# North Dakota
# Long Term Care Study
# Deliverable 3

# Final Report

***Prepared for the North Dakota***

***Department of Human Services Medical Services Division***

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# 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.

# II. Introduction

## A. Project Overview

Providing needed long-term care services is one of the greatest policy challenges facing state governments across the nation. North Dakota faces major challenges in meeting the needs of its aging and disabled populations over the next several decades.

In 2013, the North Dakota Department of Human Services engaged Myers and Stauffer LC to assist the North Dakota Department of Human Services in evaluating additional options available to continue efforts to appropriately, effectively, and creatively meet the needs of current and future cohorts of elders and others needing long-term care. The study consisted of developing two reports that review and evaluate North Dakota's long-term care continuum and develop findings and recommendations that address capacity and improve service delivery and quality.

## B. Summary of Interim Report Findings

A profile of the older population reveals that North Dakota is demographically an "old" state today. In 2012, North Dakota ranked 12$^{th}$ 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. These characteristics significantly impact the delivery of services, both in terms of the organization and payment for services, and in availability and type of provider and workforce training and education. Even with an influx of young workers in the western regions of the state, workforce availability remains a serious problem for long-term care providers, which contributes to the challenges to North Dakota's delivery of long-term care services.

Future need for long-term care services in the western counties may, however, be reduced by shifts in older adults out of these counties. There is anecdotal evidence that the western counties are losing baby boomers and older adults as cost of living increases force out those on fixed incomes and increases in housing prices entice baby boomers to sell their homes and move to other areas. Data suggest, however, that the elderly and baby boomers are not leaving the state in significant numbers but merely relocating to other areas in the state. These shifts of population will need to be monitored closely in coming years to accurately predict regional service needs.

Most rural counties in North Dakota continue to face the loss of young and a growing proportion of older adults. This has been a trend for decades and is resulting in a continuing loss of total population in almost half of North Dakota's rural counties. In the near term, services systems in these counties will struggle to meet the needs of the older population with dwindling resources. In the future, service options may be very limited in some rural counties without a considerable change in where and how long-term care services are designed, financed, and provided.

Despite rather dismal predictions for very rural areas, North Dakota has some important advantages. The older population of North Dakota is relatively healthy and functional when compared with older adults nationally. They are also relatively homogeneous racially and ethnically, which makes the design of services consistent with cultural expectations somewhat easier.

Another advantage is that four-fifths of older adults in North Dakota live in or near more populated areas. Many of these population centers are currently experiencing considerable population growth and, given the monetary resources now available in the State, opportunities for experimenting with new approaches to long-term care service delivery are optimal. Residential options with services are already evolving in Fargo, Bismarck and other more urban communities. Continuing innovation will be important as baby boomers enter the ranks of the older population in rapidly increasing numbers and the availability of informal caregivers steadily decreases.

The baby boomers are better educated, have higher incomes and are not the “Silent Generation” that preceded them. Boomer women are more likely to have spent much of the lives in the workforce making them more likely to have pensions and higher Social Security payments. As with previous older generations, baby boomers are likely to vote. They are also likely to have fewer family members and younger workers available to blunt the societal impact of their need for long-term care as they age. Services developed today must take into consideration the changes baby boomers will require, expect and demand. They are a generation that has reshaped numerous aspects of our society as they have moved through each decade. Within fifteen short years, rapidly increasing numbers of the boomers will begin to need long-term care, and the impact of this generation will again be felt. Now is the time to design, develop and adapt service systems that address the needs and preferences of current users, but can be readily adapted to future demands.

North Dakota is committed to finding solutions to meet the needs of its elderly citizens as evidenced by the number of studies that the state has conducted in the past ten years. The Department of Human Services has been actively working with key stakeholders across the state to address and identify challenges.

North Dakota’s current long term care continuum includes:

- Institutional and residential services of:
    - Nursing Facilities
    - Basic Care Facilities
    - Assisted Living Facilities
- Medicaid 1915 (c) Waivers
- Medicaid State Plan Personal Care
- Service Payments for the Elderly and Disabled (SPED) program
- Expanded Service Payments for the Elderly and Disabled (Ex-SPED) program
- Program for All-Inclusive Care for the Elderly (PACE) program

Two critical components of any long-term care system are the framework and process for accessing services. In North Dakota there are several entities that play various roles in this process. For many years county social services offices have provided eligibility staff that help individuals navigate the long-term care system. More recently the State has added Aging and Disability Resource LINK, which provides another resource to aid those seeking long-term care services. Providers also interact with both individuals seeking services and the state resources established to assist them. Together these groups fulfill the tasks of providing information and referral, assessment of needs, and eligibility determination.

"Rebalancing" is typically the term used by states and the Federal government to refer to the deliberate shifting of funds and services for persons in need of publicly-funded long term care from traditional, institutional settings, such as nursing facilities, to non-institutional residential settings, such as an individual's private home or apartment, assisted living facility, or small group home.

More specifically, CMS defines rebalancing as efforts to achieve a more equitable balance between a state's institutional and community-based LTC programs in both the number of consumers accessing and receiving each type of long-term care service and the funding provided.

North Dakota participates or has participated in the following rebalancing initiatives:

- Program of All-Inclusive Care for the Elderly (PACE)
- Money Follows the Person Rebalancing Grant, which was awarded to the Department's Medical Services Division in May 2007 to help move eligible individuals from institutions to community settings.
- Aging and Disability Resource LINK (ADRL), which is a collaborative effort led by the Administration on Aging and the Centers for Medicare and Medicaid, and supported by a grant from the US Department of Health and Human Services, Administration on Aging.
- Real Choice Systems Change Grant, which was awarded in September 2004 to the Department to take an in-depth look at the continuum of care and increase access to and use of HCBS services.

There are certainly variations in the distribution and utilization of long-term care beds across North Dakota's eight service regions. In general though, the variations are not great, and vacancy rates do not indicate a drastic shortage of beds in any given area. The most noticeable differences occur in the Williston Region where there are fewer basic care and assisted living beds relative to the 85+ population than in other areas of the state. It is not possible to determine from the current data if this situation creates an access issue but it does call attention to an area of the state that bears watching and probably deserves further investigation.

There are many factors contributing to nursing facility cost, but a few findings from the analysis of recent cost data and other historical nursing facility statistics are noteworthy.

1. Nursing salaries and benefits are the most significant cost driver for North Dakota's nursing facility providers, comprising nearly 50% of total costs and increasing at nearly 5.5% between 2012 and 2013.
2. Nursing facilities pay a premium to use contracted labor (more than 70% higher than facility staff). These costs contribute 6.1% of nursing salary costs but only pay for 3.3% of direct care hours. In 2013, contracted labor increased 7.30%, comprising 2.9% of all nursing facility costs.
3. The largest increase in per diem rates is found in the Indirect and Incentive/Margin components of the rates. Although these are small pieces of the total rate, this fact produces a shift in the composition of the rate towards these components.
4. Shifts in case mix from lower acuity to higher acuity categories also appear to be contributing to increases in program expenditures.
5. Substantial increases in cost center limits may be reducing pressure for providers to control costs.

As with nursing facilities there are many factors that may be contributing to basic care facility cost increases. There are a few observations that stand out:

1. Basic care facility per diem costs increased by about 5% between 2011 and 2012.
2. Direct care costs increased about 8%, which drove the majority of the cost increase.
3. The largest cost driver for basic care facilities is direct care worker compensation (resident care staff and licensed health care practitioner staff), which is about 30.5% of all costs.

The most significant cost for both nursing facilities and basic care facilities is their direct care labor costs. For nursing facilities this makes up about 45% of total costs, and for basic care facilities it is about 30% of the total costs. Direct care costs are also an area of costs that are increasing faster than most other costs for both nursing facilities and basic care facilities. Between 2012 and 2013 nursing salaries and fringe benefits increased 5.48% for nursing facilities. At the same time direct personal care costs increased 8.46% for basic care facilities. While these are the costs that primarily increase providers' expenses, they are not necessarily the costs that are driving provider rates and program expenditures. Due to the way reimbursement rates are calculated there are other segments of the per diem rates that are actually increasing more significantly.

The foundation of any quality incentive program 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). The main data sources for the measures are the MDS, nursing home inspections, consumer or employee surveys, and facility cost reports or other administrative systems. Some states such as Minnesota have homegrown systems that rely on state-designed performance measures, special surveys, and/or reporting mechanisms. Georgia uses a commercial product for at least some performance measures.

Review of North Dakota's long-term care continuum and feed-back obtained from stakeholders who responded to the questionnaire, who attended the public meetings and who submitted written testimony reveal a number of program and service gaps, many of which are common among states. This commonality exists largely because the gaps may result from national and regional marketplace issues (for example, workforce, housing, and transportation), or they originate from historical program funding and policy biases (for example, mandatory funding for institutional care), many of which by their nature are inherently challenging to overcome.

## C. Purpose/Contents of Final Report

The purpose of this final report is to further analyze and develop findings and recommendations needed to perform a targeted assessment of North Dakota's current and future long-term care service delivery system. Specifically, the final report will include:

- Recommendations on policy considerations for state licensing requirements for basic care and assisted living
- Recommendations on policy considerations for an occupancy incentive in basic care rate setting
- Recommendations on policy considerations for an alternative to the current rate limitation process in basic care rate setting
- Recommendations for policy considerations to incentivize the movement of capacity for all levels of long-term care to areas of greatest need
- Recommendations for adding quality measures to nursing facility rate methodology
- 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 presented herein 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. Each recommendation has been generally evaluated for its impact on North Dakota's Medicaid program and state funded services and includes the identification of needed state plan amendments, waiver amendments, and regulatory changes.

# III. Policy Considerations for State Licensing Requirements for Basic Care, Assisted Living

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).

With respect to North Dakota's elderly and physically disabled population, during the 2011-13 biennium, basic care facilities provided the setting for 9.4% of the monthly average number of people served (629 out of 6,690) at a cost of $27 million (5.4%) of North Dakota's total long term care expenditures. (2011-2013 Quarterly Budget Insight)[Note: Participant numbers for nursing facility and basic care were calculated by Myers and Stauffer from per diem units for comparison purposes.] In contrast, assisted living facilities are largely paid through private funds, serving only a small number of North Dakota's residents who depend on public assistance for services.

Based on a North Dakota Department of Health report published in November 2013, there are 68 licensed basic care facilities, 52 of which participate in the North Dakota Basic Care Assistance Program. Basic care facilities are located in 36 of the 53 counties in the state. About 57% of basic care facility residents are funded through Medicaid and state programs and approximately 43% are funded privately. Unlike other states, North Dakota does cover its residential care services (i.e. basic care) through its Medicaid State Plan.

According to the North Dakota Department of Human Services, there are 73 licensed assisted living facilities located in 35 counties throughout the state. Six counties do not have any nursing facilities, basic care facilities, or assisted living facilities, although facilities are located in one or more adjacent counties for all six. Of the approximately 1,100 residents in assisted living facilities, there are only a small number of individuals who receive Medicaid/SPED. Again, unlike other states, North Dakota does not include assisted living as a specific service within its Medicaid 1915(c) waiver program, but it does cover personal care services to individuals who qualify for assisted living services.

In this section, we will examine North Dakota's licensing requirements for both basic care and assisted living facilities, compare them in terms of their similarities and differences, provide a brief profile of the Medicaid clients who receive residential services, and then discuss the policy implications for North Dakota's LTC continuum and present recommendations for future changes that the state may wish to consider.

## A. Licensing Requirements for Basic Care

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. Basic care facilities are regulated within a licensure category that is lower than the care provided by nursing facilities but higher than

assisted living or 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.

The primary licensing regulations for basic care facilities are found in:

- North Dakota Century Code 23-09.3
- North Dakota Administrative Code 33-03-24.1

A basic care facility is defined more specifically in North Dakota Administrative Code 33-03-24.1 as:

> "… a facility licensed by the state department of health under North Dakota Century Code chapter 23-09.3 whose focus is to provide room and board and health, social, and personal care to assist the residents to attain or maintain their highest level of functioning, consistent with the resident assessment and care plan, to five or more residents not related by blood or marriage to the owner or manager. These services shall be provided on a twenty-four-hour basis within the facility, either directly or through contract, and shall include assistance with activities of daily living and instrumental activities of daily living; provision of leisure, recreational, and therapeutic activities; and supervision of nutritional needs and medication administration."

The definition found in North Dakota Century Code 23-09.3 is similar, but does not include reference to a resident assessment and care plan and emphasizes staffing requirements over resident services. The definition is as follows:

> "… a residence, not licensed under chapter 23-16 by the state department of health, 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 medical or nursing services and: a.) Makes response staff available at all times to meet the 24-hour/day scheduled and unscheduled needs of the individual; or b.) Is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility."

North Dakota's licensure requirements for basic care homes are fairly comprehensive when compared with similar residential care settings in other states (which are commonly referred to as residential care facilities, boarding homes, or housing with services establishments, etc.). Basic care facility licensure requirements are summarized according to the following general categories:

<u>Licensing</u>

- Application and fee
- Conditions
- Compliance requirements

Inspections and Surveys

- Plans for corrections
- Enforcement notifications and actions, including a ban or limitation on admissions, license suspension or revocation, license denial
- Effective dates
- Reconsideration and appeal process
- Notification
- Fire safety compliance in accordance with the national fire protection association life safety code, 1988 edition, chapter 21, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety

General Building Requirements

- Fire safety and sanitation
- Lounge and activity space
- Corridors and stairways
- Kitchen
- Dining area
- Resident bedrooms
- Toilet room and bathing facilities
- Adequate ventilation
- Office spaces and other furnishings

Resident

- Basic care facility may only admit and retain individuals for whom it provides appropriate services within the facility to attain or maintain the individual's highest practicable level of functioning, and whose abilities are consistent with the national fire protection association 101 life safety code requirements.
- Written resident rights, which must comply with ND Century Code 50-10.2 (Health Care Facility Resident Rights)
- Process for handling resident complaints
- Resident records – specifies secure maintenance and storage, items that must be included in the record and retention period

Staffing

- Minimum staffing, including an administrator, staff person to serve as back-up administrator, and "sufficient trained and competent staff employed to meet the residents' needs and available on-site on a 24 hour/day basis
- Staff educational requirements

Resident Assessments and Care Plans

- Resident assessment required for each resident within 14 days of admission and as needed thereafter, but no less frequently than quarterly
- The assessment must include: a review of health, psychosocial, functional, nutritional, and activity status; personal care and other needs; health needs; capability of self-preservation; and specific social and activity interests
- A care plan must be developed within 21 days of the admission date and must be updated as needed, but no less than quarterly

Services

- Personal care services (required), which include assistance with ADLs and IADLs
- Pharmacy and medication administration services (required)
- Social services (required)
- Nursing services (required)
- Dietary services (required)
- Activity services (required)
- Housekeeping and laundry services (required)
- Adult day care services (optional)

Moratorium on Beds

- Basic care beds may not be added during the period between August 2013 and July 2015, except when:
  a) A nursing facility converts nursing facility beds to basic care;
  b) An entity licenses bed capacity transferred as basic care bed capacity under section 23-16-01.1;
  c) An entity demonstrates to the Department of Health (DOH) and 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 radius have been occupied at 90% or more the previous 12 months...
  d) DOH and DHS grant approval of new basic care beds to an entity. The approved entity shall license the beds within 48 months from the date of approval.
- Includes additional requirements regarding basic care bed transfers and tribal facilities.

## B. Licensing Requirements for Assisted Living

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.

The primary licensing regulations for assisted living facilities are found in:

- North Dakota Century Code 50-32-01
- North Dakota Century Code 23-09
- North Dakota Administrative Code 75-03-34-01

An assisted living facility is defined in both 50-32-01 and 75-03-34-01 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. An assisted living facility does not include a facility that is a congregate housing facility, licensed as a basic care facility, or licensed under North Dakota Century Code chapter 23-16 or 25-16 or section 50-11-01.4."

This definition is much less specific than the definition used in other states, particularly those which rely on Medicaid state plan personal care services and/or a Medicaid 1915(c) waiver for services. For example, the core assisted living service definition that CMS uses for Medicaid 1915(c) HCBS Waivers is as follows:

> "Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not be made for 24-hour skilled care." [CMS Application for 1915(c) HCBS Waiver (Version 3.5) Instructions (January 2008)]

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.

In North Dakota, assisted living licensure requirements address the following:

<u>Licensing</u>

- Application and fee
- Conditions
- Compliance requirements

Enforcement

- Denial or revocation of license
- Effective dates
- Notification
- Enforcement fines
- Must be licensed by the DOH and meet lodging establishment requirements regarding: installation of smoke detection devices or other approved alarm systems; exiting; fire escapes; chemical fire extinguishers; elevator protections; sanitation and safety; drinking water standards; 2-year food safety inspections; inspection reporting to state fire marshal; failure to comply; penalty; and cancellation of license.

Other General Requirements

- Must be operated with strict regard for the health, safety, and comfort of its patrons
- Must be operated in accordance with sanitary and safety regulations
- No more than two people may occupy one bedroom of each living unit

Resident

- Written resident agreement
- Resident notice regarding how to report complaints
- Resident records
- Customer satisfaction survey

Staffing

- Specifies minimal staffing requirements
- Requires 12 continuing education hours for administrator
- Requires annual education or training for all direct care staff

Services

- Provides or coordinates individual support services, defined as services provided to individuals who may require assistance with the ADLs of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene
- Entity may provide health services to individuals residing in an assisted living facility (ALF) owned or operated by that entity. For purposes of this section, health services means 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.
- Medication management

According to the North Dakota Long Term Care Association, in 2013 94% of assisted living residents were funded privately (20% have LTC insurance that helps pay for their care), 3% by public assistance, and 3% funded by other sources.

## C. Comparison between Basic Care and Assisted Living Licensure

Although North Dakota's basic care and assist living facilities must be licensed by the state, the scope and breadth of the licensure requirements are quite different for both settings. North Dakota's basic care licensure requirements are fairly comprehensive in terms of 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.

Please refer to the Appendix for a complete comparative analysis of basic care and assisted living in North Dakota.

1. Similarities in licensing requirements

Given the difference in scope between the two residential service settings and the minimal licensure standards for assisted living facilities, there are few similarities between the licensure requirements of basic care and assisted living in North Dakota. Therefore, the similarities that do exist are primarily administrative rather than service or resident care-related and are briefly described as follows:

- **Definition of facility** – The basic care definition of facility is much more specific than the definition of assisted living; however, the definition for both specifies the provision of services to five or more residents who are not related by blood, marriage, or guardianship to the owner or manager of the facility.
- **Licensing period and display** – Both basic care and assisted living facilities must apply for a license on an annual basis, and all licenses shall expire on December 31 of the year issued. Licenses may not be sold, reassigned or transferred. Licenses must be displayed in a conspicuous place.
- **Licensing fee** – Both have annual fees, although the fee is $10/bed for basic care facility and $75 per assisted living facility license. Also, while there are several other enforcement actions that can be taken against non-compliant basic care facilities, both are subject to revocation of license related to non-compliance with licensure requirements (although unlike basic care regulations, assisted living regulations do not describe what constitutes non-compliance).
- **Staff educational requirements** – Both require the facility administrators to attend at least 12 continuing education hours per year and other facility staff to attend annual training.

2. Differences in licensing requirements

There are distinct differences between the licensing requirements for North Dakota's assisted living and basic care providers.

Assisted living in North Dakota represents a privately-funded residential living option that is targeted to generally healthy and independent elderly individuals and couples who have minimal care needs and have available private funds to pay for their housing and care needs. Its focus is primarily on living accommodations rather than services, although a limited array of services may be made available when needed.

In contrast, North Dakota and a number of states make available residential services that provide a community residential living alternative to nursing facility care for privately paying and low-income individuals and their spouses who are eligible for Medicaid and/or other state programs and who have some level of physical and/or cognitive impairments that make continued independent living difficult.

Given the different target populations, the differences between assisted living and residential care settings, both in North Dakota and in most states, are therefore deliberate, although the level and scope of regulation for assisted living varies considerably among states, with North Dakota having relatively few licensing requirements.

A comparison between the licensing requirements of North Dakota's basic care facility and assisted living facility services reveals distinct differences in the following general areas:

- **Licensing agency –** Basic care facilities are regulated by the State Department of Health, and assisted living facilities are regulated by the State Department of Human Services (and for sanitation, by the State Department of Health).
- **Number of residents/living unit** – Assisted living facilities are not permitted to have more than two people occupying one bedroom of each living unit. There is no similar licensure requirement for basic care facilities, although they must meet minimal floor space requirements for single rooms, double rooms, and rooms for three or more persons.
- **Inspections –** Basic care facilities are subject to inspections at the time of initial application and any time thereafter, and assisted living facilities are not.
- **Enforcement actions/non-compliance** – Basic care facilities are subject to enforcement actions, which include a ban or limitation on admissions, suspension or revocation of a license, or a denial to license, while assisted living facilities are subject only to license denial or revocation. Licensure requirements for basic care facilities specify several conditions of non-compliance, while requirements for assisted living facilities provide no description of non-compliance but do include the provision that facilities may be subject to a fine for non-compliance.
- **Staffing requirements** – Basic care facilities must have an administrator, a staff person that serves as a back-up to the administrator, and direct care staff, while assisted living requirements refer only to an administrator and direct care staff in terms of required training. Additionally,

basic care staff must be on-site and available 24 hours/day, while assisted living staffing must be available 24 hours/day but are not required to be on-site.

