity to provide services for five or more individuals who are not related by blood, marriage, or guardianship to the owner or manager of

the entity and which is kept, used, maintained, advertised, or held out to the public as a place that provides or coordinates individualized support services to accommodate the individual's needs and abilities to maintain as much independence as possible.

Licensure

North Dakota Century Code Section 50-32-02 provides that an entity may not keep, operate, conduct, manage, or maintain an assisted living facility or use the term "assisted living" in its advertising unless it is licensed by the Department of Human Services. An assisted living facility is to apply annually to the Department of Human Services for a license and pay the annual license fee of \$75 for each facility.

Services, Duties, and Educational Requirements

North Dakota Century Code Section 50-32-04 provides that an entity may provide health services to individuals residing in an assisted living facility owned or operated by that entity. Health services is defined as services provided to an individual for the purpose of preventing disease and promoting, maintaining, or restoring health or minimizing the effects of illness or disability.

House Bill No. 1263 (2009), which has been codified as NDCC Section 50-32-05, provides additional requirements for assisted living facilities, including:

1. Requiring each facility to have clear, concise, understandable tenancy criteria that are fully disclosed in writing to all potential tenants prior to the agreement being signed.
2. Requiring all administrators to complete 12 hours of continuing education annually and all direct care staff to have training in resident rights, fire and accident prevention and training, mental and physical health needs of tenants, behavior problems and prevention, and control of infection.
3. Outlining the minimum requirements for tenants' records. Records should include the initial evaluation to meet the tenancy criteria, the tenancy agreement signed by the tenant or the tenant's legal representative, the tenant's medication records if the facility administers the medication, and an itemized list of services.
4. Assuring every facility will conduct a reference and previous employment check on each employment applicant.
5. Requiring each assisted living facility at least once every 24 months to conduct a consumer satisfaction survey, and a copy of the survey results must be provided to each tenant.

Payment System

Individuals in assisted living facilities are responsible for paying their own room and board expenses. Individuals may be eligible to receive assistance for personal care services.

The 2009 Legislative Assembly, in House Bill No. 1327, appropriated \$200,000 from the health care trust fund for providing a grant to a nursing facility for costs associated with remodeling the facility to meet the requirements of an assisted living facility and a basic care facility. In order to receive the grant, the facility is to agree to use at least \$50,000 of the grant to conduct a rent subsidy pilot project for at least four assisted living residents.

PROPOSED STUDY PLAN

The committee may wish to proceed with this study as follows:

1. Receive information from the Department of Human Services on North Dakota's long-term care system, including information regarding the department's payment system.
2. Gather and review information on long-term care and home and community-based care services available and waiting lists for services by geographic areas of the state.
3. Receive status reports from the Department of Human Services regarding the level of spending, utilization, and cost of long-term care services and programs for the 2007-09 and 2009-11 bienniums.
4. Receive information from the State Department of Health regarding the department's survey and licensure processes for nursing home and basic care facilities.
5. Review statutory provisions and administrative rules regarding the regulation of basic care and assisted living facilities.
6. Receive testimony from interested persons, including the North Dakota Long Term Care Association, regarding the long-term care system in North Dakota, including the regulation of basic care and assisted living facilities.
7. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
8. Prepare a final report for submission to the Legislative Management.

ATTACH:4