- **Fire safety** – Basic care facilities must meet or exceed the requirements of the National Fire Protection Life Safety Code, while assisted living facilities do not, although they must meet certain minimal requirements enforced by the State Department of Health.
- **Resident complaints** – Basic care facilities are responsible for developing a process for handling resident complaints, while resident complaints in assisted living facilities must be handled through the Department of Human Services.
- **Resident assessment and care plan** – Basic care facilities must comply with a resident assessment and care plan completion and updating schedule and must include specific content within the assessment and care plan. Assisted living facility licensure requirements focus only on tenant records, which must include an initial evaluation to meet tenancy criteria, a tenancy agreement, and an itemized list of services provided.
- **Services** – Basic care facilities must meet very specific requirements for personal care services, social services, nursing services, dietary services, activity services, housekeeping and laundry services. Adult day care services are optional but also have specific requirements that must be met. In contrast, licensure requirements for assisted living facility services are not separately defined and are therefore given considerable latitude under the general term, "individualized support services".
- **General building requirements** – Basic care facilities must meet very specific specifications for**:** lounge and activity space; corridors and stairways; kitchen; dining area; resident bedrooms; toilet rooms and bathing facilities; ventilation; office spaces and other common areas. Licensure requirements for assisted living facilities are not prescriptive and primarily reference sanitary and safety regulations enforced by the State Department of Health.
- **Bed moratorium** – There is a restriction on basic care facility beds for basic care but not for assisted living.
- **Medication** - Basic care licensure allows for *medication administration*, which CMS defines for the Medicaid waiver program as, "…the administration of medications by waiver providers to waiver participants who are not able to self-administer their medications or the oversight by waiver providers of participant self-administration of medications." Assisted living licensure allows only for *Medicaid management*, which CMS defines as, "… the review of a participant's full medication regimen to ensure its appropriateness. When individuals receive medications for the purpose of modifying or controlling behavior, the state is expected to have policies and procedures concerning the effective use and management of such medications. Medication management also is relevant when a participant receives multiple medications in order to guard against over or inappropriate medication." [CMS Medicaid 1915(c)HCBS Waiver Instructions (January 2008)]
- **Customer Satisfaction Survey** – A consumer satisfaction survey must be completed at least once every 24 months by assisted living facilities but not by basic care facilities. This is typically an approach that is used in assisted living as a supplemental function to address concerns about the lack of a formal third party survey.

3. Profile of residents in each setting

Although residents in assisted living facilities are generally expected to be more independent and have fewer care needs than residents in basic care facilities, resident assessment data collected for Medicaid and SPED clients in both settings for April 2014 indicate that those clients in the assisted living facilities have considerably higher ADL scores and therefore higher needs than their basic care counterparts. Specifically, the assessment data from April 2014 for residents in basic care facilities and residents in assisted living facilities were analyzed using the following methodology:

- Data produced ADL and IADL scoring data for BCAP residents and state-supported assisted living residents.
- The average score, maximum score and standard deviation were calculated for each ADL and IADL, the total ADL score and IADL score, the combined ADL/IADL score, and the service level data provided.

Based on the methodology used, the following findings were observed.

- State supported assisted living residents have an average ADL score that is about 50% greater than BCAP residents (7.59 vs. 5.06 out of a maximum of 21).
- State supported assisted living residents also have a higher average IADL score than BCAP residents (5.35 vs. 4.68 out of a maximum of 8) but the difference is not as large (only about 14% greater) as it is for the ADL score.
- Eating, transferring, and toileting are the three ADL/IADLs with the greatest disparity between state-supported assisted living residents and BCAP residents. The average score for these three ADLs is 90% to 190% higher for state-supported assisted living residents than for BCAP residents. This is consistent with the fact that regulations do not permit basic care facilities to care for residents with high needs in these areas, while assisted living facilities are not subject to the same regulatory limitation.
- Scores for the four IADLs are much more consistent between the two groups of residents with the score for state-supported assisted living residents ranging from -4% to +27% different than the same score for BCAP residents.
- Overall state-supported assisted living residents have a total ADL/IADL score that on average is about 33% higher than the average BCAP resident (12.94 vs. 9.74).
- Service data indicates an even greater disparity between state-supported assisted living residents and BCAP residents. The average service level for state-supported assisted living residents is more than 115% greater than that for BCAP residents (280.65 vs. 130.77).

4. What this means in terms of North Dakota's long-term care continuum

The licensure analysis identifies basic care and assisted living as two distinct long-term care options in North Dakota with basic care facility licensure more heavily regulated. Both settings appear to be highly utilized, which indicates that they meet an established service need/demand in the state, although basic

care facilities serve many low income individuals who receive public assistance while assisted living facilities primarily serve individuals who have available private funds. The resulting effect of this difference is that assisted living is not equally available and accessible to North Dakota's low-income elderly and disabled citizens.

The ADL analysis that we performed indicates that state-funded (SPED) residents in assisted living facilities have considerably greater care needs on average than Medicaid residents in basic care facilities. This is due to SPED eligibility criteria that require a person to meet the nursing facility level of care threshold. If basic care residents reach the nursing facility level of care threshold it is expected that they move on to a nursing facility. These circumstances create an inconsistency between eligibility criteria and the intended level of care provided in the two settings.

## D. Issues with Current Requirements and Recommendations

In concept, both assisted living and basic care facility services represent important features for a full continuum of long-term care services. They may or may not have similar licensure requirements, but their range of services should be distinct and available to meet the needs of the state's demographics and long-term care objectives for its citizens.

In most states assisted living represents a residential services option primarily available only to individuals and their spouses who do not meet nursing facility level of care and who can afford to pay privately. It is also typically characterized by minimal licensure/regulatory requirements, which the assisted living provider industry argues is part of a "social model" for services and necessary to promote consumer independence and flexibility in meeting consumer demand for residential services and care. In contrast, Medicaid-funded residential care facilities are typically more comprehensively regulated to establish basic standards for physical plant, resident services, staffing, safety, sanitation, monitoring and oversight, and other aspects that are generally considered necessary to assure the residents' overall health, welfare, and safety.

The level and scope of licensure requirements for residential care services is primarily determined at the state level and often reflect the state's philosophical position regarding the balance between provider and consumer flexibility and consumer health, safety, and overall welfare. However, in terms of residential care provided in assisted living facilities that primarily serve private paying individuals, there is commonly less regulation (fewer licensure requirements), since it is assumed that individuals who pay privately are free to make their own decisions and can and will take their business elsewhere if they are dissatisfied with the services provided. In this scenario, state legislators may be slow to establish broad and costly service standards, especially in the absence of widespread consumer complaints, risk of consumer health and safety, or other provider abuses.

In terms of regulation, fewer licensure standards and regulations in effect gives providers considerable flexibility and discretion in delivering services and are trusted to "do the right thing" for its residents. The practical effect of this approach is that there are fewer resident care and safety requirements that must be met, no/minimal objective third party inspections and surveys to assure the delivery of quality

care, and there are no basic standards that establish consistency among the providers. While minimal assisted living licensure requirements continue to be in place in some states, most have adopted expanded licensure requirements that address some basic living and care elements regarding 24 hour on-site staffing, resident admission and care criteria, and basic services. Additionally, licensure requirements are typically more stringent for assisted living and residential care services in which the resident clientele includes elderly and disabled individuals who are dependent on Medicaid and state-funded programs for services.

In contrast, residential services that serve individuals who are aged and disabled and are dependent upon taxpayer funded programs like Medicaid and SPED in North Dakota are considered to be more vulnerable, frail, and less able to choose and move freely between providers, services, and settings. For this population, the state shares responsibility with the federal government to ensure that quality services are delivered to frail elderly and disabled consumers consistently and cost-effectively. Moreover, for a state Medicaid program to cover assisted living services through any of its 1915(c) Medicaid waiver programs, the state must have in place either a solid regulatory framework or comprehensive certification standards that are managed and overseen by the state Medicaid agency or the state department of health. Because of its minimal licensure requirements, North Dakota would need to establish comprehensive certification standards to assure CMS approval and to administer and monitor care provided to Medicaid waiver clients in assisted living facilities.

An examination of the occupancy (capacity) of assisted living and basic care in North Dakota reveals that the two settings are both desired and highly utilized by the state's elderly and disabled populations. Occupancy in assisted living is reported by the North Dakota Long Term Care Association (NDLTCA) to be above 90%, while basic care facility occupancy is somewhat lower at 83% [Source: 2012 provider cost reports]. While a lower occupancy in basic care might indicate that there is less demand for this type of service, that is likely not the case in North Dakota. There are several factors that influence this occupancy dynamic. First, North Dakota's Medicaid nursing facility reimbursement methodology includes an occupancy limit, which provides an incentive to take beds out of service. Providers can do that by converting nursing facility beds to basic care beds or by selling them to other providers. Since basic care reimbursement does not have an occupancy limit, there is no incentive to take basic care beds out of service. Given the general stability in the number of people served in nursing facilities in North Dakota in recent years (decrease of only 4% from 2005 to 2010 [AARP, 2012], it is however more likely that a lower occupancy rate in basic care is to some extent indicative of real or perceived obstacles encountered in accessing services, eligibility criteria, service delivery, location, quality of care and services, staffing, or a combination of these factors.

Based upon our analysis of North Dakota's basic care and assisted living licensure requirements, Myers and Stauffer offers the following observations and recommendations:

Observation: 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.

**Recommendation 1:** The Department of Human Services should meet with consumers, providers, and the State Department of Health to develop implementable solutions to identify obstacles and issues that hinder consumer placement and continued residence in basic care facilities. The Department should also explore best practices in other states to identify specific methods to expand assisted living services for elderly and disabled individuals on Medicaid. This can be accomplished in several ways although many states do so within their existing Medicaid 1915(c) Waiver Programs and/or by establishing a separate 1915(c) waiver program (or a section 1115 demonstration waiver) that targets individuals in assisted living facilities. The development of a separate 1115 or 1915(c) waiver program would provide the state with considerable flexibility in terms of defining services, resident criteria, reimbursement methodology and rates, and provider certification standards, all of which are needed to develop provider capacity and build a viable assisted living service option for Medicaid eligible individuals.

Observation: 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.

**Recommendation 2:** The Department of Human Services should raise awareness of the policy implications of assisted living licensure and services as part of a broader discussion regarding the state's overall strategy for long-term care services. The Department should identify concerns regarding minimal standards and lack of state oversight in this licensure category, and assess whether there is interest to examine additional standards or protections that may help to strengthen resident care, safety and welfare.

Observation: 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.

**Recommendation 3:** The Department of Human Services should develop and implement policy changes that will expand the availability of assisted living services to elderly and disabled individuals who are Medicaid and SPED eligible. States such as Washington, Oregon, and Maine have successfully developed assisted living services for its Medicaid and Medicaid waiver program recipients to function as a deliberate alternative to nursing home services.

Some states have established policies which promote the admission and retention of Medicaid-funded consumers in assisted living facilities. Texas, for example, requires certified assisted living facilities to accept referrals from the department of human services or justify decisions to deny admission to Medicaid-eligible applicants. New Jersey requires Medicaid-certified assisted living facilities to reserve at least ten percent of their occupied beds for Medicaid-funded individuals, and Illinois requires assisted living providers to reserve at least 25% of their beds for Medicaid-funded individuals. [NSCLC Policy Issue Brief (February 2011)]

Observation: 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.

**Recommendation 4**: The Department of Human Services must carefully evaluate Medicaid and SPED client placement in assisted living facilities to ensure that the individual's care needs can and will be met. Additionally, in the absence of licensure standards for this residential care setting, regular program review for these residents must occur to assure their ongoing health, safety and welfare. In the absence of formal third party review, the Department must perform the additional review function.

Observation: State-funded clients in assisted living facilities have on average higher care needs than Medicaid-funded clients in basic care facilities. This is consistent with the Department of Human Services level of care criteria for the two settings but inconsistent with the level and scope of services and oversight provided in the two settings.

**Recommendation 5**: In light of these findings and a recent assisted living licensure revocation, the Department of Human Services 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. Additionally, in the absence of licensure standards regarding resident care assessment, services, and third party review, the Department must serve as the third party reviewer and provide the additional planning and oversight that is otherwise provided in a basic care facility.

As mentioned previously, other options available to the state to enhance residential care services within its LTC continuum include the addition of assisted living services into its existing 1915 (c) waiver or development of an additional Medicaid 1915(c) waiver program that is targeted specifically to individuals who receive services in assisted living facilities and that will provide the flexibility needed to develop available assisted living alternatives for individuals eligible for the Medicaid waiver program. With respect to the services offered by North Dakota through its basic care facilities, some states offer similar residential care services to individuals who meet nursing facility level of care (Medicaid HCBS waiver clients) and to individuals who are at risk of needing nursing home services (individuals on Medicaid). Arkansas for example, uses Medicaid state plan - personal care to provide residential services to individuals who are medically eligible for nursing home level-of-care and who receive services through the Medicaid 1915(c) home and community-based services waiver [NCAL 2013].

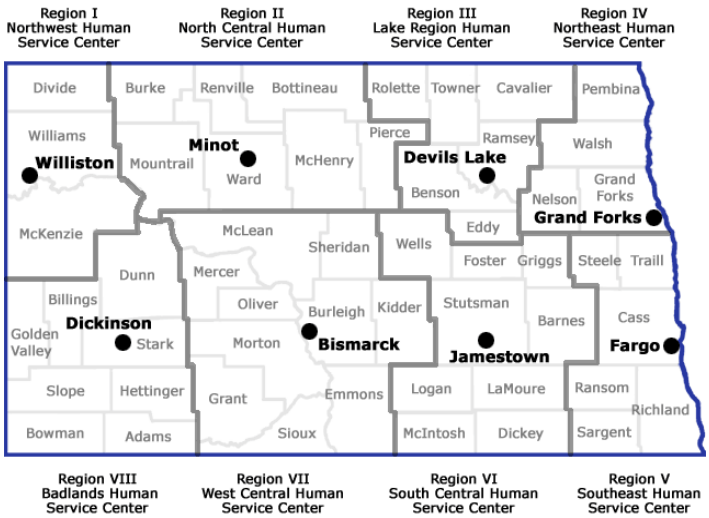
# IV. Policy Considerations to Incentivize the Movement of Capacity for All Levels of LTC to Areas of Greatest Need

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 meet the needs of people while also addressing user's preferences for how and where services are provided. The range of services include: nursing home care for those with the highest levels of impairment; residential options for those with somewhat less impairment in ADLs and 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 home. 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.

## A. Additional Analysis on Long-Term Care Bed Capacity

The capacity analysis in the Interim Report showed that long-term care beds appear to be adequate in relation to number and distribution across the state. According to 2013 reports from the North Dakota Department of Health, the state 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. The following charts detail the distribution of residential long-term care alternatives by population 65+ and 85+ for each region of the state listed in Chart 1.

**Chart 1: North Dakota Human Service Center Regions**




From: North Dakota Department of Humsn Services. http://www.nd.gov/dhs/locations/regionalhsc

Chart 2: Long-term care beds per 1,000 residents 65+ in North Dakota

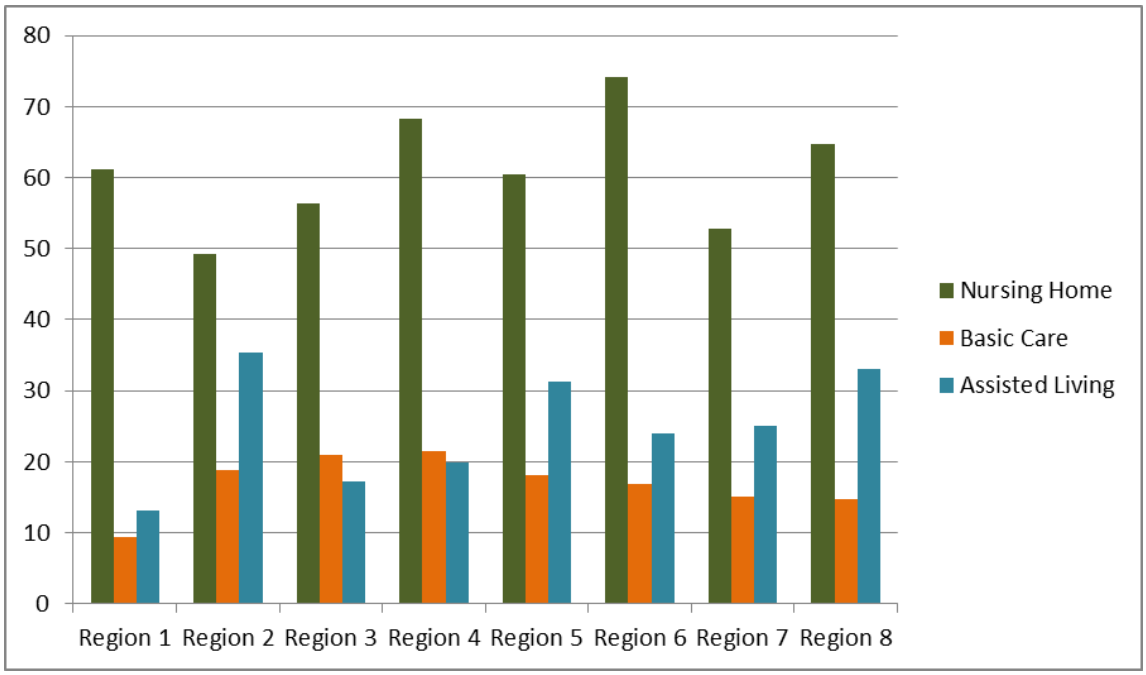
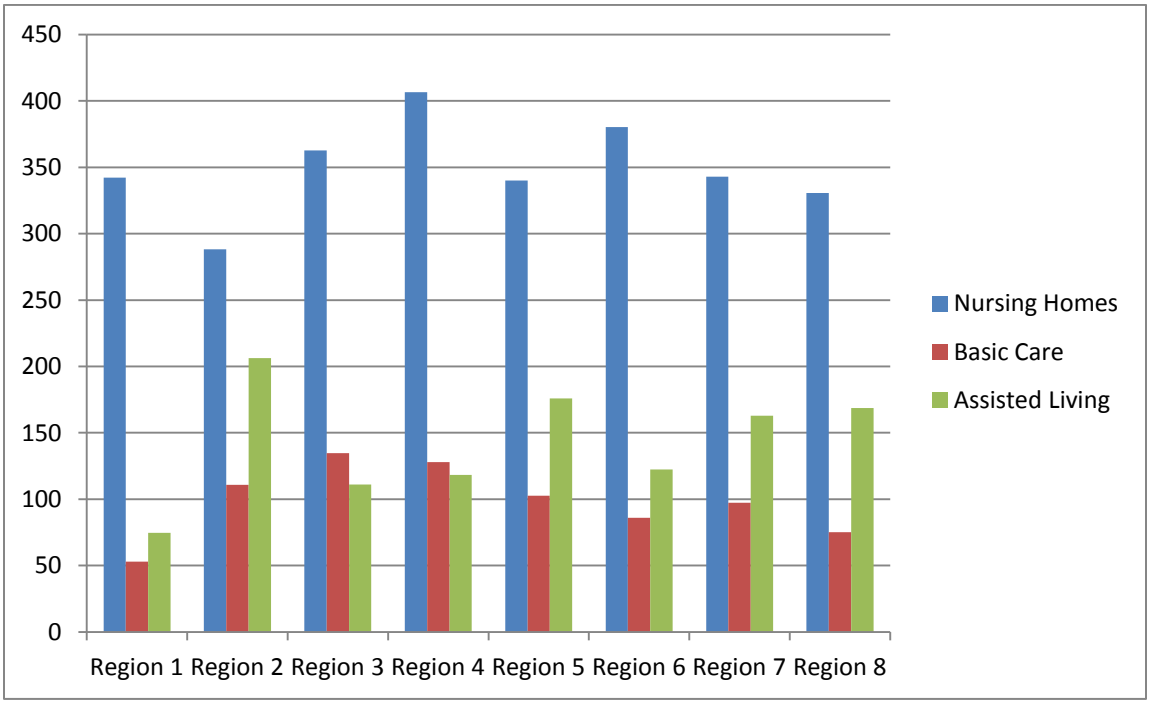


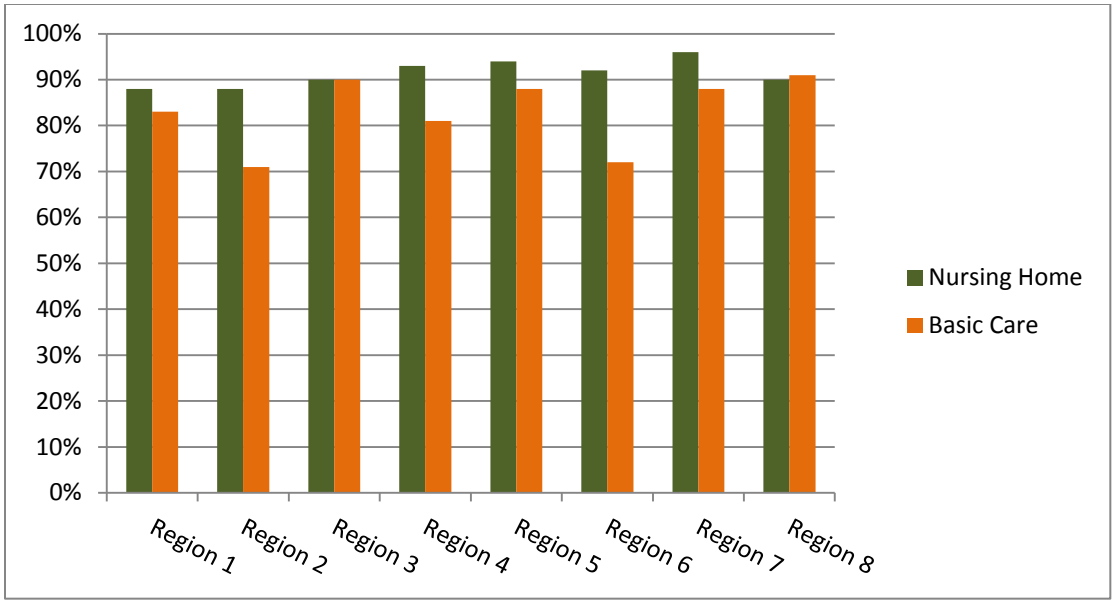

Chart 3: Long-term care beds per 1,000 residents 85+ in North Dakota



Nursing homes are the major resource for long-term care services in North Dakota, but there is considerable variability across regions in the number of nursing home beds per population 65+ and 85+. In part, this variability may be explained by greater availability of assisted living in some regions. For example, the Minot, Fargo and Bismarck areas have more assisted living and somewhat fewer nursing facility beds. In these areas, assisted living may be substituting for or delaying the need for nursing home care, although not for those individuals who depend on Medicaid or state funded programs for services. The Dickinson and Williston regions are somewhat anomalous in this respect. In the Dickinson region, the numbers of both assisted living and nursing facility beds are relatively high. The Williston region has a relatively small number of assisted living and basic care facility beds and only a moderate supply of nursing facility beds.

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). This is likely due to nursing homes and basic care being the primary options for institutional and residential long-term care for persons on Medicaid and/or state SPED, although there are also other factors involved, as discussed previously. Cost report data from 2013 shows that the average occupancy rate for nursing facilities in North Dakota is 92.51%, with a low of 68.66% and a maximum of 99.88%. Recent facility cost reports by region show that the beds are rather evenly occupied throughout the state, with a range of 88% to 96%, and the occupancy rates in basic care range from 71 percent to 91 percent (Note Chart 4). Occupancy rates for assisted living in 2012 were 94%, higher than both nursing facilities and basic care rates (NDLTCA, 2013).

**Chart 4: Occupancy rates for nursing homes and basic care by region in North Dakota Note:(Geographic data for assisted living was not available)**



The relationship between numbers of long-term beds to population 65+ and 85+ and occupancy rates do not show a consistent pattern. The Williston and Minot regions have relatively low numbers of beds per the 65+ population, but these regions also have the largest percentage of open beds (12%). It has been reported that providers in the western sector of the state may be reducing admissions due to inadequate staffing. Dickinson, however, faces similar staffing issues and has some of the higher occupancy rates in both nursing and basic care facilities (90 and 91 percent respectively). Discussions with the State and with providers have focused on workforce costs and availability of workers to provide long-term care in the western sector of the state. While providers in the western region face challenges in recruiting staff and incur higher costs in providing services, no evidence was provided for this study indicating that there are significant waiting lists or unmet needs in the region. Still, given the rapid demographic, economic and social changes occurring in the western region of the state, the impact on long-term care requires close monitoring.

## Findings

Several factors may change the dynamics in all areas of the state. Projections that McKenzie and Williams counties along with Divide will more than double the number of seniors from 2011 to 2025 were made before the dramatic demographic and social changes resulting from the energy boom. The influx of younger persons into these counties will reduce the relative proportion of older adults and lower the median age in these counties, but it is unclear whether the actual number of persons in the counties who will become 65+ over the next 10 years will change. Predictions made in the mid-2000s of a dramatic increase in numbers and proportion of older adults in the most western sector counties was predicated on the assumption that those already over 65 years of age and those turning 65 over the next 10 years would continue to reside in these counties. Anecdotal reports from providers and community residents suggest that some older adults on fixed incomes are leaving the area due to high housing costs, increasing costs of living, and discomfort with changes in the culture of their communities. Among baby boomers who own property, there may be additional factors that encourage relocation. They are now able to sell their properties for large profits and have the means to relocate to other areas. Studies have suggested that baby boomers are less emotionally attached to their dwellings than previous generations and, given the opportunity, may be more inclined to downsize and/or relocate to areas closer to family or to areas with more amenities.

While some older adults and baby boomers may be relocating out of state to be closer to family or retirement amenities, data suggest that most migration remains within the state. In 2012, an estimated 7.9 percent of older (65+) North Dakotans moved. Of those who moved, 4.1 percent moved within the same county; 2.6 percent left the county but stayed within the state, and only 1.2 percent moved out of the state (US Census, 2012b). This suggests that the need for long-term care resources may shift, particularly if those leaving certain areas are migrating to counties in other regions of the state. Regrettably more recent data are not available that support or refute this conjecture.

Other forces may also be at play in shifting demographics and creating challenges for long-term care providers in the western counties. While the movement of a younger working age population into the

western sector of the state would seem to hold promise for increasing the availability of persons to care for the aging population, this has not proven to be the case. In fact, the energy industry has put numerous pressures on communities that actually undermine service industries, particularly those serving predominantly older segments of the population. Discussions with providers suggest that long-term care providers cannot compete with the wages offered by energy companies and are experiencing a drain of potential workers. The rapid influx of younger people into communities in the Bakken Region has also placed tremendous pressure on the entire infrastructure of communities and drawn attention to issues of affordable housing, daycare, schools, roads, and other aspects of the service industry such as restaurants, hotels, groceries, etc. [KLJ, 2014; Beckman, 2011] In some respects, issues of the aging population may be getting lost or reduced in relation to these priorities [Weber, B., Geigle, J, & Barkdull, C., 2014].

It is important that rural counties outside of the Bakken energy region and urban areas of the state receive particularly close attention as the demography of North Dakota shifts. The majority of rural counties in the south central and eastern side of North Dakota lost or had only small gains in population between 2010 and 2013 (U.S. Census, 2014). The more urban counties of Williams, Stark and Ward in the west saw gains in population of approximately 32, 17, and 10 percent respectively. Burleigh and Cass Counties in the central and east experienced more modest increases of 8 to 9 percent. It is known that much of the increase in population of the western counties is due to the influx of a younger population. This influx may, however, mask movement of other segments of the population out of the area. The lower occupancy rates (88 percent) in nursing facilities in Regions 1 and 2 may be the result of providers limiting admissions due to staffing shortages or may suggest that persons needing long-term care are leaving some of the western sector counties. These individuals may be migrating to more urban areas, but this remains conjecture. Regions with urban centers generally show higher occupancy rates than the more rural regions even though their bed capacity per 65+ population is similar and options for long-term care, such as in-home care, are likely to be more abundant. Counties such as Burleigh county which has a relatively low number of long-term care beds to population is already facing high occupancy rates (96 percent) suggesting that need may be shifting to the urban areas more rapidly than anticipated. Since concise data are not available on the exact characteristics of elders who are moving and where they move, this assumption remains conjecture.

Given the rapid changes in North Dakota demographics, predictions about the future are difficult to make with great certainty. It is unlikely, however, that there will be a significant need for expansion of nursing home and basic care options statewide until at least 2021 and beyond. The 85+ population in North Dakota more than doubled between 1980 and 2011, but is projected to remain fairly stable for the next 14 years (NDSU, 2013). The leading edge of the baby boomers will not reach 75 years of age until 2021, and are unlikely to need nursing home or other residential care options until around 2026 and beyond when they reach 80 years. This does not mean that there will not be significant shifts in need for services across the state, as older adults migrate within and outside of various regions of the state.

There is one particularly positive aspect of the energy boom for some older adults and the state. The newfound wealth of some North Dakotans may mean they will have more expendable income for meeting their own long-term care needs. This should fuel both the assisted living industry that primarily serves a private pay population, as well as private sector in-home providers. Baby boomers in North Dakota may also follow the lead of boomers elsewhere by downsizing and seeking living arrangements that will provide services and support them throughout their lives. Further, encouraging the use of additional monetary resources for purchase of long-term care insurance may relieve the state of some of the long-term care burden in future years.

# V. Basic Care Assistance Program Upper Limit Analysis

## A. Introduction

Basic Care facilities in North Dakota may participate in the Basic Care Assistance Program (BCAP), which pays facilities separate per diem rates for personal care and room and board for serving individuals that are eligible for assistance through Medicaid. While basic care licensure is the responsibility of the Department of Health, basic care facility rate-setting is performed by the Medical Services Division of the Department of Human Services.

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
- 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.

### *Current BCAP Limit Methodology*

The current BCAP limit methodology uses the 80th percentile facility, based on beds, to determine the limit. The first step in the process is to calculate per diem costs for each facility using cost report data, dividing allowable costs (including inflation) by the applicable units (resident days). The direct and indirect per diems are separately ranked from lowest to highest. Using this array, a cumulative bed count is calculated, adding each facility's bed count together in order. The 80$^{th}$ percentile facility is the facility in the array in which the cumulative bed total first surpasses 80% of the total number of beds.

**Table 1: Direct Care Limit Array**

| Rank Based on Per Diem | Provider Name | BCAP Beds | Cumulative Beds | Resident Days (Census) | Cumulative Resident Days | Assistance Days | Cumulative Assistance Days | Direct Care Per Diem |
|---|---|---|---|---|---|---|---|---|
| 1 | Pembilier Nursing | 8 | 8 | 1,578 | 1,578 | 118 | 118 | 18.35 |
| 2 | Edgewood Village | 18 | 26 | 5,523 | 7,101 | 0 | 118 | 22.13 |
| 3 | Bethel 4 Acres | 16 | 42 | 4,994 | 12,095 | 4,113 | 4,231 | 22.41 |
| | | | | | | | | |
| 17 | The Leach Home | 39 | 560 | 13,647 | 179,911 | 4,806 | 91,147 | 34.86 |
| 18 | Borg Pioneer | 43 | 603 | 13,843 | 193,754 | 5,305 | 96,452 | 36.18 |
| 19 | Edmore Memorial | 20 | 623 | 4,039 | 197,793 | 2,155 | 98,607 | 36.19 |
| .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 24 | Good Sam Devils Lake | 13 | 767 | 3,917 | 240,957 | 3,156 | 116,422 | 38.2 |
| .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 29 | St. Lukes Sunrise | 16 | 918 | 4,081 | 285,438 | 2,027 | 146,715 | 42.06 |
| 30 | Edgewood Vista | 20 | 938 | 7,723 | 292,711 | 4,249 | 150,964 | 42.19 |
| 31 | Maple View Kenmare | 44 | 982 | 6,593 | 299,304 | 4,933 | 155,897 | 42.23 |
| 32 | Gackle Care | 41 | 1,023 | 10,363 | 309,667 | 7,982 | 163,879 | 42.54 |
| .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 37 | Bethel Lutheran | 19 | 1,139 | 6,421 | 346,234 | 2,295 | 186,984 | 48.27 |
| 38 | McKenzie County | 9 | 1,148 | 2,873 | 349,107 | 1,141 | 188,125 | 54.33 |
| .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 46 | Northwood | 5 | 1,212 | 184 | 361,039 | 184 | 193,116 | 81.67 |
| 47 | Parkside Lutheran | 10 | 1,222 | 3,312 | 364,351 | 1,946 | 195,062 | 90.72 |

The partial array in Table 1 illustrates the process. The first column indicates the rank of each facility in the array. The second column identifies the provider by name. The third and forth columns show the number of BCAP beds for each facility and the cumulative number of BCAP beds. In other words, the cumulative number of beds for the 3rd ranked facility, Bethel 4 Acres, consists of the total number of beds for Bethel 4 Acres and all the facilities that precede it in the array. The final column, labeled Direct Care Per Diem, lists the per diem costs of direct care for each facility and is the basis for ranking the facilities in the array. Resident days and assistance days (days paid through the BCAP program as reported by the facility) are additional information to be discussed in later sections.

There were 47 facilities included in the array. Parkside Lutheran Home, the final facility in the array had a cumulative total number of beds of 1,222. Taking 80% of this total indicates where the 80th percentile bed would fall. Since 80% x 1,222 = 977.6, Maple View Kenmare is the facility in the array where the cumulative beds total first exceeds 977.6 and is determined to be the 80th percentile facility based on beds. Thus, the Direct Care per diem cost for Maple View Kenmare, $42.23, became the Direct Care limit for all facilities effective July 1, 2013.

### *Historical Limits*

The process explained above is repeated each year for both Direct Care and Indirect Care to establish per diem cost center limits. Although state staff and provider representatives reported that the limits

historically increase from year to year, the limits for both Direct Care and Indirect Care decreased for the most recent rate setting period, FY 2013-2014. Table 2 lists the limits for each cost center for the last three fiscal years. The table also includes assistance day-weighted cost coverage and the number of homes whose per diem rate was limited.

**Table 2: Historical Direct Care and Indirect Care Limits**

| | Direct Care | | | Indirect Care | | |
|---|---|---|---|---|---|---|
| **Fiscal Year** | **Limit** | **Cost Coverage** | **Homes Limited** | **Limit** | **Cost Coverage** | **Homes Limited** |
| **2012** | $40.62 | 97.27% | 15 | $36.81 | 94.43% | 17 |
| **2013** | $44.07 | 96.43% | 16 | $38.92 | 94.53% | 19 |
| **2014** | $42.23 | 97.59% | 16 | $38.82 | 97.45% | 18 |

The cost coverage statistic is determined by dividing the facility's allowed per diem rate by its total per diem cost. Homes with per diem costs below the limit have 100% cost coverage while homes whose per diem costs exceed the limit have cost coverage below 100%.

The assistance day-weighted cost coverage is calculated to focus the cost coverage statistic on facilities that provide the majority of the services reimbursed through the assistance program. Summing the product of the cost coverage for each facility and the number of assistance days reported for that facility creates a weighting that reflects where assistance days are provided. Dividing the weighted total by the total of all assistance days provided produces a weighted average. This process prevents homes with only a few assistance days from skewing the cost coverage statistics.

The number of homes limited by each cost center limit represents the number of homes whose allowed per diem costs exceed the limit for that cost center and whose cost coverage is less than 100%.

These statistics measure the impact of the limits and will be referred to later to help evaluate the impact of various limit options.

### *Goals of This Analysis*

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. The analysis that follows identifies different options that could be used to establish the basic care limit. It also evaluates the impact that a few specific proposals would have had on the limits between FY 2011-2012 and FY 2013-2014.

## B. BCAP Limit Methodology Options

### *Percentile Based Methodologies*

The current 80$^{th}$ percentile methodology used for both direct care and indirect care is based on beds and sets the limit for all providers. As explained previously the 80$^{th}$ percentile bed for direct care in FY 2014

set the limit at the 31st ranked facility, Kenmare. However, beds are not the only option available to use as the basis for the limit; the percentile could be based on facilities, resident days, or assistance days.

A facility-based percentile limit would find the 80th percentile home in the array based on facility rankings. Again using Table 1, the 80th percentile facility would be the 38th ranked facility (47 x 80% = 37.6). The 38th ranked facility in the array is McKenzie County Healthcare with a direct care per diem cost of $54.33. Thus under a percentile methodology based on facilities, the FY 2014 direct care limit would have been $54.33.

Resident days could also be used as the basis for a percentile limit. In this case the same array would have been used, but with a cumulative resident day total. The 80th percentile would be the facility where the cumulative resident day total first exceeds 80% of total resident days. Since the total resident days in the array is 364,351 (cumulative total for Parkside Lutheran Home), the 80th percentile would have been the home where the cumulative total first exceeds 291,481 (364,351 x 80%). This occurs with the facility ranked 29th on the array, St. Luke's Sunrise, and its per diem cost is $42.06. Thus a resident day based 80th percentile limit would have set the limit at $42.06 for FY 2014.

One more option would be to use assistance days as the basis for a percentile limit and would require calculation of a cumulative total for assistance days. The 80th percentile would then be selected based on the facility in the array where the cumulative total number of assistance days first exceeds 80% of the total number of assistance days. For this array, the facility ranked 32nd, Gackle Care, is the facility in which the cumulative total of assistance days exceeds 80%.

There are at least four possible options that could be used as the basis for a percentile limit - beds, facilities, resident days, and assistance days - each of which has its merits. Bed and facility based limits do not rely as heavily on facility-reported statistics since provider enrollment activities capture the data needed for these options. However, resident day and assistance day based limits create a limit that is weighted more towards where services are provided. Specifically, assistance day based limits focus on the facilities that provide the majority of the services paid by the state and diminishes the influence of data from providers that do not participate significantly in the assistance program.

Another aspect of these limit setting options is that all produce a different limit. Although three options produce limits that are relatively close to each other, the limit based on facilities is much different. This illustrates the importance of applying careful consideration when choosing the basis for the limit. Questions to consider when evaluating the appropriateness of the limit methodology include:

- What is the average cost coverage produced by the resulting limit
- How many facilities will be impacted by the rate limit
- What is the fiscal impact of any change to the methodology

One drawback of a percentile limit methodology is that it automatically limits some providers. That is, because the limit is a percentile rank, there will always be some providers that exceed the limit. For example, if the limit is set at the 80th percentile, then the highest 20 percent of the facilities in the array

will be limited. The percentile limit methodology makes it impossible for every home to achieve 100% cost coverage unless the limit is set at the 100th percentile. So even if the per diem costs for all homes were grouped closely together, there would still be 20% of the homes whose reimbursement is held to the per diem limit. This is not typically the goal of a limit methodology; rather, limits are generally set to reduce outliers to a level that is closer to an expected range.

### *Median Plus Methodologies*

An alternative to a limit set from a percentile methodology is a system that establishes a limit based on the central tendencies of the provider population, typically the median. Under such a system the median cost per diem is determined and then a percentage is usually added to the median to set the limit. One advantage of this type of methodology is that it theoretically allows all providers to stay below the limit, rather than automatically limiting a certain percentage of providers.

As with the percentile methodology, a median plus methodology begins with an array of facilities ranked in order by their per diem costs. Table 1 can also be used to explore options for a median plus methodology.

The median could also be selected from the raw per diem cost data. This would be a facility-based median plus system. With 47 facilities in the array, the median would be the facility ranked 24th (the midpoint of the array) which is Good Samaritan Society – Devils Lake. Its Direct Care cost per diem is $38.20. If the limit was established at 120% of the median, the add-on would be 20% of $38.20, or $7.69, making the facility-based median plus limit for FY 2014 equal to $45.84.

The same options discussed for the basis of a percentile limit can also be used as the basis for the median plus methodology. The median could be determined from beds, resident days or assistance days. Determining the median facility using whatever basis has been selected begins with an array of costs and other statistics sorted by the per diem costs, which is the same as finding the 50th percentile in a percentile methodology.

A bed-based median plus methodology uses the cumulative bed count to determine the median facility. Similar to the percentile calculation employed in the previous section the total number of beds in the array is multiplied by 50% to determine the median bed. The median facility is then the first facility for which the cumulative bed total exceeds the median bed count. Using the data in Table 1 again, the total number of beds in the array is 1,222. Taking 50% of this yields 611 (1,222 x 50%). In the FY 2014 Direct Care array, the facility ranked 19th, Edmore Memorial, is at the median. Its per diem cost for direct care is $36.19. To complete the limit calculation, the percentage add-on is added to the median. Continuing with the example of a limit set at 120% of the median, the limit would be $43.43 (120% x $36.19).

Similarly, a resident-day based median plus limit utilizes a running cumulative resident day total within the array. The facility in the array where the cumulative resident day total first exceeds 50% of the total resident days is the median facility. In the FY 2014 Direct Care example, there are a total of 364,351 resident days. Multiplying that total by 50% yields 182,175.5. So the facility in the array where the cumulative resident day totals first exceeds 182,175.5 is the median facility. In the FY 2014 Direct Care

array, the 18th ranked facility, Borg Pioneer Home, is the median facility. Its per diem cost is $36.18, and adding 20% to that results in a limit of $43.42.

Finally, a median plus limit could be calculated using assistance days rather than total resident days. The process is very similar to that done using resident days but relies instead upon a cumulative total for assistance days. For the FY 2014 Direct Care array, there are a total of 195,062 assistance days in the array. 50% of that total is 97,531, which establishes the 19th ranked facility, Edmore Memorial Rest Home, as the median facility with a per diem cost of $36.19. Applying the 20% add-on then produces a limit of $43.43.

As with the percentile methodology, there are at least four options for applying a median plus methodology. The same advantages also apply. Methodologies based on facilities or beds rely less on facility-reported data since provider enrollment work captures the needed statistics. At the same time, resident day or assistance day based methodologies would give more weight to the facilities that provide the majority of the care. As pointed out in the percentile methodology section, application of assistance days would give the most weight to providers with a high Medicaid utilization.

Another common factor of a percentile methodology and a median plus system is that changing the basis for selecting the median impacts the final value of the median and ultimately the limit. In the FY 2013-2014 example, two different basis options produced the same limit, but together the four options discussed produced three different limits. So, once again, careful consideration needs to be given to the impact of the particular methodology selected.

While there are no differences between the basis options for a median plus methodology versus a percentile methodology, there is an advantage in general. That advantage is the fact that a median plus methodology does not automatically limit a number of homes. If providers have per diem costs that are very similar or the percentage add-on is high, most if not all providers could fall below the calculated limit. This makes the median plus methodology more favorable since it gives each facility the opportunity to be reimbursed the full amount of their costs. This methodology allows the limit to reduce outliers without automatically limiting a set number of facilities.

## C. Modeling Options

### *Explanation of Modeling Decisions*

There are many options for establishing the limits for Direct Care and Indirect Care. The major methodologies from which to choose include a percentile cap or a median-plus limit. Setting the level of the percentile or the percentage add on presents a wide range of possible values. There are additional options regarding what data to use as the basis for the selected methodology: beds, facilities, resident days, or assistance days. To investigate the potential impact of changing the BCAP rate setting parameters, modeling was limited to three scenarios. These scenarios were determined through input from state staff and providers. The first is a budget-neutral version of a median-plus methodology. The second also employs a median-plus methodology but borrows its parameters from the nursing facility

program. The final scenario was derived from feedback provided by members of the North Dakota Long-Term Care Association and is a percentile methodology.

A model was built for each scenario, and statistics were generated to review the potential impact of implementation. The analysis looks at the impact each methodology would have had on the BCAP reimbursement system for FY 2011-2012 through FY 2013-2014. It includes a review of the number of homes that would have been impacted by the alternative limits, the percentage cost coverage that would have occurred under the alternative limits, and the estimated fiscal impact that would have resulted.

### *Budget Neutral Median-Plus Methodology*

It is possible to set up a median-plus methodology that produces the same limits as the current system for any given year. This can easily be done by adjusting the add-on percentage so that the median-plus limit is equal to the limit under the current (percentile) methodology. However, it's impossible to choose one add-on value that will replicate the historical limits for all fiscal years 2012-2014. To investigate budget neutral scenarios across FY 2011-2012 through FY 2013-2014, separate budget neutral add-on amounts were calculated for each fiscal year. These were then tested by applying them to each of the other fiscal years. To simplify the analysis, only whole number percentages were used as add-ons. The scenario that came closest to producing a budget neutral impact across the three-year period used assistance days as the basis for selecting the median and applied a 25% add-on to Direct Care and a 20% add-on to Indirect Care. Tables 3 and 4 show the limit parameters and results of this model compared to the historical limits from FY 2012 through FY 2014

**Table 3: Budget Neutral Median Plus Model Parameters**

| Parameters | Direct Care | Indirect Care |
|---|---|---|
| **Limit Type** | Median + | Median + |
| **Array Basis** | Assistance Days | Assistance Days |
| **Percent Add-on** | 25% | 20% |

Table 4: Budget Neutral Median Plus Model, Direct Care Limit

| | Direct Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | Actual Limit | Cost Coverage | Homes Limited | Model Limit | Cost Coverage | Homes Limited | Fiscal Impact |
| **FY 2012** | $40.62 | 97.27% | 15 | $41.08 | 97.45% | 14 | $17,152 |
| **FY 2013** | $44.07 | 96.43% | 16 | $42.73 | 96.06% | 22 | -$40,771 |
| **FY 2014** | $42.23 | 97.59% | 16 | $45.24 | 98.29% | 13 | $71,601 |
| | | | | | **Combined Fiscal Impact** | | $47,981 |

Table 5: Budget Neutral Median Plus Model, Indirect Care Limit

| | Indirect Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | Actual Limit | Cost Coverage | Homes Limited | Model Limit | Cost Coverage | Homes Limited | Fiscal Impact |
| **FY 2012** | $36.81 | 94.43% | 17 | $37.26 | 94.54% | 16 | $10,947 |
| **FY 2013** | $38.92 | 94.53% | 19 | $39.67 | 94.75% | 17 | $24,810 |
| **FY 2014** | $38.82 | 97.45% | 18 | $38.65 | 97.37% | 21 | -$6,910 |
| | | | | | **Combined Fiscal Impact** | | $28,847 |

While this model produces the closest option to a budget-neutral scenario across the entire three-year period, there are some other outcomes that are also noteworthy. Namely, average cost coverage varies little between the model and the historical data with none of the averages changing more than 0.70%, while, the number of homes impacted by the limits changes more. For Direct Care there would have been six more homes limited in FY 2013. For Indirect Care the number of homes limited in FY 2014 would have increased by three. There would have been decreases in the number of homes limited for Indirect Care in FY 2012 (1) and FY 2013 (2) and for Direct Care in FY 2012 (1) and FY 2014 (3). The model also eliminates the decline in the Direct Care limit between FY 2013 and FY 2014 but does not do the same for Indirect Care.

The fiscal impact of the model results in fluctuations from year to year and between the cost centers, but produces a combined impact for the three-year period of an increase of just under $77,000. The most significant change for any one cost center would have been for Direct Care in FY 2014 where costs would have increased by about $72,000; while the smallest impact is for Indirect Care in FY 2014 with a change of just about -$7,000.

### *Median-Plus Model Using Nursing Facility Limit Parameters*

A second option modeled also uses a median-plus limit but borrows the limit parameters used for the nursing facility reimbursement rates. In the nursing facility reimbursement methodology, limits are also set for Direct Care and Indirect Care. The limit for Direct Care is 120% of the median cost and the limit for Indirect Care is 110% of the median cost. These parameters were applied to the basic care reimbursement methodology for the same three-year period as was modeled for the budget neutral approach. Table 6, 7 and 8 list the parameters and results of this modeling.

Table 6: Median-Plus Model with Nursing Facility Parameters, Parameters

| Parameters | Direct Care | Indirect Care |
|---|---|---|
| **Limit Type** | Median + | Median + |
| **Array Basis** | Facilities | Facilities |
| **Percent Add-on** | 20% | 10% |

Table 7: Median-Plus Model with Nursing Facility Parameters, Direct Care Limits

| | Direct Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Actual Limit** | **Cost Coverage** | **Homes Limited** | **Model Limit** | **Cost Coverage** | **Homes Limited** | **Fiscal Impact** |
| **FY 2012** | $40.62 | 97.27% | 15 | $44.24 | 98.08% | 8 | $82,750 |
| **FY 2013** | $44.07 | 96.43% | 16 | $44.45 | 96.50% | 15 | $8,126 |
| **FY 2014** | $42.23 | 97.59% | 16 | $45.84 | 98.37% | 13 | $80,457 |
| | | | | | **Combined Fiscal Impact** | | $171,333 |

Table 8: Median-Plus Model with Nursing Facility Parameters, Indirect Care Limits

| | Indirect Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Actual Limit** | **Cost Coverage** | **Homes Limited** | **Model Limit** | **Cost Coverage** | **Homes Limited** | **Fiscal Impact** |
| **FY 2012** | $36.81 | 94.43% | 17 | $38.98 | 94.94% | 14 | $49,737 |
| **FY 2013** | $38.92 | 94.53% | 19 | $38.86 | 94.51% | 23 | -$2,099 |
| **FY 2014** | $38.82 | 97.45% | 18 | $38.06 | 97.10% | 21 | -$31,258 |
| | | | | | **Combined Fiscal Impact** | | $16,380 |

To bring this model as close to budget neutral as possible, the basis for selecting the median was set to facilities. This brought the combined fiscal impact for the three-year period to just under $190,000. This also reduced fluctuations in cost coverage to where those changes are all less than one percent.

As with the previous model there are more differences in the number of homes impacted by the limits. For Direct Care the model reduced the number of homes limited in FY 2012 by seven, in FY 2013 by one, and in FY 2014 by three. For Indirect Care the model reduced the number of homes limited in FY 2012 by three. However, in FY 2013 and FY 2014 the model increased the number of homes limited by four and three respectively. This model also eliminated the decrease in the Direct Care limit between FY 2013 and FY 2014 but created a progressive decrease in the Indirect Care limit from FY 2012 through FY 2014.

### *95th/90th Percentile Facility Model*

One more option was modeled using a percentile methodology based on facilities. This model was based on input from the North Dakota Long Term Care Association. Their recommendation was to set the limits using the 95th percentile facility for Direct Care and the 90th percentile facility for Indirect Care. Tables 9, 10 and 11 list the parameters and results for this model.

Table 9: 95th/90th Percentile Facility Model, Parameters

| Parameters | Direct Care | Indirect Care |
|---|---|---|
| **Limit Type** | Percentile | Percentile |
| **Array Basis** | Facilities | Facilities |
| **Percentile** | 95% | 90% |

Table 10: 95th/90th Percentile Facility Model, Direct Care Limits

| | Direct Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Actual Limit** | **Cost Coverage** | **Homes Limited** | **Model Limit** | **Cost Coverage** | **Homes Limited** | **Fiscal Impact** |
| **FY 2012** | $40.62 | 97.27% | 15 | $74.13 | 99.41% | 2 | $287,421 |
| **FY 2013** | $44.07 | 96.43% | 16 | $71.03 | 98.62% | 2 | $289,327 |
| **FY 2014** | $42.23 | 97.59% | 16 | $79.88 | 99.82% | 2 | $292,059 |
| | | | | | **Combined Fiscal Impact** | | $868,807 |

Table 11: 95th/90th Percentile Facility Model, Indirect Care Limits

| | Indirect Cost Center | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Actual Limit** | **Cost Coverage** | **Homes Limited** | **Model Limit** | **Cost Coverage** | **Homes Limited** | **Fiscal Impact** |
| **FY 2012** | $36.81 | 94.43% | 17 | $63.33 | 97.25% | 3 | $315,743 |
| **FY 2013** | $38.92 | 94.53% | 19 | $55.31 | 97.79% | 5 | $399,129 |
| **FY 2014** | $38.82 | 97.45% | 18 | $51.95 | 99.29% | 5 | $192,214 |
| | | | | | **Combined Fiscal Impact** | | $907,086 |

This model had a much more drastic impact on cost coverage, the number of homes limited and fiscal impact. Cost coverage increased by about 2% for each cost center for each year, bringing it to over 98% in most cases. The number of homes limited by the cost center limits decreased significantly with only two homes being limited by the model in any year for Direct Care and only three to five facilities being limited in Indirect Care. The fiscal impact was also significant with this model, requiring an additional $1.7 million in reimbursement.

## D. Summary and Conclusions

### *Considerations Concerning the FY 2013 Limit Declines*

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 is tied more to 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.

### *Recapping the Advantages and Disadvantages of Different Limit Parameters*

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.

# VI. Basic Care Occupancy Limit Analysis

## A. Introduction

### *Rationale for Including a Minimum Occupancy Limit*

Another limit that is sometimes included in a per diem reimbursement system is a minimum occupancy limit. Such limits are used to encourage efficiency. The premise behind a minimum occupancy limit is that fixed expenses become less efficient when a provider has a lower census to spread those costs over. Therefore a minimum occupancy limit adjusts the resident days used as the divisor to a set percentage when actual resident days fall below that level.

Occupancy limits are most often applied to fixed costs. However, for this analysis all costs were included. Determining what costs to apply a minimum occupancy limit to would require further policy consideration.

### *North Dakota Occupancy Limit Example*

The North Dakota nursing facility reimbursement system includes a minimum occupancy limit of 90% for indirect care and property. If a facility falls below 90% occupancy during a cost report period, the resident day total is adjusted up to 90%. To illustrate consider a home with 100 beds. In a typical year that home could provide 36,500 days of care (365 x 100). If that home had an average occupancy of 80% for the year they would have provided 29,200 days of care (36,500 x 80%). If their property costs during the year total $292,000, then their per diem property costs would be $10.00 ($292,000/29,200). Without a minimum occupancy limit their per diem reimbursement for property would be $10.00 per resident day.

However, since the nursing facility reimbursement system includes an occupancy limit the per diem reimbursement would actually be less than $10.00. Instead of dividing the total property costs by 29,200 the system would divide by 32,850, or 90% of the resident days this facility could have provided (36,500 x 90%). Thus the per diem reimbursement would actually have been $8.89 ($292,000/32,850). With a minimum occupancy limit, total costs are always divided by the greater of the actual resident days or the minimum occupancy days as determined by multiplying the minimum occupancy rate by the total resident days that could have been provided. Thus when a minimum occupancy rule is triggered it encourages providers to maintain a higher level of efficiency.

### *Determining Appropriate Levels for Occupancy Limits*

Generally an occupancy limit is set relative to the average occupancy of a group of providers. This allows market factors that may be affecting occupancy rates to also influence the benchmark used for the limit. The limit is usually set near the average occupancy but seldom above it. In the case of the North Dakota nursing facility occupancy limit, it is set a couple of percentage points below the average occupancy rate (92.51%). The average occupancy rate for Basic Care Assistance Program (BCAP) facilities is 83%. Therefore, it would seem that an occupancy limit should not be set higher than about 80%.

### *Unique Circumstances to Consider with BCAP Facilities*

There are some unique circumstances that impact BCAP occupancy rates and that should be considered if a minimum occupancy limit were to be implemented. Most importantly, since an occupancy limit has not existed for this provider group there are many homes that have very low occupancy rates. According to 2012 cost report data, 14 facilities (out of 52) had an occupancy rate below 70%. Six of these were below 50%, and one home had an occupancy rate of just over 10%. A factor that contributes to the lower BCAP occupancy rates is that nursing homes can convert their beds to BCAP beds and thus help themselves stay above the nursing facility occupancy limit. This may be adding beds to the BCAP program even if they will not be used. Before any occupancy limit is imposed for BCAP facilities, these factors need careful consideration.

## B. Occupancy Limit Analysis

### *Modeling*

In order to investigate the potential impact of adding an occupancy limit requirement to the BCAP reimbursement methodology, a model was utilized to determine the fiscal impact of setting a minimum occupancy limit at various percentages. For this investigation the other rate setting parameters were not changed. Five different occupancy limits were tested; 50%, 60%, 70%, 75% and 80%. The table below shows the results of these different scenarios.

**Table 12: Minimum Occupancy Limit Modeling**

| Occupancy Limit | Homes Impacted | Fiscal Impact | Direct Care Limit | Direct Cost Coverage | Homes Limited Direct | Indirect Care Limit | Indirect Cost Coverage | Homes Limited Indirect |
|---|---|---|---|---|---|---|---|---|
| **0%** | **0** | $0 | $42.23 | 97.66% | 17 | $38.82 | 97.52% | 18 |
| **50%** | **6** | -$89,539 | $42.06 | 96.99% | 21 | $38.82 | 97.00% | 18 |
| **60%** | **9** | -$165,485 | $42.06 | 96.37% | 21 | $38.82 | 96.52% | 18 |
| **70%** | **14** | -$281,721 | $41.87 | 95.61% | 22 | $38.30 | 95.72% | 21 |
| **75%** | **19** | -$505,412 | $40.76 | 94.51% | 23 | $35.74 | 94.19% | 24 |
| **80%** | **23** | -$629,632 | $40.76 | 93.65% | 23 | $35.64 | 93.40% | 24 |

The impact listed is understated because the modeling did not adjust the reimbursement for property or room and board components of the BCAP rates.

### *Facilities Impacted by Occupancy Limit*

As one would expect the higher that the occupancy limit is set the more facilities there are that are affected by the occupancy limit rule. An occupancy limit of 50% would impact just 6 facilities, while an occupancy limit of 80% would affect 23 facilities. The total fiscal impact also increases as the occupancy

limit is raised. At 50% the occupancy limit has a fiscal impact of approximately $90,000. That increases every time the occupancy limits is raised reaching $630,000 for an occupancy limit of 80%. The most significant change in the fiscal impact occurs from moving the occupancy limit from 70% to 75%. This increased the fiscal impact by over $220,000. There are also other indirect impacts of adding an occupancy limit.

### *Effect on Cost Center Limits and Cost Coverage*

Cost center limits might also be changed by adding an occupancy limit to the BCAP reimbursement methodology. Since an occupancy limit can change the per diem cost for a facility it can change the Direct Care and Indirect Care arrays used to set the cost center limits. This kind of shifting can alter where the limits are set. Table 12 illustrates this by showing that the limit for Direct Care would decrease if a 50% occupancy limit were added to the methodology. The Direct Care limit drops even further when the occupancy limit is set to 70% or 75%. The Indirect Care Limit would drop if an occupancy limit was set at 70%, 75% or 80%.

Another statistic to consider with this analysis is the cost center cost coverage. Cost coverage for Direct Care under the current rate parameters is 97.66%. Cost coverage decreases with each incremental increase in the modeled occupancy limit. With an occupancy limit of 50%, cost coverage falls to 96.99%, and if the occupancy limit were raised to 80% cost coverage falls to 93.65%. The same experience would occur for Indirect Care with cost coverage starting at 97.52%, declining to 97.00% with a 50% occupancy limit, and falling to 93.40% with an 80% occupancy limit. Cost coverage statistics provide some measure of the adequacy of reimbursement rates and should be reviewed in the process of adjusting the reimbursement methodology.

## C. Summary and Conclusions

There are reasons for adding a minimum occupancy requirement to the 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 were added, these factors should be considered and implementation might need to be phased in over a period of a few years.

There are also reasons to consider revising the cost center limit calculation methodology for Direct Care and Indirect Care. The current limit methodology prevents all homes from getting their full costs reimbursed even if cost differences between providers are relatively small. There is also concern that the limit methodology may have caused a decrease in the limit for the most recent fiscal year.

### *Observations and Recommendations on Basic Care Reimbursement Limits*

Observation: Adding a minimum occupancy limit to the BCAP reimbursement methodology would have a fiscal impact but could be 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.

Observation: 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.

Observation: 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.

# VII. Recommendations for Adding Quality Measures to NF Rate Methodology

## A. Introduction

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.

CMS defines P4P or value based purchasing as the use of payment methods and other incentives to encourage quality improvement and resident-focused high value care. P4P should, in theory, encourage providers to invest in better quality of care.

States have been experimenting with nursing home P4P programs dating back nearly three decades. Most early P4P programs were unsuccessful and ultimately abandoned (Briesacher, Field, Baril, & Gurwitz, 2009). 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 (CO, GA, IN, KS, MD, MN, NV, OH, OK, UT, AND VT) (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).

### *Performance Measures*

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.

The following table lists typical pay for performance dimensions, possible measures used in the dimension and data sources that could be used to obtain the data.

Table 13: Pay for Performance Dimensions, Measures and Data Sources

| Dimension | Measure | Typical Data Source |
|---|---|---|
| Staffing | Nurse and other direct care staffing levels (hours per resident day); staff retention or turnover rate; use of pool or contract staff; DON retention; Administrative retention; | Cost Report |
| | Staff satisfaction with work environment, management, relations with other staff, teamwork, training opportunities, and organizational culture | Staff satisfaction survey |
| Nursing Home Inspection | Scope and severity of deficiencies in clinical care, resident quality of life, resident rights, dietary services, and physical environment, or other services | Nursing home inspection data |
| Clinical Quality Indicators | Nursing home quality measures (QMs) such as pressure sores, physical restraints; decline or improvement in ADLs, etc. | Minimum Data Set (MDS) |
| Resident Quality of Life | Resident self-perceived quality of life | Quality of life survey |
| Consumer Satisfaction | Resident or family satisfaction with nursing home services, environment, staff and quality of life | Resident or Family satisfaction survey |
| Resident-Centered Care | Enhanced dining, flexible and enhanced bathing, flexible daily schedule, end of life program, private resident rooms, neighborhood/households, and consistent staff assignment | Specialized surveys |

For existing systems, the main data sources for the measures are the MDS, nursing home inspections, consumer or employee surveys, and facility cost reports or other administrative systems. Some states such as Minnesota have homegrown systems that rely on state-designed performance measures, special surveys, and/or reporting mechanisms, while other states such as Georgia use a commercial product like My InnerView for at least some performance measures.

STAFFING AND RELATED MEASURES – In current state pay for performance programs, quality measures tied to direct care staffing level have been a significant part of the measures. Staffing level (hours per resident day), turnover and retention rates, use of pool staff and other quantitative measures are derived from Medicaid cost reports or other administrative systems. Arriving at accurate and fair measures of staffing

is complicated because of variation in the mix of licensed and unlicensed staff and the types of residents being served in different facilities. Minnesota weights staffing hours according to average statewide direct care wage levels and then adjusts the weighted hours by facility acuity. Employee turnover and retention rates and use of pool or contract staff also require accurate measurement (Castle, 2006). Three states conduct employee satisfaction surveys (GA, OH, and OK). Direct care staff satisfaction relates broadly to care quality (Castle, 2007; My InnerView, 2007b); however, staffing surveys may be subject to gaming, i.e., facilities placing pressure on employees to report satisfaction with their work. Some states track administrator or director of nursing turnover as indicators of continuity in facility leadership. Indiana is studying the feasibility of indicators for medical director training and certification and the amount of time spent performing medical director duties each month.

REGULATORY FINDINGS – Care deficiencies uncovered through nursing home inspections are potentially fruitful performance measures. Some states calculate a summary quality score based on the number, scope and severity of care deficiencies. Other states typically allocate points according to a threshold such as few or no serious deficiencies. Nursing home inspection data has been criticized because of inconsistency in survey practices and rates of citations between states and regions within states (Harrington & Carrillo, 1999; Harrington, Mullan, & Carrillo, 2004). Nonetheless, consideration should be given to maintaining consistency between P4P reimbursement systems and state regulatory efforts. In fact, CMS has required states to include some evaluation of regulatory findings in the process of determining P4P reimbursement.

MDS-BASED QUALITY MEASURES –Quality Measures (QMs) derived from the Minimum Data Set (MDS) have been applied widely in public reporting and quality assessment. They have been critiqued from both clinical and methodological perspectives (Arling, Kane, Lewis, & Mueller, 2005; Mor, 2005; Mor, Angelelli, Gifford, Morris, & Moore, 2003; Mor, Berg, et al., 2003; Schnelle, Osterweil, & Simmons, 2005; Zimmerman, 2003). Most states rely on the Centers for Medicare and Medicaid Services' (CMS) QMs reported on Medicare's Nursing Home Compare web site, although the CMS QMs have minimal risk adjustment and are likely to contain missing information for smaller facilities (Arling, Lewis, Kane, Mueller, & Flood, 2007; Mor, Berg, et al., 2003; Mukamel, Glance, et al., 2008). In 2012, CMS implemented the new MDS 3.0, and as a result of the change in the assessment tool redefined and implemented revised quality measures in October 2012. This was necessary due to the fact that certain items needed to calculate the quality measures were no longer available, items that could be used in differing quality measures were added and differing care standards had been incorporated.

RESIDENT AND FAMILY SATISFACTION – Several states conduct surveys to gather data on resident or family satisfaction. They rely on established instruments (Ejaz, Straker, Fox, & Swami, 2003; Grant, 2004; Lowe, Lucas, Castle, Robinson, & Crystal, 2003; MyInnerView, 2007a; Richards & Uman, 2007; Sangl, et al., 2007; Straker, Ejaz, McCarthy, & Jones, 2007; Tornatore & Grant, 2004). Minnesota also conducts a resident quality of life survey (R. A. Kane, 2003; R. A. Kane, et al., 2003; R. L. Kane, et al., 2004). Some states rely on paper survey forms distributed to residents or families and then returned to a central location. Response rates with this method can be relatively low and may be biased toward healthier cognitively intact residents. In contrast, Minnesota and Ohio conduct in-person quality of life and

satisfaction interviews with a probability sample of residents in each facility. Questions are in a simple format that can be completed by all but the most cognitively impaired residents; only 15 percent of residents are screened out. The survey has an average 87 percent response rate.

The time it takes to answer a resident's call light in North Dakota was a concern identified by a stakeholder. Resident satisfaction surveys collect this type of information. Today's technology can also evaluate these issues. Nursing facilities that have eliminated the standard call light system and implemented nurse pagers collect data on many of these concerns, which can be analyzed to develop quality improvement programs. The system collects data on when the call light was pushed and how long it took the caregiver to respond to the light. Having this data available could improve the response time to calls and support the action the facility has taken to make sure lights are being answered in a timely manner. Several states have required that the over-head pagers be discontinued and used only in emergency situations and replaced with the pager systems that can analyze caregiver response times and supports a more home-like environment.

ORGANIZATIONAL MEASURES OF QUALITY – Some states have attempted to go beyond conventional process or outcome measures in order to capture organizational dimensions of care, such as culture change, resident-centered care, percentage of private rooms, and dispute resolution. Minnesota is developing a measure of facility discharge rates from nursing facility to community in order to emphasize community transitions and re-balancing between nursing facility and community-based care. Colorado and Kansas have person-centered care measures included in their current P4P programs. In these two states the providers report to the state the status of their programs and the state verifies the submitted information with onsite visits. The state of Ohio has also developed person-centered components in its program and providers submit program status on a state web-site. Currently in Ohio, the state does not verify the information the provider has reported.

ACCESS AND OPERATING EFFICIENCY - Several states have performance measures for access to care, e.g., percentage Medicaid days or licensure for special populations, and efficiency, i.e., occupancy rate. These measures are only indirectly related to quality and might be better handled outside the P4P system.

### *Financial Incentives and P4P System Design*

Payment, although not the only factor influencing provider behavior, is important. Providers should be adequately compensated for taking good care of all types of residents. Payment should provide opportunities for providers to share in the benefits of quality improvement and for consumers and purchasers to recognize quality differences based on best practices and resident outcomes and enable providers to coordinate quality care (Institute of Medicine Crossing the Quality Chasm).

All 11 P4P states offer financial incentives for better performance. The most common is a bonus or add-on to the per diem Medicaid nursing facility rate. In addition, some states offer financial rewards for recognized excellence in care quality (Vermont and Colorado); and one state (Minnesota) invests in facility capacity building by supporting facility-initiated quality improvement projects that are evidence-based and tied to established quality measures (Cooke, et al., 2010).

P4P must be designed to serve as a good financial investment for a state, given the enormous pressures on state budgets. A basic question from a state's perspective is therefore whether P4P will result in Medicaid savings, a break-even situation, or additional costs. The state might achieve savings through reduced Medicaid payments for residents whose health or functional status improves, particularly if the state has a case-mix reimbursement system, such as the Resource Utilization Group (RUG-III or RUG IV). The P4P also might counteract the apparent pattern of greater functional decline and behavioral problems in states where these conditions receive higher case-mix reimbursement (Bellows & Halpin, 2008a, 2008b). Other savings may come from lower nursing home utilization through re-balancing and increased community discharges. The P4P plan should identify areas of performance most likely to achieve savings and, if possible, model the fiscal impact of P4P.

P4P should present providers with a clear business case for investing in better care. Many providers will want evidence that quality pays before making the investment necessary to improve performance. The P4P system may have to counteract pressure from nursing facility investors to maximize profits by cutting operating costs regardless of their consequences for care quality (Kitchener, O'Meara, Brody, Lee, & Harrington, 2008).

P4P should align the interests of the state, nursing facility industry and other stakeholders. A conflict of interest can arise if savings to the state from improvements in quality or other areas of performance end up reducing facility revenue. Although better care should lead to lower costs, providers sometimes gauge a program more by its effect on revenue than by its effect on costs. The situation is further complicated because quality improvement strategies may have a greater financial impact on nursing home revenue from other payer sources such as Medicare, private health plans, or privately paying consumers. These payers might be the primary recipients of benefits, such as savings to the Medicare program from reduced hospitalizations of nursing home residents, yet not share in the expense of financial incentives (Grabowski, 2007).

P4P should equip providers with the tools to improve their performance including needed resources or expertise. Simply offering a financial incentive for better performance will probably not be sufficient for many providers; they may have the will to perform better but not know how to improve performance. The efficacy of many long-term care interventions is well established. Examples include intensive feeding (Remsburg, et al., 2001), fall prevention (Vu, Weintraub, & Rubenstein, 2006), bathing (Hoeffer, et al., 2006; Sloane, et al., 2004), and pressure sore prevention (Reddy, Gill, & Rochon, 2006). Yet, few of these interventions have been widely adopted by nursing facilities. Minnesota's Nursing Facility Performance-Based Incentive Payment Program is intended to build facility capacity for better performance (Cooke, et al., 2010).

P4P should motivate facilities at all performance levels to improve their performance. Facilities starting out as the best performers will be highly motivated to participate in P4P. Low performers have the most room to improve yet may lack the expertise to improve their performance or feel that too much effort would be required. A P4P system that reduced payment rates for poor performers might deny needed resources and fuel a sense of futility leading to even lower quality of care.

P4P should minimize negative or unintended consequences while maximizing secondary or spin-off benefits of quality improvement efforts. For example, providers could concentrate on areas of care that are part of the P4P system while neglecting other care areas. On the positive side, performance incentives may have a ripple effect with increased attention and commitment to areas such as resident-centered care leading to improved quality across the board (Farrell & Elliot, 2008).

P4P should be a part of a comprehensive approach to quality improvement and part of an overall strategy of expanded consumer information and a more consistent regulatory process. Nursing facility performance measures that are conveyed through public reporting systems can influence consumer demand and encourage better performance by providers (Mukamel, Weimer, Spector, Ladd, & Zinn, 2008), as well as serve as tools for quality improvement efforts. Nursing facility inspection results in addition to punishing poor quality care should figure prominently as performance measures in the positive incentive structure of P4P.

### *Capacity Building and P4P*

A major challenge in making P4P programs effective is building facility capacity to improve quality of care in response to financial incentive (Werner & Konetzka, 2010). An example of a P4P approach aimed at capacity building is Minnesota's Performance-Based Incentive Payment Program (PIPP). The PIPP program was established by the Minnesota Legislature in 2006 to provide performance-based incentive payments to support provider-initiated quality improvement projects. The PIPP has three major goals:

- Encourage providers to experiment with and adopt effective quality improvement programs
- Equip providers with the organizational tools to improve their quality
- Motivate providers to make an investment in better quality

The PIPP uses a competitive application process where providers identify a high priority area for quality improvement and develop an evidence-based approach for addressing that problem. Projects are time-limited (1-3 years) and providers are at risk for up to 20 percent of their project funding if they fail to achieve measurable outcomes. Project objectives are tied to the state's nursing home quality measures (QMs) or other quality performance measures. Providers are expected to sustain their improved outcomes beyond the project period through enhanced revenues or greater organizational effectiveness.

Minnesota has made a major investment in PIPP, having funded seventy individual or collaborative PIPP projects, representing approximately 180 facilities and total funding of more than $18 million per year. Two hundred and seventy nursing facilities (70 percent of the state's facilities) have submitted applications. Projects involve a wide range of interventions, such as fall reduction, wound prevention, exercise, improved continence, pain management, resident-centered care and culture change, and transitions from nursing facility to community.

### *Evaluation of P4P Systems*

As P4P systems are relatively new, evaluations of their success in improving quality have been limited. However, there have been some research and study that does suggest positive results in states that have implemented P4P. The following discussion highlights some of those areas.

- An unpublished study of the Iowa P4P system found general trends toward improvement in resident satisfaction, nursing hours, employee retention rates, and facilities with deficiency-free surveys from FY 2003-2005 (Arling, Knerr, & Ross, 2006). Valerie Cooke and her colleagues analyzed preliminary trends from the Minnesota system that showed significant improvement in several of the nursing home QIs (2004-2007) and quality of life/resident satisfaction scores (2005-2007).
- Researchers at the University of Kansas examined trends in nursing facility turnover rates before and after implementation of a Kansas nursing home P4P incentive to promote lower turnover (Dunton, et al., 2008). They found a decline in turnover rates during the pre-incentive period and then an increase after the incentive. They concluded that turnover might have been influenced more by labor market conditions, i.e., increases in employment opportunities coinciding with the introduction of the incentive, than by the P4P system. The design of the incentive tended to reward providers with historically low turnover rates while offering insufficient motivation for providers to improve.
- The Pacific Health Policy Group conducted a formative evaluation of the Oklahoma Focus on Excellence program (Pacific Health Policy Group, 2009). They carried out stakeholder interviews and drew information from experiences in other states. The evaluation pointed to weaknesses in the methods for setting performance thresholds, transparency of the quality scoring, and integrity of the data collection processes. They recommended setting higher and more challenging thresholds, rewarding sustained improvement, assigning higher weights to more important measures, offering more information to consumers on the Focus on Excellence web site, and introducing more controls and oversight of the facility data collection process.
- A report on Nursing Home Clinical Quality and State Medicaid Pay for Performance written by Kyle Bulka and Meghan Skira in December 2012 reported states with a P4P program had reductions in: physical restraints, pressure ulcers, pain, and urinary tract infections. They also found that the nursing homes did not have issues with other quality measures while focusing on those identified within the P4P programs. Data used for the report was from the MDS 2.0 completed from 2003 through 2010.

## B. Other State Pay for Performance Programs

Most states with P4Ps have developed point systems that reward additional dollars for a certain range of points. The payments are usually an add-on tied to a quality score. Quality results have been communicated to consumers and providers through both federal and state websites and report cards. The following details pay for performance initiatives in Colorado, Iowa, Minnesota, Indiana and Ohio.

### *Colorado*

The Colorado Nursing Facility Pay for Performance program began in 2009 to encourage and support the implementation of resident-centered policies and home-like environments. Each facility must submit an application by February 28 of each year to demonstrate its performance. Incentive payments are funded by a nursing facility provider tax that is guaranteed to be paid to nursing facilities as supplemental payments. Pay for performance measures have been developed in two domains: Quality of Life and Quality of Care. To participate in the quality incentive facilities must meet the participation criteria and submit an application that is desk reviewed for accuracy. A sample of applications is also selected for on-site field reviews.

Table 14: Colorado's 2014 Pay for Performance Application, Measures and Available Point Values

| Domain | Point Value (Maximum or Assigned) |
|---|---|
| ***Quality of Life*** | |
| *Resident Directed Care* | |
| Enhanced Dining | 3 |
| Flexible and Enhanced Bathing | 3 |
| Daily Schedules | 3 |
| End of Life Program | 2 |
| *Home Environment* | |
| Public and Outdoor Space | 3 |
| Communities | 5 |
| *Relationships with Staff, Family, Resident and Community* | |
| Consistent Assignments | 6 |
| Daily Living Environment | 2 |
| Volunteer Program | 2 |
| *Staff Empowerment* | |
| Care Planning | 6 |
| Career Ladders and Career Paths | 2 |
| Person-Directed Care | 4 |
| Hand in Hand Training | 7 |
| New Staff Program | 2 |
| ***Total Quality of Life Points Possible*** | 50 |
| ***Quality of Care*** | |
| Continuing Education | 6 (Max) |
| Quality Program Participation | 1 |
| Nationally Reported Quality Measure Scores | |
| Falls with Major Injury | 5 (Max) |
| Moderate/Severe Pain | 5 (Max) |
| High Risk Resident with Pressure Ulcers | 5 (Max) |
| Urinary Tract Infection | 5 (Max) |
| Antipsychotics | 5 (Max) |
| Reducing Re-hospitalizations | 3 |
| Medicaid Occupancy Average | 5 (Max) |
| Staff Stability | |
| Staff Retention Rate or Improvement | 3 |
| Director of Nursing Retention | 2 |
| Nursing Home Administrator Retentions | 2 |
| Employee Satisfaction Survey | 3 (Max) |
| ***Total Quality of Care Points Possible*** | 50 |
| ***Total Points*** | 100 |

There are currently 186 nursing homes in Colorado. The Colorado Department of Health Care Policy and Financing received applications from 119 of those homes by the 2013 deadline for the July 1, 2013 rate

effective date. The Public Consulting Group (PCG) was hired by CDHPF to review, evaluate, and validate the nursing home applications. The following table shows the amount of per diem add-on that was obtained for 2013.

**Table 15: Colorado's Calculation of the Pay for Performance Per Diem Rate Add-On**

| Calculation of the Per Diem Rate Add-On |
|---|
| 0 -20 points = No add-on |
| 21 – 45 points = $1.00 per day add-on |
| 46 – 60 points = $2.00 per day add-on |
| 61 – 79 points = $3.00 per day add-on |
| 80 – 100 points =$4.00 per day add-on |

Colorado also has two prerequisites for participation in the incentive program:

- No home with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for P4P.
- The home must perform a resident and family satisfaction survey. The survey must (a) be developed, recognized and standardized by an entity external to the home; and, (b) be administered on an annual basis with results tabulated by an agency external to the home. The home must report its response rate, and a summary report must be made publically available along with the home's state survey results.

Of 117 providers whose applications were ultimately reviewed by PCG in 2013, 5 received no add-on, 25 received $1.00, 21 received $2.00, 28 received $3.00 and 38 received $4.00 additional per day.

### *Iowa*

The Iowa Accountability Measures Incentive Program was implemented in 2002. It required all nursing facilities to participate in all measures except those related to resident satisfaction. It was composed on ten measures that included deficiency free surveys, regulatory compliance, case mix adjusted nursing hours, resident satisfaction, resident advocate committee, employee retention, occupancy rates, administrative costs, special licensure and Medicaid utilization. To qualify for the additional Medicaid reimbursement, the facility had to achieve a minimum score of 3 points out of a maximum available of 11. The additional Medicaid reimbursement was available in the following amounts:

**Table 16: Iowa Accountability Measures Incentive Program**

| | |
|---|---|
| 0 – 2 points | No additional reimbursement |
| 3 – 4 points | 1 percent of the direct care and non direct care cost component patient day weighted medians |
| 5 – 6 points | 2 percent of the direct care and non direct care cost component patient day weighted medians |
| 7 or more points | 3 percent of the direct care and non direct care cost component patient day weighted medians |

In 2002 the average incentive was $2.86 per day and in 2005 87 percent of the facilities received an incentive payment.

The Iowa Accountability Measures Incentive Program was redesigned and renamed the Iowa Pay for Performance Program effective July 1, 2010. The newly designed program was not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. The new program includes the following parameters.

**Table 17: Iowa Pay for Performance Program Criteria (the redefined and renamed Iowa Incentive Program)**

| | |
|---|---|
| **Domain 1 Quality of Life** | |
| Person-Directed Care | |
| | Enhanced Dining |
| | Resident Activities |
| | Resident Choice |
| | Consistent Staffing |
| | National Accreditation |
| Resident Satisfaction | |
| | Long-Term Care Ombudsman |
| | |
| **Domain 2 – Quality of Care** | |
| Survey | |
| | Deficiency-Free Survey |
| | Regulatory Compliance with Survey |
| Staffing | |
| | Nursing hours Provided |
| | Employee Turnover |
| | Staff Education |
| | Staff Satisfaction Survey |
| Nationally Reported Quality Measures | |
| | High-Risk Pressure Ulcer |
| | Physical Restraints |
| | Chronic Care Pain |
| | High Achievement of Nationally Reported Quality Measures |
| **Domain 3 - Access** | |
| Special Licensure Classification | |
| High Medicaid Utilization | |
| **Domain 4- Efficiency** | |
| High Occupancy Rate | |
| Low Administration Costs | |

Table 18: Iowa Pay for Performance Program Incentive Calculation

| Incentive Calculation | |
|---|---|
| The Iowa Medicaid Enterprise shall annually award points based on the measures achieved in each of the four domains. The maximum available points are 100. To quality for additional Medicaid reimbursement a facility must achieve a minimum score of 51 points. | |
| Score | Amount of Add-on Payment |
| 0-50 points | No additional reimbursement |
| 51-60 points | 1 percent of the direct care plus non-direct care cost component patient-day-weighed medians as subject to reduction |
| 61-70 points | 2 percent of the direct care plus non direct care cost component patient-day-weighed medians as subject to reduction |
| 71-80 points | 3 percent of the direct care plus non direct care cost component patient-day-weighed medians as subject to reduction |
| 81-90 points | 4 percent of the direct care plus non direct care cost component patient-day-weighed medians as subject to reduction |
| 91-100 points | 5 percent of the direct care plus non-direct care cost component patient day-weighted medians as subject to reduction. |

Since the redesign of the system, it has not been funded by the Legislature. So although it remains in regulation it has not been implemented in Iowa.

### *Minnesota*

The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (MDHS), collaborating with the University of Minnesota have implemented a quality program with two components - a report card and a Performance-Based Incentive Payment Program (PIPP).

The nursing home report card can be used to compare facilities on the following seven quality measures:

Table 19: Minnesota Nursing Facility Report Card Criteria

| |
|---|
| 1. Resident satisfaction and quality of life |
| 2. Quality indicators – clinical quality |
| 3. Hours of direct care |
| 4. Staff retention |
| 5. Use of temporary nursing staff |
| 6. Proportion of beds in single bedrooms |
| 7. State inspection results |

In addition to providing information to help consumers choose a nursing home, the report card is designed to promote a high standard of quality in all nursing homes across the state. It is anticipated that by publishing information about quality of care in nursing homes, all facilities will strive to get the best scores possible. Specific details on how the ratings are calculated are included in the following technical user guide http://nhreportcard.dhs.mn.gov/technicaluserguide.pdf .

The PIPP program connects performance-based incentive payments with quality improvement projects that capitalized on financial incentives while focusing facility efforts on tangible QI projects. Goals of the PIPP project are to:

- Provide better quality care more efficiently
- Encourage nursing facilities to experiment and innovate
- Equip facilities with organizational tools and expertise to improve their quality
- Motivate facilities to invest in better care
- Disseminate successful PIPP strategies throughout the nursing home industry

The PIPP program takes a grassroots approach to encouraging local organization to implement solutions to quality problems. Established by the Minnesota legislature and administered by the Department of Human Services, the eighth round of performance-based incentive payments will be implemented on or after July 1, 2014. Funding available to implement new projects under this provision for fiscal year ending June 30, 2015 is equal to approximately $3.1 million (state share).

Awards are made through a competitive application process. The quality improvement projects must identify the problem and develop evidence-based interventions that include a sustainability plan. Facilities can receive up to 5% of the per diem rate for 1 to 3 years to finance their project but must achieve identified outcome goals to keep the full payment. Providers are expected to sustain their improved outcomes beyond the project period through enhanced revenues or greater organizational effectiveness. Facilities completing projects can then apply for new projects.

PIPP projects can be in the following areas:

**Table 20: Project Areas for the Minnesota Performance-based Incentive Payment Program**

| | |
|---|---|
| Clinical | |
| | Fall reduction |
| | Strength training |
| | Sleep promotion |
| | Pain assessment and management |
| Psycho-social | |
| | Dance program |
| | Music therapy |
| | Behavior management |
| | Cognitive care |
| Re-balancing | |
| | Community transition skills |
| | Rehabilitation |
| Technology | |
| | Safe patient handling |
| | Call or alarm systems |
| | Environmental modifications |
| Organizational Change | |
| | Person-centered care |
| | Culture change |
| | Nursing assistant mentoring |

Minnesota has made a major investment in the PIPP by supporting 45 individual or collaborative projects, representing approximately 160 facilities and annual funding of approximately $18 million. The PIPP can serve as a model for other states seeking to promote nursing facility quality either in combination or in place of conventional pay-for-performance efforts.

Minnesota also had a quality add-on program that was discontinued in 2007 due to budget constraints.

### *Indiana*

July 1, 2013 Indiana implemented Value Based Purchasing ("VBP"), or Phase III of the move to incentive-based nursing facility reimbursement rates. Seventy five percent of the performance add-on is determined by state surveys, and the remaining 25% will depend on facility performance with staff retention, turnover, and nursing hours per resident day (see below).

Table 21: Indiana Value Based Purchasing Methodology

| VBP Quality Measures | 100 points possible |
|---|---|
| ***Report Card Score*** - Score derived from nursing home survey findings, as calculated by the Indiana State Department of Health. | 75 points |
| ***Nursing Hours per Resident Day*** - Nursing hours (RN, LPN, CNA) per resident day weighted by facility-specific wage rates by staff type and by total acuity | 10 points |
| ***RN/LPN Retention*** – Proportion of RNs/LPNs employed by the facility at the beginning of the year who are still employed at the end of the year. | 3 points |
| ***CNA Retention*** – Proportion of CNAs employed by the facility at the beginning of the year who are still employed at the end of the year. | 3 points |
| ***RN/LPN Turnover*** – Expressed as a ratio: Number of RNs/LPNs leaving employment during the year divided by the number employed at the beginning of the year. | 1 point |
| ***CNA Turnover*** – Expressed as a ratio: Number of CNAs leaving employment during the year divided by the number employed at the beginning of the year. | 2 points |
| ***Administrator Turnover*** – Number of Administrators employed by the facility in the prior 5 years | 3 points |
| ***DON Turnover*** – Number of Administrators employed by the facility in the prior 5 years | 3 points |

Facilities with 18 or fewer Quality Points will not receive any VBP payment, those with 84 or more points will receive the maximum payment of $14.30 per patient day, and those between 19 and 83 points will receive a proportional amount of the maximum $14.30 per patient day. The current estimated average payment across all nursing facilities, based upon 7/1/12 cost report data, is $8.52.

Originally part of the proposed VBP methodology, satisfaction surveys of residents, family and staff will take place between July and September 2013, but will not impact the VBP Quality Point calculation until July 1, 2014 at the earliest.

### *Ohio*

The Ohio pay for performance system is composed of twenty accountability measures, each of which is worth one point for a total of twenty points. In 2013 the nursing homes had to meet five measures to receive $16.44 per Medicaid bed. Future plans are that the nursing homes would eventually work to meet all 20 measure thresholds.

Table 22: Ohio Pay for Performance Accountability Measures

| | |
|---|---|
| **Framework** | |
| Resident Satisfaction (Face-to-face interviews) | 1 pt |
| Enroll in Advancing Excellence with 3 goals | 1 pt |
| Survey = No deficiencies greater than F on annual survey or complaint surveys | 1 pt |
| **Choice** | |
| 50% resident choice in dining at 1 meal/day (restaurant style, buffet, family style, open dining) | 1 pt |
| 50% of residents bathe when requested as they like | 1 pt |
| Score of 89+ - go to bed when you like and score of 76+ - choose when to get up (Family response – 88 and 75) | 1 pt |
| 75% residents included in care planning | 1 pt |
| **Clinical – Quality Measures (average 4 quarters preceding years calculated from survey agency, not CMS)** | |
| 4% Long-stay Pain | 1 pt |
| 9% Long-stay Pressure Ulcers | 1 pt |
| 2% Long-stay Physical Restraints | 1 pt |
| <10% Long-stay UTI | 1 pt |
| Document Hospital Admissions Policy to reduce hospital admissions and implement tool to track hospital admissions (INTERACT) | 1 pt |
| **Environment** | |
| 50% of Medicaid beds are private rooms | 1 pt |
| Accessible bathroom (Score of 4) | 1 pt |
| Turned off overhead paging (ER only) | 1 pt |
| Score of 90 for personalized rooms (95 family response) | 1 pt |
| **Staffing** | |
| Consistent assignment of CNAs No more than 8 CNAs/resident/30 days | 1 pt |
| Employee Retention Rate of 75% or greater (all employees) | 1 pt |
| CNA Turnover Rate at 65% or below | 1 pt |
| CNA (primary caregiver) participated in 50% of resident care conferences | 1 pt |

Providers report measures using the Quality Incentive Data Submission Tool, which must be completed by May 31 for the following July rate setting period.

Resident Surveys completed odd years through face-to-face interviews conducted by Vital Research. Ohio has 950 nursing homes with 27,000 residents and 600 assisted living providers with 11,000 residents, with an annual budget of $ 990,000. Family surveys are mailed out and tabulated by the state.

The incentive program was developed between August and December of 2011, and is funded by a reduction in Medicaid rates. There are no audits of the nursing homes supporting documentation for measures claimed. Rather, the state views the program as a “unifying” program and a consensus building process. A state supported website provides resources for every measure.

## C. Potential North Dakota Incentive Parameters

Most states have a point system that provides a bonus payment for achieving a certain level of points. Bonuses are the most common approach and are typically paid from a pool of Medicaid funds set aside for this purpose. They can be carved out of the current Medicaid budgets or provided through additional revenue such as a provider assessment or tax. Fixed payments can be paid to high performing facilities or varying payments paid in proportional to facility quality scores.

In the programs detailed above, there are a variety of indicators used and a variety of methods employed to calculate scores and award additional payment. Funding can be in addition to the base rate calculation or carved out from the rate, contingent on legislative approval (and not always funded) or obtained through a provider tax or assessment. Verification that a provider has met the established thresholds also range from self-reported in Ohio to field visits to check documentation in Colorado.

In a study prepared for the Washington State Legislature in May 2011, L&M Policy Research, LLC conducted interviews, stakeholder meetings and surveys to obtain input on criteria to include in a pay for performance program. The following table shows the result of that input:

**Table 23: Results of the Washington State Stakeholder Interviews Concerning Major Quality Dimensions to Include in a Pay for Performance Program**

| Major Quality Dimensions | | | | |
|---|---|---|---|---|
| | Yes | No | Maybe | No Response |
| Staffing | 41% | 22% | 37% | 0% |
| Consumer Satisfaction | 68% | 18% | 14% | 0% |
| Clinical Quality Indicators | 77% | 5% | 18% | 0% |
| Survey Performance | 23% | 59% | 18% | 0% |
| Culture Change | 41% | 32% | 27% | 0% |

**Source 1: L&M Policy Research Stakeholder Interviews (Note: Interviews were conducted on a wide variety of stakeholders representing single nursing homes, local and national nursing home chains, and nursing home associations. Interviews were also conducted with individuals involved in the implementation of P4P in nursing homes in other states: Iowa, Minnesota, Oklahoma, Utah, and Vermont.)**

Observation: The majority of those interviewed indentified Clinical Quality Indicators as an important dimension to include. There was however concern in distinguishing between clinical problems and issues endemic with the population or linked to a provider's service specialty. It was felt that a review of appropriate risk adjustments should be included.

The following table was included in the Interim Report and shows that North Dakota ranks below the national average of CMS quality measures in the following categories: residents with a urinary tract infection, residents with pressure ulcers, residents who lose control of their bowels or bladder, residents who were physically restrained, residents who lose too much weight and residents who receive antipsychotic medication.

Table 24: Comparing North Dakota Long Stay Quality Measures to National Averages

| Long-Stay Quality Measures<br>Comparing North Dakota to National Average | | |
|---|---|---|
| | North Dakota | National Average |
| Percent of long-stay residents experiencing one of more falls with major injury | 4.6% | 3.2% |
| Percent of long-stay residents with a urinary tract infection | 5.3% | 6.4% |
| Percent of long-stay residents who self-report moderate to severe pain | 10.3% | 8.5% |
| Percent of long-stay residents with pressure ulcers | 4.4% | 6.2% |
| Percent of long-stay residents who lose control of their bowels or bladder | 43.2% | 43.8% |
| Percent of long-stay residents who have/had a catheter inserted and left in their bladder | 3.3% | 3.3% |
| Percent of long-stay residents who were physically restrained | 0.6% | 1.5% |
| Percent of residents whose need for help with daily activities has increased | 16.0% | 15.6% |
| Percent of long-stay residents who lose too much weight | 6.8% | 7.6% |
| Percent of long-stay residents who have depressive symptoms | 6.8% | 6.4% |
| Percent of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine | 96.7% | 94.7% |
| Percent of long-stay residents assessed and given, appropriately, the pneumococcal vaccine | 97.1% | 94.6% |
| Percent of long-stay residents who received an antipsychotic medication | 18.6% | 21.3% |

**Recommendation 9:** The indicators for falls with injury, moderate to severe pain, increased need for help with ADL's and with depressive symptoms (although only slightly higher than the national average)might be ones to focus on in a pay for performance program.

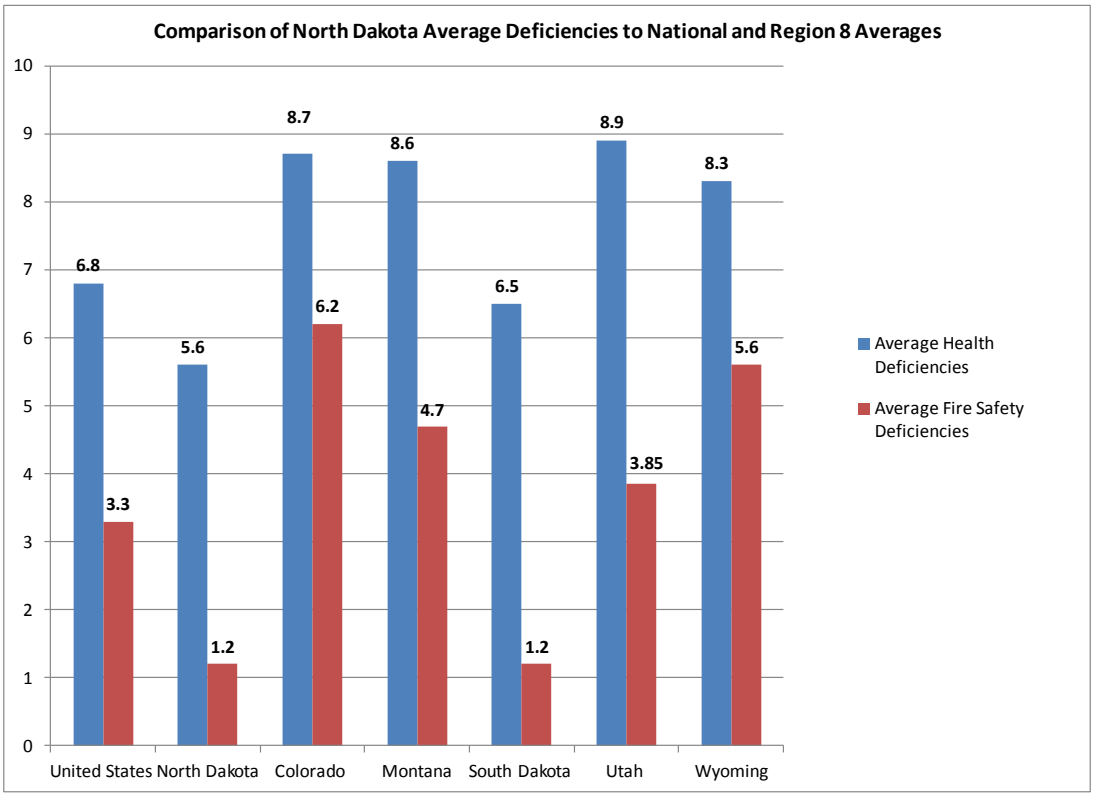
It should, however be noted that survey performance and deficiencies were a controversial measure in the Washington survey. Of the stakeholders that were interviewed, two factors were indentified that might lessen concerns with inclusion of survey results:

1. To benchmark results against Washington state providers only
2. The implementation of the computer assisted Quality Indicator Survey (QIS) process, which determines if Medicare and Medicaid certified nursing homes meet the Federal requirements

and is intended to improve consistency and accuracy of quality of care and quality of life problem identification by using a more structured process

Observation: It is anticipated that stakeholders in North Dakota may hold the same view. The following chart compares North Dakota survey results to national averages and to the other states in Region 8.

**Chart 5: Comparison of North Dakota Average Deficiencies to National and Region 8 Averages**



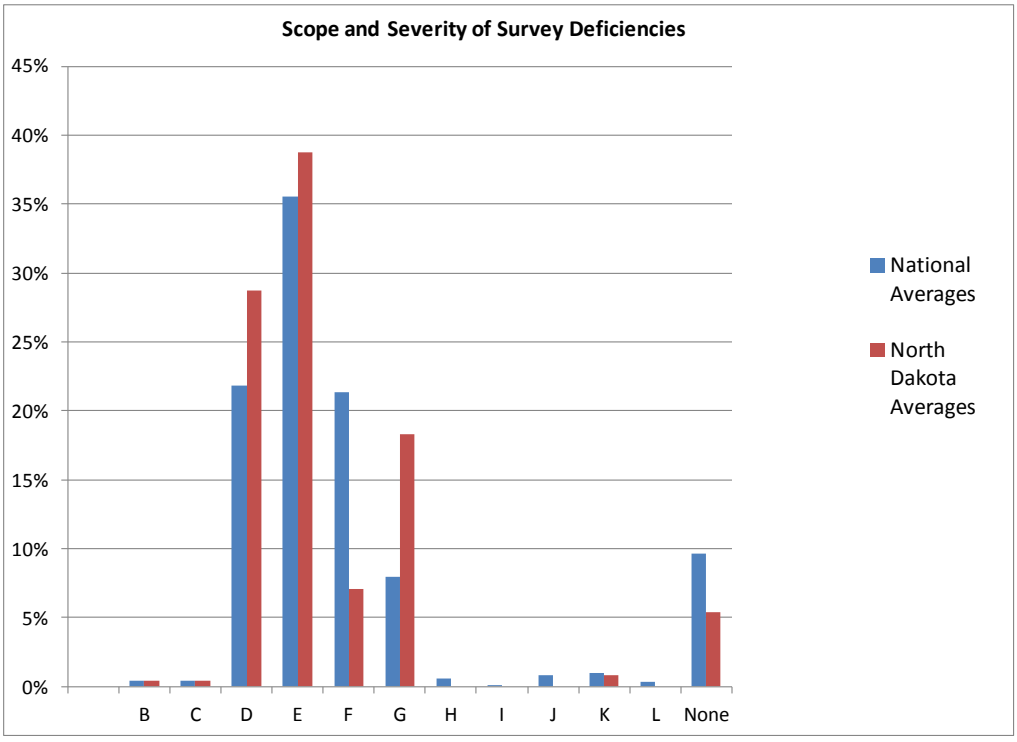

In terms of the total number of deficiencies, North Dakota ranks below both the national average and the average for all states in Region 8. However, when evaluating scope and severity of the deficiencies, North Dakota has fewer F level citations and more G level compared to the national average.

On the scope and severity grid an F level citation is one that is widespread but with no harm and with potential for more than minimal harm that is not immediate jeopardy. G level citations are isolated but represent non-compliance that results in a negative outcome that compromises the residents' ability to maintain or reach the highest practicable physical, mental and psychosocial well-being.

### Table 25: Scope and Severity Grid

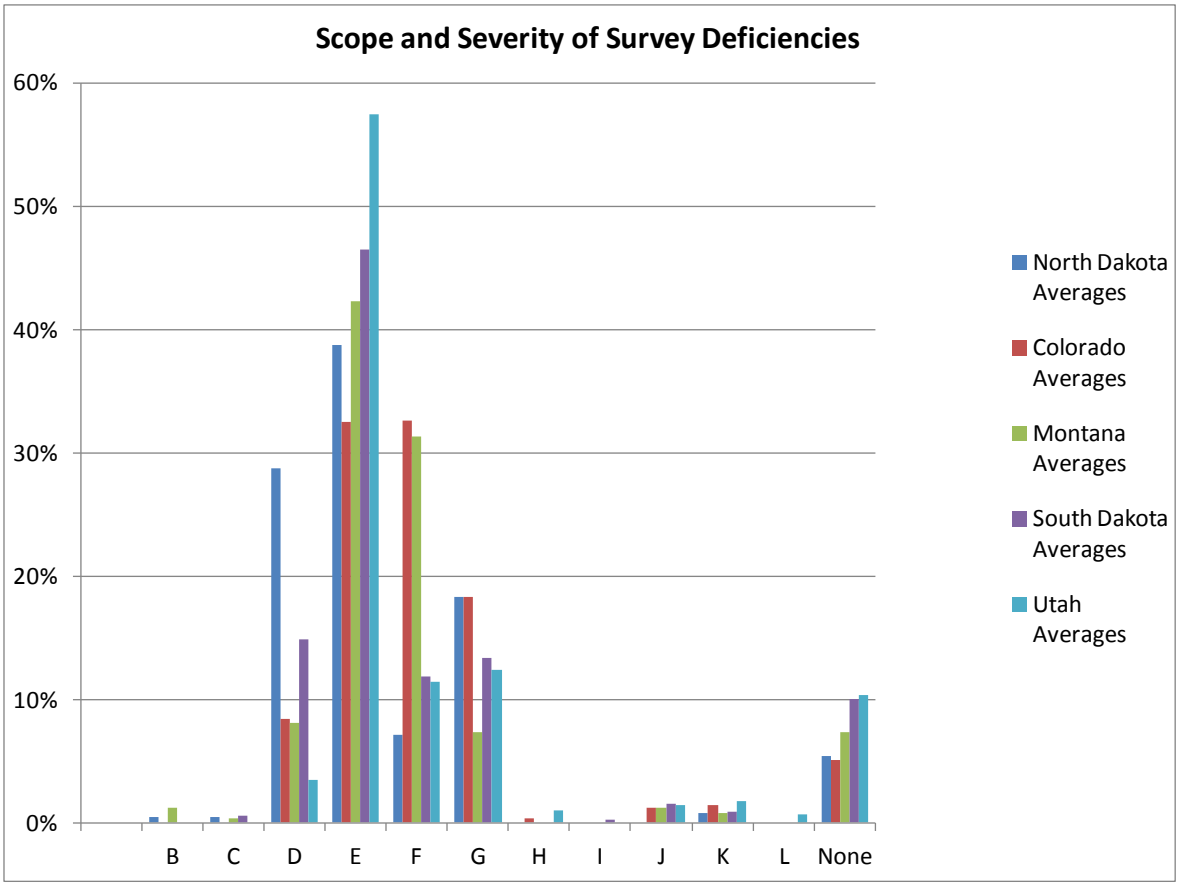
| Nursing Home Pro's Scope & Severity Grid | SCOPE | | |
|---|---|---|---|
| SEVERITY | Column 1 - Isolated | Column 2 - Pattern | Column 3 - Widespread |
| Immediate jeopardy to resident health or safety | J | K | L |
| Actual harm that is not immediate jeopardy | G | H | I |
| No actual harm with potential for more than minimal harm that is not immediate jeopardy | D | E | F |
| No actual harm with potential for minimal negative impact | A | B | C |

### Chart 6: Comparison of North Dakota Scope and Severity of Survey Deficiencies to National Percentages



There is a similar finding when comparing North Dakota nursing facilities to the facilities in Region 8. Colorado compares most closely with North Dakota for G level citations, coming in at 18.31% of the total deficiencies compared to North Dakota's 18.33%. This is interesting particularly since Colorado is the state that requires no substandard deficiencies as a prerequisite to participation in the P4P program.

**Chart 7: Comparison of North Dakota Scope and Severity of Survey Deficiencies to Region 8 Percentages**




**Recommendation 10:** North Dakota may not want to include survey results as a pay for performance indicator, or if included, might want to set the benchmark consistent with North Dakota-only findings. It is important to note that whatever criteria are included, CMS requires that any approved pay for performance program be consistent within the state. In obtaining approval for a state plan containing a pay for performance program, the state must identify how it will assure this consistency.

Consumer satisfaction was also identified among the Washington stakeholders as being very important to include in any pay for performance system.

Observation: Although consumer, family and staff satisfaction contributes much to the quality of care received and is an important factor to include in a pay for performance program, it is a measure that is more difficult to obtain and may have a significant price tag.

**Recommendation 11**: This indicator could be added to a pay for performance program after it has been implemented and in operation for a period of time such as in Indiana, spreading the development costs over a longer period or as a self performed function of the facilities such as Colorado's prerequisite.

One surprise in the Washington results was the lack of focus on culture change. Although providers supported the idea of culture change, there was concern about how the indicator would be developed, how it would be measured and if there would be sufficient dollars to fund the endeavor.

Observation: A broad of a range of indicators and limited funds for the add-on makes it difficult to effect positive change. Linking the incentive payment to a composite score may also allow providers to focus their efforts rather than attempting to measure all threshold levels.

**Recommendation 12**: Limit the number of criteria so that providers can effectively concentrate on making meaningful improvements. It is also important to recognize not only achievement at a particular threshold, but also improvement. Several states have awarded points either for achieving a particular threshold or demonstrating improvement from one period to the next. Indiana's award methodology for example is indexed so that all providers who meet the minimum criteria receive some incentive payment with providers meeting or exceeding the overall threshold receiving the maximum add-on.

Observation: To meaningfully impact change the volume of dollars distributed through a quality initiative may be large.

**Recommendation 13:** It is important to have some audit or review of provider submitted documentation. This does not need to be as extensive as the program in Colorado but should probably include some review outside of the impacted provider.

Summary Recommendation: As a state designs a pay for performance program, it is important to have the key stakeholders represented. State policy makers, industry representatives, consumer advocacy groups should be included in the discussions. A pay for performance program should address a broad range of quality issues. A good pay for performance 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 pay for performance program should be a part of a comprehensive approach to quality improvement.

# VIII. Policy Considerations to Help Eliminate Service Gaps in the LTC Continuum

## A. Licensure, Capacity, and Quality Measures

Although this final report includes an analysis of North Dakota's basic care facility and assisted living facility licensure requirements, the broader licensure debate is beyond the scope of this analysis insofar as it should be considered as part of an organized state strategy for providing services to North Dakota's elderly and disabled populations. States in which assisted living is highly regulated and that serve a significant percentage of its consumers of long-term care in community and residential settings have committed significant resources in developing service settings that will be utilized to offset a shift from reliance on nursing facility as the primary long-term care service option. In those states, resident eligibility criteria is clearly established and residents are regularly assessed to ensure that they are in a setting in which their care and support needs are being met. Additionally, reimbursement methodologies are more sophisticated and typically based on facility costs and may be tiered according to resident case mix/ staffing resources needed.

Given North Dakota's current heavy reliance on nursing facility services, it may make sense to consider changes other than or in addition to licensure that can similarly and positively assist in rebalancing efforts. Examples of these include: 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 Medicaid 1915 (c) waiver program and/or developing a section 1115 demonstration waiver or another Medicaid 1915 (c) waiver 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).

Based on available data, 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.

There are many examples of nursing facility reimbursement systems that incorporate quality measures. Some of these systems have been in place long enough that they have gone through one or more revisions. This provides some insight into selecting best practices to incorporate into a pay for performance program. One best practice is to set aside funding for the pay for performance program separately so that it can be allocated out specifically for this purpose. A point system is often used in determining how to allocate the funding to qualifying providers. This removes the funding from the

traditional program budget and also enables it to be funded through separate initiatives such as a provider tax.

Using a broad range of measures derived from various sources is also a preferred practice. Cost report data, survey results, resident assessment data, and consumer satisfaction surveys are all good sources of data that can be utilized.

Including survey performance in a pay for performance system is probably the most controversial question to resolve regarding the use of quality measures for reimbursement. Nonetheless, it is important to include some sort of review of survey results in the system to ensure consistency across the state's regulatory efforts. Since there are wide variations in survey results across the states it would be best to use only state data in setting up incentives related to this quality measure.

## B. Recommendations and Potential Options for Addressing Identified Service Gaps

As reported in the Interim Report performed for this study, stakeholders identified numerous program, service, and process issues within North Dakota's LTC continuum that were beyond the scope of this study. Rather, the focus of the Interim Report included the identification of several high-level gaps which are systemic and have significant implications on LTC service availability, accessibility, quality, processes, and/or rebalancing. Within that context, a gap was defined as a basic feature that is missing or not fully developed with respect to meeting the long-term care needs of North Dakota's elderly and disabled population, or a break in continuity in a process or between programs.

A brief recap of the gaps identified in the Interim Report is presented below, with each followed by a selection of recommendations or options that the state may wish to consider.

### *1. Consumer Education and Outreach*

Consumer and provider groups in North Dakota report confusion and general lack of awareness regarding available programs and services; who to contact and how to access programs and services; financial, and categorical eligibility criteria; and how to arrange for services for persons who need immediate services (for example, upon hospital discharge, for persons with episodic mental/ behavioral issues, etc.).

The results of our review find that the Department of Human Services website is not clear about the single point of entry contact or how to navigate within the LTC system. It requires significant effort to find available resources; and for a family member in a crisis looking for assistance in sorting out the full range of long term care service options, there is not an effective or efficient path that leads to the single point of entry contact to begin the process.

**Recommendation 14:** The Department of Human Services should review the website and current program materials, identify needed changes, additions and enhancements, and develop a strategy and timeline for implementation. This presents an opportunity to significantly enhance consumer education

and outreach with minimal expense and administrative effort. This may be accomplished either internally with external stakeholder review or by establishing a small workgroup made of consumer and provider representatives and state staff.

### *2. Service Point-of-Entry*

Three primary gaps have been identified within this feature of North Dakota's LTC continuum of programs and services.

First, North Dakota has two primary points of entry for most consumers to obtain information and access programs: the county social services offices and the ADRLs. The two entities have different responsibilities and may not be administered consistently between counties or regions, which creates a gap in service/program accessibility for consumers.

Secondly, Options Counseling does not provide a full array of screening functions. Counselors can only provide a list of options; they cannot help consumers and families with the paperwork, selection of programs and services, etc., which, according to those stakeholders who provided input to this study, is desperately needed. This appears contradictory to the functions outlined in federal resource materials.

Lastly, there is no streamlined application and eligibility determination process for persons who are in immediate need of services, often resulting in nursing facility placement as a first rather than last service option. This is especially evident for persons upon discharge from a hospital inpatient stay and for individuals with mental and/or behavioral health issues who may be relatively few in number but are in need of immediate placement and/or alternative treatment.

**Recommendation 15:** The Department should expand the services that can be performed through Options Counseling, as well as work with participating hospitals to educate discharge planners of the state's objectives for long-term care service delivery and nursing home placement alternatives. Note: the success of hospital discharge planning to community and residential services is highly contingent upon the availability of these non-institutional services. Therefore, it may be necessary to concurrently focus on growing community and residential provider capacity. This may be accomplished internally with external stakeholder review of by establishing a stakeholder workgroup to review service point of entry processes in other states, identify best practices, and recommend changes that will improve North Dakota's point of entry for its consumers of long term care services.

### *3. Systems Bias toward Institutional Care*

An initial assessment must be performed to determine whether an individual meets the level of care (LOC) criteria for nursing facility placement and Medicaid HCBS Waiver Programs. This initial assessment is typically referred to as a level of care (LOC) determination. And while Federal law does not prescribe post-admission LOC reviews, it does establish that Federal funding is available only for persons who meet and continue to meet institutional LOC. For this reason, many states require the performance of LOC determinations not only prior to or upon admission to a nursing facility, but also at least once annually thereafter to assure that individuals continue to meet nursing facility LOC criteria.

North Dakota requires LOC determinations to be performed only at the time of admission for nursing facility placements unless there is a potential for medical improvement. In contrast, additional LOC determinations must be performed on an annual basis for persons receiving HCBS services. This represents a difference in screening and review between the two programs. A person's care needs often fluctuate, and performance of a third party review assures that each individual's care needs are carefully re-evaluated regularly to affirm that they continue to receive the level of services needed in the least restrictive setting possible. Because annual LOC determinations are not required, an individual (particularly one with lower care needs) who resides in a nursing facility in North Dakota is denied the type of third party review that is extended to all other individuals who receive LTC services. Further, the nursing facility resident may be denied choice of services and unnecessarily remain in the facility when he or she no longer meets nursing facility level of care or has improved in condition such that care in a basic care or other community setting is now feasible.

**Recommendation 16:** North Dakota should implement an annual (and more frequently when changes occur) level of care re-determination of all nursing facility residents. Additionally, those annual level-of-care determinations should be performed by the state or by its designated contractor (an impartial third party reviewer) and not by the nursing facility. Note: this will result in an expansion in the number of level-of-care determinations performed and will likely have a fiscal impact to perform these reviews. This is, however, an essential element for a successful rebalancing of long-term care services.

### *4. Mental/Behavioral Health Programs*

There are not enough institutional or HCBS options for people with mental illness/behavioral issues. There are only two inpatient options for individuals in need of more intensive mental health services: two gero-psychiatric units, and the North Dakota State Hospital in Jamestown. Ex-SPED is the only community funding option for serving people in the long-term care continuum with mental health or behavioral issues. The state does not have specialized residential or Medicaid Waiver services or (reportedly) enough mental health providers to serve this population. It is however, important to point out that the 2013 Legislature authorized the Department to open another gero-psychiatric unit within a nursing facility based on the need for services.

The North Dakota Department of Human Services operates eight regional human service centers throughout the state. The centers provide an array of community-based services, either directly or through contracted providers, which include mental health services. The centers are also the access point for admissions into the State Hospital.

The lack of options represents a gap in service options for persons with mental illness and behavioral health needs, with implications not only for those persons, but also for their families, other consumers, providers, and the community at large.

**Recommendation 17:** The Department of Human Services should 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. Some states have made significant

progress in mental and behavioral health care, so the state should investigate best state practices and the potential to develop new services/programs or enhance existing programs and processes. This may also be facilitated in part through modifications to the Medicaid Rehab Option and development of a mental health waiver program such as for the seriously mentally ill. This may be accomplished internally with external stakeholder review or by convening a workgroup of stakeholders made of consumer/families, providers, the State Department of Health, and other state staff who are familiar with mental health services and processes.

### *5. Workforce Shortage and Retention Issues, Especially with Respect to Rural Communities.*

Economic conditions in the western part of North Dakota, as well as challenges typical to rural communities have created workforce recruitment and retention issues, which impact not only consumer choice and accessibility of services, but also ability to age-in-place, and provider sustainability.

These workforce problems are created by several factors: increased competition for employees, increases in cost of living expenses for workers driven by the influx of oil field workers, and workforce shortages created as workers relocate to other communities.

Although these issues similarly affect larger, institutional providers and small community providers such as Qualified Service Professionals (QSP), the impact is often quite different. Institutional providers respond to these workforce issues by increasing wages, offering retention and training incentives, and by hiring contract nurses and other staff. Small providers, such as QSP's, do not have similar options, and therefore often leave the community-based services work pool altogether to pursue higher paying employment opportunities or relocating.

**Recommendation 18:** These issues are linked to much broader infrastructure issues that are beyond the scope of this study. The Department is however encouraged to engage the University of North Dakota or other academic institutions, state agencies and others who specialize in workforce development and housing to begin or continue discussions regarding the development of an overall state strategy for addressing significant issues such as workforce development, and senior and low-income housing.

### *6. Transportation and Support*

Two primary gaps in transportation have been identified. The first is (reportedly) with respect to availability of transportation services and providers in rural areas, which is a common challenge for states. This involves not only development of qualified drivers to meet community needs, but also establishment of adequate reimbursement and outreach.

The second gap identified is less clear but nevertheless warrants attention. Several stakeholders identified the lack of reimbursement for a professional to accompany the consumer to medical and other health-related appointments to provide assistance during medical appointments, to help ask questions, to understand and remember treatment plans and changes in medication, etc.

**Recommendation 19:** Given the numerous times that this issue was cited by stakeholders as an obstacle to maintaining individuals in the community, the Department should identify and resolve any policy and process issues that present obstacles, as well as develop a proactive and concerted strategy to develop additional transportation providers, both as Medicaid-enrolled providers for Medicaid transportation and QSPs for non-medical transportation services.

### *7. Housing*

In North Dakota, housing is not a gap per se, but represents an area within the LTC Continuum which requires close attention both now and in the future. This is because of the extremely high number of older North Dakotans who live in the community (almost 95.8 %). Of those approximately 49 % live alone (US Census, AmerFF, 2012). This number exceeds the national average and represents a huge asset that the state should make every effort to preserve when refining its LTC Continuum of programs and services. Specifically, the high percentage of individuals already residing in the community represents housing costs which are paid privately rather than subsidized with public funds.

**Recommendation 20:** Since Federal funding sources generally prohibit any payment for room and board other than for institutional services, the state should 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 for as long as possible. This should include a review of waiver program service options, development of qualified service professionals (QSPs) and Medicaid transportation providers, especially in rural areas, involvement of Options Counselors, and expanded consumer and provider outreach and training.

### *8. Service / Program Review*

North Dakota does not have a comprehensive compliance approach for its LTC providers (both institutional and HCBS). Basic review programs can be utilized by states to positively influence compliance among providers; assure that consumer care needs are met in the least restrictive setting; assure that funds are properly allocated; identify and validate program and process problems; and identify training needs and provide additional momentum for rebalancing efforts. Indeed, if performed correctly, these reviews have repeatedly demonstrated their value and contribution within the overall LTC continuum through calculated returns on investment, identification of process issues, provider problems, billings for services not delivered, training needs, staffing concerns, and identification of needed changes and improvements, and to preserve availability of Federal Financial Participation (FFP).

In addition to implementing and performing level-of-care reviews for nursing facility residents according to the same criteria applied for individuals who are on the HCBS Waiver Program (Recommendation 16), additional or expanded quality assurance reviews should be considered as follows.

NURSING FACILITY MDS REVIEWS – This verification process assists in ensuring integrity of the data used in rate determination. It is an important compliance tool for states that case-mix adjust their rates and provides a needed check and balance to ensure that nursing facilities clearly understand MDS and

supportive documentation requirements and self-initiate MDS record assessment changes within prescribed timelines.

**Recommendation 21:** The more responsive a rate system is to individual MDS responses, the more important a review process becomes. North Dakota currently performs these onsite reviews on a limited basis but should expand the number and frequency of these reviews. This will be even more important if the state also implements pay for performance measures based on the MDS.

COMMUNITY BASED PROVIDER REVIEWS – States may incorporate within their HCBS review functions the performance of desk-top and on site Waiver Program reviews to review provider documentation and validate that services are delivered according to individual care plans and that services are billed properly.

**Recommendation 22:** North Dakota currently has two individuals who perform this type of review. The Department should evaluate whether the number and scope of the reviews that are currently being performed are sufficient to satisfy minimum quality assurance standards or whether additional staffing resources are needed. The Department should also consider expansion of review staff and functions in response to increases in services and/or the number of enrolled providers and individuals served.

CONSUMER SATISFACTION REVIEWS –There are clearly very different challenges in reviewing community-based services and provider compliance that do not exist in traditional, institutional settings. This is because many of the community-based services are provided in a private setting and with a single provider and are not independently observed and verified by a third party. This characteristic of non-institutional care presents unique challenges to state administrators both in terms of consumer safety, vulnerability, and risk, and in terms of improper billings for services never or not completely delivered.

**Recommendation 23:** To address these issues, particularly as North Dakota continues to rebalance services between nursing facility and HCBS, North Dakota should consider implementation of consumer interviews and satisfaction reviews either independently or as part of a broader on-site provider performance and documentation review.

# IX. Identify Applicable Medicaid State Plan Amendment Changes, Waiver Amendments, and Regulatory Changes

The primary focus of this Final Report is on general policy review and analysis of state licensing requirements and service gaps, long-term care bed capacity, basic care limitations, the addition of quality measures to the nursing facility rate methodology, and developing recommendations for consideration by the Department.

In most cases, the recommendations are fairly general and often present a number of options regarding how and to what extent they can be implemented. State Plan amendments, waiver amendments, and regulatory changes could all be necessary in order to adopt the recommendations. However, limited adoption of the recommendations might not require any amendments to the Medicaid State Plan, Medicaid Waiver, or State Regulations. Therefore it is difficult to identify applicable changes without first determining the scope of revisions.

There are a few of the recommendations that would require formal policy revisions even if they were only adopted on a limited scope. Chart 8 lists those recommendations that would clearly require revisions to the Medicaid State Plan, the Medicaid Waiver, or State Regulations. Appendix B provides a full list of all recommendations, report page references, recommendation descriptions, provider groups that might be impacted, and indicates where other policy changes might be necessary.

**Chart 8: Formal Policy Changes Required to Implement Recommendations**

| Rec# | Recommendation Description | State Plan Change | Waiver Change | Regulatory Change |
|---|---|---|---|---|
| 3 | Expand Medicaid & SPED assisted living utilization. | X | X | X |
| 7 | Set BC limits with median plus methodology | X | | X |
| 16 | Implement NF level of care reassessments | | | X |

# X. Conclusion

The conclusion of this Long Term Care Study of services and supports in North Dakota is that the state 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. The core elements are there, and include: Medicaid State Plan Personal Care Services, a Medicaid 1915(c) HCBS Waiver Program, residential services (basic care and assisted living), PACE, Money Follows the Person program, and two state-funded programs, SPED and Ex-SPED. 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 to shift the service balance away from the most expensive institutional forms of care toward more desirable and cost-effective community-based care. According to a 2012 AARP study, North Dakota had 58 people living in a nursing facility for every 1,000 people over age 65, compared to the national average of 35 per 1,000, ranking North Dakota number one among states.

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. According to the AARP Report, in 2010 North Dakota ranked the 50$^{th}$ lowest among states for the number of people in the 18-64 and 65+ age categories who have self-care and cognitive difficulties, and 9$^{th}$ highest among states for the number of people aged 75+ who live alone. From a public health and welfare standpoint, these two long-term care characteristics present North Dakota with huge social and financial opportunities that most states do not have. Namely, 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 community residential setting. Additionally, when considering the great expense associated with nursing home services and the desire of most individuals to remain in their own homes or alternative non-institutional setting for as long as possible, 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.

With respect to the very high percentage of North Dakota's elderly who already reside in nursing facilities, the lack of affordable and accessible senior congregate and other publicly-subsidized housing represents a significant challenge to any efforts (such as Money Follows the Person) to transition lower-needs residents out of nursing facilities and back into the community. This is a challenge particularly common among states and highlights the exceptional value in investing funds and resources to expand community service options and divert persons from institutional placement whenever possible.

To address all these issues and promote a strong long-term care services continuum for North Dakota, it is essential that the state develop a comprehensive rebalancing strategy that will establish achievable goals for its long-term care continuum that will be more responsive to consumer choice and simultaneously re-direct limited funding to less expensive, non-institutional long-term care service options. This becomes even more critical as North Dakota and all states brace themselves for the influx of the baby boom generation into the long-term care service delivery system and other safety net programs. Today, 10,000 baby boomers will turn 65, and this will continue every day for the next 16 years [Pew Research Center, 2010]. In the early 2020s, these thousands of boomers will begin entering their mid-70s and their likelihood of need for long-term care will increase rapidly. This cohort is likely to demand a broader range of options for care and greater flexibility in how and where those options are delivered. States need to begin planning now to avert a future human, financial and political crisis.

To achieve this, the state will need to carefully examine North Dakota's existing community-based and residential care options and brainstorm with consumers and providers to develop a reasonable strategy for expanding the availability of and access to community based, assisted living, and basic care facility for the low-income elderly and disabled populations. This can be accomplished in many ways, and may include:

- Changes in regulation
- Changes in licensure requirements for residential care facilities
- Development/implementation of new Medicaid waiver programs and/or expansion of existing waiver programs
- Re-evaluation of eligibility policies, including program criteria that continue to present obstacles to less-expensive service options
- Evaluation of best practices in other states to identify opportunities to improve services to elderly and disabled individuals with mental health and behavioral needs.
- Regular reviews of resident level of care and other assessment forms to ensure that they are accurate, responsive to change, and applied consistently among all service settings
- Improvements or expansions in compliance and review programs

Additionally, it is important to point out that a comprehensive long-term care continuum includes as one of its primary components a strong education and outreach strategy that will empower consumers to understand the full range of long-term care options available to them so that they can make informed choices, as well as develop a strong provider base. This should include a critical review of educational

materials, including program brochures, manuals, and website, to optimize ease of navigation and improve consumer understanding of options.

Finally, a strong long-term care continuum and long-term care rebalancing strategy must include strong program oversight and monitoring features designed to support individual choice to “age in place”, help them to maintain their dignity, yet assure their overall health, welfare, and safety. As resources are shifted out of traditional institutional forms of care, so too should the resources devoted to program monitoring. This should include: consistent and frequent care planning and assessments across all settings; home visits; documentation reviews; expanded ombudsman responsibilities; and more.

# XI. Appendix

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

# Appendix A: Comparative Analysis of Basic Care and Assisted Living in North Dakota

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Definition of Facility** | **Basic care facility (as defined in 23-09.3-01)** means a residence, not licensed under chapter 23-16 by the state department of health, 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 medical or nursing services and: a.) Makes response staff available at all times to meet the 24-hour/day scheduled and unscheduled needs of the individual; or b.) Is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility. **Basic care facility (as defined in 33-03-24.1)** means a facility licensed by the state department of health under North Dakota Century Code chapter 23-09.3 whose focus is to provide room and board and health, social, and personal care to assist the residents to attain or maintain their highest level of functioning, consistent with the resident assessment and care plan, to five or more residents not related by blood or marriage to the owner or manager. These services shall be provided on a twenty-four-hour basis within the facility, either directly or through contract, and shall include assistance with activities of daily living and instrumental activities of daily living; provision of leisure, recreational, and therapeutic activities; and supervision of nutritional needs and medication administration. | **DOH**:<br>NDCC 23-09.3-01.1<br>NDAC 33-03-24.1-01.5 | **Assisted living facility** means 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. An ALF does not include a facility that is a congregate housing facility, licensed as a basic care facility, or licensed under North Dakota Century Code chapter 23-16 or 25-16 or section 50-11-01.4. [An ALF in this chapter (23-9) includes a facility that is defined as an ALF in any other part of the code.] | **DHS:**<br>NDCC 50-32-01.1;<br>NDAC 75-03-34-01.1;<br>**DOH**:<br>NDCC 23-09-01.1 |

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Other Definitions** | Abuse; Activities of daily living; Activity staff; Adult day care services; Capable of self-preservation; Department; Facility; Governing body; Instrumental activities of daily living; Licensed health care practitioner; Medication administration; Misappropriation of resident property; Neglect; Personal care; Resident | NDAC 33-03-24.1-01 | Department; Entity; Individualized support services; Living unit; Medication management; Related by blood or marriage to the owner or manager | NDCC 50-32-01; NDAC 75-03-34-01 |
| **State Agency Responsible for Licensing Requirements** | State department of health | NDAC 33-03-24.1-03 | Department of human services; (state department of health for fire and food safety) | NDCC 50-32-02.3; NDAC 75-03-34-02.1; NDCC 23-09-16 |
| **Licensing Application** | Must be made prior to opening a facility, prior to change in ownership, annually, and upon determination be department that a facility meets the definition of a BCF. | NDAC 33-03-24.1-03.1 | Shall apply to the department of human services annually. The department shall notify a licensed ALF of the need to renew at least 30 days prior to expiration of that license. | NDCC 50-32-02.3; NDAC 75-03-34-02.1 |
| **Licensing Fee** | $10/bed | NDCC 23-09.3-05.1 | ALF must pay a licensing fee of $75 annually for each facility. | NDCC 50-32-02.2; NDAC 75-03-34-02.4a; NDCC 23-09-16 |
| **Resident Rights/ Written Agreement** | Governing body is also responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility, which shall address: … Resident rights which comply with North Dakota Century Code 50-10.2 [Health Care Facility Resident Rights]. | NDAC 33-03-24.1-09.2g | Maintain a written agreement with each tenant that includes the rates for rent and services provided to the tenant, payment terms, refund policies, rate changes, tenancy criteria, and living unit inspections. | NDAC 75-03-34-02.4b |

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Resident Complaints** | BCF governing body is also responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility, which shall address: … A process for handling complaints made by residents or on behalf of residents. | NDAC 33-03-24.1-09.2f | …**ALF shall** provide each tenant with written notice of how a tenant may report a complaint regarding the ALF, which includes the telephone number of the department's senior info-line and the address of the aging services division of the department. 1.) **The department of human services shall** receive complaints made by, or on behalf of, ALF tenants, shall forward complaints regarding ALFs to the appropriate agency, entity, or program for investigation, and 2.) shall request the agency to which complaints are referred to report to the department its findings and disposition of the complaint. The department shall establish a method to receive complaints related to ALFs and to forward the complaints to the appropriate agency for investigation. | NDCC 50-32-03.2:<br>NDAC 75-03-34-02.4c<br>NDAC 75-03-34-04 |
| **Licensure Period and Conditions** | An initial license is valid for a period not to exceed one year and shall expire on December 31st of the year issued. Licenses must be issued on a calendar year basis and expire on December 31 of each year. A license is not subject to sale, assignment, or other transfer, voluntary or involuntary. A license is not valid for any premises other than those for which originally issued. | NDAC 33-03-24.1-03.4<br>NDAC 33-03-24.1-03.5<br>NDAC 33-03-24.1-03.7 | License is valid for the calendar year in which it is issued. A license is not subject to sale, assignment, or other transfer, voluntary or involuntary or for any premises or entity other than those for which it was originally issued. | NDAC 75-03-34-02.5 |

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Application** | An application for licensure renewal must be received by the state department of health with sufficient time prior to the beginning of the licensure period to process. A provisional license… | NDAC 33-03-24.1-03.5<br>NDAC 33-03-24.1-03.6 | ALF must submit to the department of human services an application for renewal 30 days prior to the calendar year end. ALF is subject to the same reqts and has the same responsibility to furnish information for renewal as it did during its initial application. | 75-03-34-02.6 |
| **Licensure Display** | Facility shall display license in a conspicuous place. | NDAC 33-03-24.1-03.7 | ALF shall disply its license in a conspicuous place on its premises. | NDAC 75-03-34-02.7 |
| **# Residents / Living Unit** | | | No more than two people may occupy one bedroom of each living unit. | NDCC 50-32-02.5<br>NDAC 75-03-34-02.8 |
| **Licensure (Other)** | | | An entity may not keep, operate, conduct, manage, or maintain an ALF or use the term "assisted living" in its advertising unless it is licensed by the department of human services. | NDCC 50-32-02.1 |
| **Licensure (Other)** | | | Continuation of existing licenses | NDCC 50-32-02.1 |

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Inspections/ Compliance** | Upon receipt of an application for initial license, department may schedule an inspection. The department may at any time inspect a facility that meets the definition of a BCF. The facility must provide the department access to any material and information necessary for determining compliance with these requirements. | NDAC 33-03-24.1-03.3<br>NDAC 33-03-24.1-03.8<br>NDAC 33-03-24.1-03.9 | | |
| **Waiver Provision** | Department may waive licensure requirements for specified periods of time in specific instances, provided compliance with the requirement would result in an unreasonable hardship upon the facility and lack of compliance does not adversely affect the health or safety of the residents. | NDAC 33-03-24.1-04 | | |
| **Plans of Correction** | A BCF must submit a plan of correction within 10 days of receipt of notification of deficiencies. Plan of correction must address how each deficiency will be corrected, what the facility will put in place to assure continued compliance, and the date upon which the corrective action will be completed. The state department of health may accept, reject, negotiate modifications to, or direct the plan of correction (developed in coordination with the dept.). Correction of deficiencies must be completed within 60 days of the survey completion date, unless an alternative schedule of correction has been approved. Department shall determine what followup (telephone, mail, or onsite revisit) is necessary to verify the correction of deficiencies has been completed. | NDAC 33-03-24.1-05 | | |
| **Enforcement Actions/ Revocation of License** | Facilities are subject to one or more enforcement actions, which include a ban or limitation on admissions, suspension or revocation of a license, or a denial to license, **for the following reasons:** | NDAC 33-03-24.1-06 | Department of human services may deny or revoke license **if:** | NDAC 75-03-34-03 |

| | Basic Care Facilities | | Assisted Living Facilities | |
|---|---|---|---|---|
| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Enforcement Actions (Cont.)** | a.) Noncompliance related to: (f) fraud, deceit, misrepresentation, or bribery in obtaining or attempting to obtain a license; (g) knowingly aiding and abetting in any way the improper granting of a license. | NDAC 33-03-24.1-06.1.f<br>NDAC 33-03-24.1-06.1.g | a.) Application or renewal of a license or supporting documents contain fraudulent or untrue representations or if the license was issued based upon bribery or fraudulent or untrue representations; | NDAC 75-03-34-03.1 |
| **Enforcement Actions (Cont.)** | a.) Noncompliance related to: (b) Recurrence of the same or substantially same deficient practice in a 36 month period; (c) Failure to provide an acceptable plan of correction or to correct any deficiency pursuant to an approved plan of correction. | NDAC 33-03-24.1-06.1.b<br>NDAC 33-03-24.1-06.1.c | b.) ALF is in violation of this chapter or is unwilling or unable to conform to the requirements of this chapter; | NDAC 75-03-34-03.1 |
| **Enforcement Actions (Cont.)** | a.) Noncompliance… : (e) Gross incompetence, negligence, or misconduct in operating the facility as determined through department investigation or by a court of law. | NDAC 33-03-24.1-06.1.e | c.) ALF or the premises proposed is not or will not be maintained according to this chapter; | NDAC 75-03-34-03.1 |
| **Enforcement Actions (Cont.)** | | | d.) ALF is denied any license necessary under federal, state, or local law or such license has been revoked; | NDAC 75-03-34-03.1 |
| **Enforcement Actions (Cont.)** | a.) Noncompliance … : (d) Refusal to allow a survey of the facility by the department. | NDAC 33-03-24.1-06.1.d | e.) ALF refuses to allow the department access to any material or information necessary to determine compliance with licensing requirements; or | NDAC 75-03-34-03.1 |
| **Enforcement Actions (Cont.)** | | | f.) ALF demonstrates a pattern of failing to abide by the terms of its contract with tenants. | NDAC 75-03-34-03.1 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Enforcement Actions (Cont.)** | a.) Noncompliance which: (1) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time; (2) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or (3) Have a potential for jeopardizing resident health, safety, or security if left uncorrected. | NDAC 33-03-24.1-06.1.a | | |
| **Effective Dates of Enforcement Actions** | The effective date of the enforcement action must be 90 days from the date department notifies the facility in writing of the department's decision to initiate an enforcement action, unless the department determines there is imminent danger to the residents. | NDAC 33-03-24.1-06.2 | Except when conditions exist that present imminent danger to ALF tenants, the effective date of a revocation of a license shall be 30 days from the date the department provides written notification to the ALF of the decision to revoke the license. | NDAC 75-03-34-03.2 |
| **Enforcement Notifications** | The notice to the facility must include…. | NDAC 33-03-24.1-06.3 | The department of human service's revocation notice to the ALF must include… | NDAC 75-03-34-03.3 |
| **Enforcement Notifications (Cont.)** | If the department sustains the decision, department shall publish a public notice in the local newspaper not less than 15 days prior to the imposition of the enforcement action stating the name of the facility, the enforcement action to be imposed, the reason for the action, the date on which the enforcement action will be effective, and the length of time for which it will be imposed. The state department of health will also notify in writing the department of human services and the county social service office in the county in which the facility is located regarding the enforcement action. | NDAC 33-03-24.1-06.4<br>NDAC 33-03-24.1-06.5 | The ALF must notify all tenants and third-party payers of the department's revocation of its license within 15 days from the date of the final revocation notice. | NDAC 75-03-34-03.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Enforcement (General)** | | | Department of human services shall provide written notice of the need for a license to any individual, institution, organization, limited liability company, or public or private corporation that provides assisted living services or uses the term assisted living in its marketing which does not have a license issued by the department. | NDAC 75-03-34-05 |
| **Enforcement Fines** | | | 60 days after the written notification of noncompliance with annual licensing, department of human services may assess a fine of up to $50 per day against any individual, institution, organization, limited liability company, or public or private corporation that provides assisted living services or uses the term assisted living in its marketing without a license issued by department. | NDCC 50-32-02.3<br>NDAC 75-03-34-05.2 |
| **Reconsideration of Enforcement Actions** | Facility has the right to request a reconsideration of decisions resulting in enforcement actions. … | NDAC 33-03-24.1-07 | | |
| **Appeals** | A facility dissatisfied with the decision on a request for reconsideration may appeal… | NDAC 33-03-24.1-08 | | |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Governing Body** | The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure that overall operation of the facility in is compliance. It is also responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility, which shall address: … | NDAC 33-03-24.1-09 | | |
| **Staffing** | The governing body shall appoint an administrator to be in charge of the general administration of the facility. Provisions must be made for a staff member to be identified in writing to be responsible for the onsite operation of facility in absence of the administrator. Governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents 24 hours/day. | NDAC 33-03-24.1-09.4<br>NDAC 33-03-24.1-09.5 | | |
| **Fire Safety** | BCF shall comply with national fire protection association life safety code, 1988 edition, chapter 21, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety; hold monthly fire drills; annual fire drill; post fire evacuation plans; maintain written records of fire drills; conduct individual fire drill walk-through within 5 days of admission. | NDAC 33-03-24.1-10 | Must be licensed by the state department of health and meet requirements regarding: installation of smoke detection devices or other approved alarm systems; exiting; fire escapes; chemical fire extinguishers; elevator protections; sanitation and safety; drinking water standards; 2-year food safety inspections; inspection reporting to state fire marshal; failure to comply; penalty; and cancellation of license. | NDCC 23-09 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Staff Educational Requirements** | BCF shall design, implement, and document new employee and continuing employee educational programs, and provide annual inservice staff training. Administrator shall attend at least 12 CE hours/year relating to resident care and services, staff responsible for food preparation shall attend at least 2 dietary educational programs/year, and staff responsible for activities shall attend a minimum of 2 activity-related educational programs/year. | NDAC 33-03-24.1-11 | Each ALF shall require the administrator of the facility to complete 12 hours of continuing education per year. The ALF shall require all direct care staff to receive annual education or training in the areas of : Resident rights; Fire and accident prevention and training; Mental and physical health needs of tenants; Behavior problems and prevention; and Control of infection, including universal precautions. | NDCC 50-32-05 |
| **Resident Assessments and Care Plans** | An assessment is required for each resident within 14 days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly and must include: a review of health, psychosocial, functional, nutritional, and activity status; personal care and other needs; health needs: the capability of self-preservation; and specific social and activity interests. A care plan must be developed within 21 days of the admission date… and must be updated as needed, but no less than quarterly. | NDAC 33-03-24.1-12 | **Not directly specified.**.. Each ALF shall maintain a record for each tenant, which must include: (a) An initial evaluation to meet tenancy criteria; (b) The tenancy agreement signed by the tenant or the tenant's legal representative; (c) If applicable, a medication administration record that documents medication administration consisten with applicable state laws, rules, and practices; and (d) An itemized list of services provided for the tenant. | NDCC 50-32-05.3 |
| **Resident Retention and Storage** | A record of every individual admitted to any basic care facility must be kept at the place licensed by the owner or manager in the manner and form prescribed by the dept. Facility shall provide for secure maintenance and storage of all resident records, which must include…. Facility shall maintain resident records for at least 5 years from date of discharge or death. | NDCC 23-09.3-08<br>NDAC 33-03-24.1-13 | | |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Customer Satisfaction Survey** | | | At least once every 24 months, each ALF shall conduct a consumer satisfaction survey. The ALF shall provide each tenant with a copy of the results of the survey. | NDCC 50-32-05.5 |
| **Personal Care Services** | Facility shall provide personal care services to assist the resident to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. These services must include assistance with: ADLs and IADLs and observation and documentation of changes in physical, mental, and emotional functioning; arrangements to seek health care when the resident shows signs or describes symptoms of an illness or abnormality that needs treatment; arrangements for appropriate transfer and transport as needed; functional aids or equipment, such as glasses, hearing aids, canes, crutches, walkers, or wheelchairs, and clothing and other personal effects and maintenance of personal living quarters. | NDAC 33-03-24.1-14 | **Not directly addressed**. ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Pharmacy and Medication Administration Services** | 1.Facility shall provide assistance to the resident in obtaining necessary medications and medical services. 2. Facility shall provide a secure area for medication storage consistent with Chaper 61-03-02. a. A specific system must be identified for the accountability of keys issued for locked drug storage areas. b. Residents who are responsible for their own medication administration must be provided a secure storage place for their medications. 3. Medication administration services must be available for all residents. 4. All medications used by residents which are administered or supervised by staff must be: properly recorded by staff at the time of administration; kept and stored in original containers labeled consistently with state laws; properly administered. 5.) The resident's licensed health care practitioner, another licensed health care professional consistent with applicable state practice acts, or a consulting pharmacist shall review the medication regimen of each resident as needed, but at least annually. 6. A medication record need not be kept for those residents for whom authorization has been given by the licensed health care professional to keep their medication in their rooms and to be fully responsible for taking the medication in the correct dosage and at the proper times. | NDAC 33-03-24.1-15 | Medication management means providing assistance to an ALF tenant with prescribed medications. | NDAC 75-03-34-01.6 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Social Services** | Social services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate agency offering social services. | NDAC 33-03-24.1-16 | **Not directly addressed.** ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Nursing Services** | Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services. | NDAC 33-03-24.1-17 | **Not directly addressed**. ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Dietary Services** | Facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include: 1. A minimum of three meals each day. Meals must be nutritious and well-balanced in accordance with the recommended dietary allowances of the food and nutrition board of the national research council, national academy of sciences. 2. No more than a 14-hour span may exist between an evening meal and breakfast. 3. Snacks between meals and in the evening. These snacks must be listed on the daily menu. Vending machines may not be the only source of snacks. 4. Provisions for prescribed diets, if the facility accepts or retains individuals in need of such diets. a.) Facility shall provide for preparation and serving of prescribed diets. b.) Menus for prescribed diets must be planned and reviewed as needed by a professional consistent with North Dakota CC chapter 43-44. 5. Menus of food served, which must be kept for at least 3 months. 6. Preparation of food by methods that will conserve nutritive value and enhance flavor and appearance, and be served at the proper temperatures and in a form to meet individual needs. 7. Meals must be served to all residents in a dining room, except for residents with a temporary illness. | NDAC 33-03-24.1-18 | **Not directly addressed.** ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Activity Services** | There must be a planned and meaningful activity program to meet the needs and interests of the residents and encourage self-care and continuity of normal activities. This program must: 1. Be developed based on the activity needs and interests of each resident identified through the initial and ongoing assessments. 2. Develop and post a monthly group activity calendar, based on the individual interests identified, which lists social, recreational, and other events available to residents. 3. Activities must be available and provided to meet the needs of all residents during the day, in the evening, and on the weekend. 4. Assist residents with arrangements to participate in social, recreational, religious, or other activities within the facility and the community in accordance with individual interest and capabilities. | NDAC 33-03-24.1-19 | **Not directly addressed.** ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Housekeeping and Laundry Services** | Facility shall maintain the interior and exterior of the facility in a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents. | NDAC 33-03-24.1-20 | **Not directly addressed**. ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means services provided to an individual for the purpose of preventing disease and promoting, maintaining, or restoring health or minimizing the effects of illness or | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Adult Day Care Services** | 1. Facility must obtain approval from the state department of health to provide adult day services. 2. Use of existing space and equipment to deliver adult day care services is acceptable if this does not diminish the services provided to the residents of the facility and their needs being met. 3. Medications and treatments must be administered only by order of a licensed health care practitioner. 4. Records must be maintained of services provided to individuals participating in adult day care services. 5. An area allowing privacy for adult day care individuals must be developed to allow for rest periods. | NDAC 33-03-24.1-21 | **Not directly addressed**. ALF provides or coordinates individual support services provided to individuals who may require assistance with the activities of daily living of bathing, dressing, toileting, transferring, eating, medication management, and personal hygiene.<br>Entity may provide health services to individuals residing in an ALF owned or operated by that entity. For purposes of this section, health services means 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. | NDCC 50-32-04<br>NDAC 75-03-34-01.4 |
| **General Building Requirements** | Facility must be operated in conformance with all state and local laws, rules, and ordinances concerning fire safety and sanitation and according to specifications for: 1. Lounge and activity space; 2. All corridors and stairways; 3. Kitchen. Dietary areas and equipment must be designed to accommodate the requirements for sanitary storage, processing, and handling. 4. Dining area… 5. Resident bedrooms. …. 6. Toilet rooms and bathing facilities. …. 7. Adequate ventilation throughout… 8. Office spaces and other areas must be furnished with desks, chairs, lamps, cabinets, benches, worktables, and other furnishings essential to the proper use of the area. | NDAC 33-03-24.1-22 | Every ALF must be operated with strict regard for the health, safety, and comfort of its patrons. The following sanitary and safety regulations must be followed …. Certify that operation of its facility is in compliance with all applicable federal, state, and local laws and, upon request, make available copies of current certifications, licenses, permits, and other similar documents. | NDCC 23-09-09<br>NDAC 75-03-34-02.4.d |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Surveys** | SDH shall establish standards for BCFs. SDH shall inspect all places and grant annual licenses to BCFs as conform to the standards established and comply with the rules prescribed, as provided in this chapter. The dept shall implement a survey process for BCFs which for purposes of the life safety portions of the survey, all surveys must be announced; and which for purposes of complaints related to health and life safety, all surveys must be unannounced. As part of the survey process, dept shall develop, in consultation with BCFs, and shall implement a two-tiered system of identifying areas of noncompliance with the health portions of the survey. Dept shall prosecute all violations of this chapter. | NDCC 23-09.3-04 | | |
| **Resident Admissions - Restrictions** | A BCF may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning. A BCF may admit or retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements. | NDCC 23-09.3-08.1 | | |

| | Basic Care Facilities | | Assisted Living Facilities | |
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| **Licensure Requirements** | **Description** | **Regulatory Authority** | | **Regulatory Authority** |
| **Moratorium on Expansion of Bed Capacity** | BC beds may not be added during the period between 08/01/2013 and 07/31/2015, except when: a.) NF converts NF beds to basic care; b.) An entity licenses bed capacity transferred as BC bed capacity under section 23-16-01.1; c.) An entity demonstrates to the SDH and DHS that BC services are not readily available within a designated area of the state or that existing BC beds within a 50-mile radius have been occupied at 90% or more the the previous 12 months… d.)SDH and DHS grant approval of new BC beds to an entity. The approved entity shall license the beds within 48 months from the date of approval. More on BC bed transfers and tribal facilities… | NDCC 23-09.3-01.1 | NA | NA |

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## Appendix B: Possible Policy Changes Needed to Implement Recommendations

| Rec # | Report Page | Description | Provider Groups Impacted | Possible Change to SPA | Possible Impact on Regulations | Medicaid 1915(c) waiver amendment | Policy Updates Required |
|---|---|---|---|---|---|---|---|
| **1** | 30 | Develop solutions and strategies to overcome obstacles to basic care utilization. Explore best practices in other states, including waiver expansion. | Basic Care Facilities | Yes | Yes | Yes | Provider manuals; policy manuals |
| **2** | 30 | Raise awareness of assisted living policy implications. Identify concerns regarding oversight and interest in additional standards. | Assisted Living Facilities | NA | NA | NA | NA |
| **3** | 30 | 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. | Assisted Living Facilities | Yes | Yes | Yes | Yes |
| **4** | 31 | Implement regular review of Medicaid and SPED ALF clients to assure ongoing health, safety and welfare. | Assisted Living Facilities | No | Yes | Depends | Provider manuals; policy manuals |
| **5** | 31 | 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. Serve as third party review for assessment and services. | Assisted Living Facilities | NA | NA | NA | NA |

| Rec # | Report Page | Description | Provider Groups Impacted | Possible Change to SPA | Possible Impact on Regulations | Medicaid 1915(c) waiver amendment | Policy Updates Required |
|---|---|---|---|---|---|---|---|
| **6** | 51 | Phase in an occupancy limit for BC rate setting. | Basic Care Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |
| **7** | 51 | Set Basic Care cost center limits with median plus percentage. | Basic Care Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |
| **8** | 51 | Include nearly all providers in the Basic Care limit arrays. | Basic Care Facilities | No | Yes | No | Provider Manual, Reimbursement Guide |
| **9** | 68 | Consider creating a P4P including indicators for falls with injury, moderate to severe pain, increase need for help with ADLs and depressive symptoms. | Nursing Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |
| **10** | 71 | Incorporate some review of survey results to ensure consistency with other regulatory efforts. | Nursing Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |
| **11** | 72 | Implement a P4P measure tied to satisfaction only after a satisfaction survey process has operated for a few cycles. | Nursing Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |
| **12** | 72 | Limit P4P criteria and improvement as well as achievement. | Nursing Facilities | Yes | Yes | No | Provider Manual, Reimbursement Guide |

| Rec # | Report Page | Description | Provider Groups Impacted | Possible Change to SPA | Possible Impact on Regulations | Medicaid 1915(c) waiver amendment | Policy Updates Required |
|---|---|---|---|---|---|---|---|
| **13** | 72 | Audit/review provider submitted P4P documentation. | Nursing Facilities | NA | Yes | No | Provider Manual, Reimbursement Guide |
| **14** | 74 | Review the website and current program materials, identify needed changes, additions and enhancements, and develop a strategy and timeline for implementation | All Provider Groups | No | No | NA | No |
| **15** | 75 | Expand the services that can be performed through Options Counseling, as well as work with participating hospitals to educate discharge planners. | All Provider Groups | Depends | No | NA | Yes |
| **16** | 76 | 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. | Nursing Facilities | NA | Likely | Provider manual, internal policy manuals | Provider manuals; policy manuals |
| **17** | 76 | 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. | All Provider Groups | Depends | Depends | Depends | Yes |

| Rec # | Report Page | Description | Provider Groups Impacted | Possible Change to SPA | Possible Impact on Regulations | Medicaid 1915(c) waiver amendment | Policy Updates Required |
|---|---|---|---|---|---|---|---|
| **18** | 77 | Engage workforce development experts to create statewide strategy for addressing workforce issues. | All Provider Groups | NA | NA | NA | NA |
| **19** | 78 | Identify and resolve any policy and process issues that present obstacles; develop a proactive and concerted strategy to develop additional transportation providers. | All Provider Groups | Depends | Depends | Depends | Provider manuals; policy manuals |
| **20** | 78 | 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. | Assisted Living Facilities | Depends | Depends | Yes | Provider manuals; policy manuals |
| **21** | 79 | Expand Nursing Facility MDS reviews. | All Provider Groups | NA | NA | NA | NA |
| **22** | 79 | Evaluate whether the number and scope of the HCBS reviews that are currently being performed are sufficient or whether additional staffing resources are needed. | NA | No | No | No | Provider manuals; policy manuals |
| **23** | 79 | Consider implementing consumer interviews and satisfaction reviews. | All Provider Groups | No | NA | NA | NA |

## Appendix C: References


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