

# North Dakota Long Term Care Study Deliverable 2

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## Interim Report

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*PREPARED FOR THE NORTH DAKOTA  
DEPARTMENT OF HUMAN SERVICES MEDICAL SERVICES DIVISION*

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CERTIFIED PUBLIC ACCOUNTANTS*

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## **I. Introduction**

### **A. Purpose of Study**

The North Dakota Department of Human Services (DHS) Medical Services Division has contracted with Myers and Stauffer to review and evaluate the long-term care (LTC) continuum in North Dakota and to provide two comprehensive reports. The study will focus on the following programs and payment systems:

- Nursing Facilities
- Basic Care Facilities
- Assisted Living Facility Licensure
- Home and Community Based Services
- Money Follows the Person Program
- Programs for All-Inclusive Care of the Elderly (PACE)
- Service Payments for the Elderly and Disabled (SPED) Program
- Expanded Service Payments for the Elderly and Disabled (Ex-SPED) Program

### **B. Long Term Care: An Integrated System to Improve Access, Choice and Quality of Care and Life**

Long-term care encompasses the organization, delivery, financing, administration and coordination of an array of services designed to assist people who are limited in their ability to function independently over a relatively long period of time. The intensity of the need may vary over time. The LTC system should coordinate social, supportive, rehabilitative and health services across all settings.

Long-term care and support services, including assessment, care management and coordination of services and supports, rehabilitative services, adaptive aids, transportation, nursing facility, and other residential services should be designed to help individuals and families:

- Perform basic life functions.
- Improve skills and capabilities to maximize independence and function.
- Maintain optimal health status.
- Establish and maintain social and personal relationships in the individual's neighborhood and community.
- Care for family members with functional limitations.
- Provide comfort, supervision and support to persons with an irreversible illness or condition when needed.

Ideally, an integrated system of long-term care will improve access, choice, quality of care and quality of life while also containing cost. Thus, states are challenged to develop a system that uses limited health

care dollars to maximize consumer preferences, while also slowing future budget growth through the use of strategies to avoid unnecessary expensive care options. The system should:

- Coordinate Medicaid and state benefits and financing with Medicare, private insurance and private consumer resources.
- Minimize inappropriate cost shifting.
- Match state resources with personal resources based on a person-centered plan and an assessment of the individual’s functional capacity.

### **C. Report Organization and Contents**

This report includes an evaluation of North Dakota’s current long-term care (LTC) services and programs, with focus on the following:

- North Dakota demographics
- Identification and description of home and community-based services (HCBS) and programs, including Money-Follows-the-Person, that are available to individuals in the State
- Evaluation of how PACE fits into the LTC continuum
- Capacity for and disbursement of nursing facilities, basic care, and assisted living
- Defining primary cost drivers to publicly-funded institutional services
- Identification of LTC quality and access measures, including sample data indicators or surveys
- Evaluation and definition of service delivery gaps within the LTC continuum

To perform a more comprehensive evaluation of programs and services, this report also incorporates the input of providers, case managers, consumers, state staff, and other interested stakeholders, which was obtained through meetings, distribution of a ND-specific questionnaire, and two on-site public meetings held in Bismarck and in Fargo.

## II. Demographics

### A. The Older Population in the United States

#### 1. The Older Population Today

##### *Demographics*

The characteristics of older adults and the environments in which they reside must be a consideration in designing and developing long-term care services that will be acceptable and effective in meeting the needs and preferences of older users. It cannot be assumed that the long-term care service systems designed 30 years ago are appropriate for today's elders, and it is very unlikely services today will be appropriate or acceptable in their entirety for the future aging population. To meet the objectives of this LTC Study, this report will highlight certain demographic features about the current senior population, both nationally and in North Dakota specifically, to help stakeholders most effectively serve today's older adults and prepare for the changes in long-term care services the baby boom segment of the population will need and demand.

Approximately 41.4 million people (13.7 percent of the U.S. population) are 65 years of age or older, and this segment of the population is growing by more than 7,000 people per day (US Census, 2012a: Love 2010). Approximately 3.6 percent (1.5 million) of persons 65 years and older live in institutional settings such as a nursing facility, with the actual percentage being significantly higher for those in their mid-seventies and older. Only one percent of people ages 65-74 years reside in an institutional setting as compared with three percent of those 75 to 84 years and eleven percent of persons 85+ years (AoA, 2012). Many more remain in their homes or more homelike community dwellings, but require assistance from others with basic personal care tasks.

The percent of older persons staying in the community with disabling conditions has increased over the last 30 years, primarily because of an increase in the use of assistive technology (Houser, Gibson, & Redfoot, 2010). This trend has been accompanied by a decrease in the percentage of older adults in nursing facilities. Between 1984 and 2004, the percent of older adults in nursing facilities declined by nearly 37 percent, while the number of older adults living in the community, who needed assistance with two or more ADLs, rose by two-thirds (Redfoot, Feinberg, & Houser, 2013). By 2010, the number of older people who received Medicaid assistance for nursing facility services had declined by 26 percent from its peak in 1995 (Redfoot & Houser, 2010). Much of this decline is attributable to the care provided by families and other informal providers, but changes in Medicaid policy encouraging use of funds for home and community-based services has also contributed to this trend and has been shown to ultimately reduce Medicaid costs for long-term care (Mollica, R., 2009).

Whether care is provided in the community or the nursing home, women tend to have a disproportionate impact on the informal and formal long-term care system, primarily because of their greater life expectancy. There are approximately 96.7 males per 100 females in the population today (US

Census, 2010a). This gap widens with advancing age, and by the time people reach 90 years of age, there are only 38 males for every 100 females. The age gap has begun to slowly narrow in recent years, but it is unlikely to close for generations, if ever. This means that women are more likely to reach advanced age and experience the health and disability issues that often accompany it. For this reason and others cited below, women are also at greatest risk of need for formal (paid) long-term care.

Marital status is another important variable in the need for formal care during one's lifetime. In 2012, 72 percent of older males were married as compared to only 45 percent of older females (AoA, 2012). This places men at a distinct advantage of never requiring formal long-term care services. Since women tend to live longer than men, they often serve as the primary caregivers for their spouses. At the point when women need assistance, they are frequently alone and may have few informal resources for care. This is reflected in the ratios of women to men in nursing facilities. Between the ages of 75-84, there are 246 women for every 100 men, and among those age 85 and older, there are 425 women for every 100 men (Gurwitz, 2005).

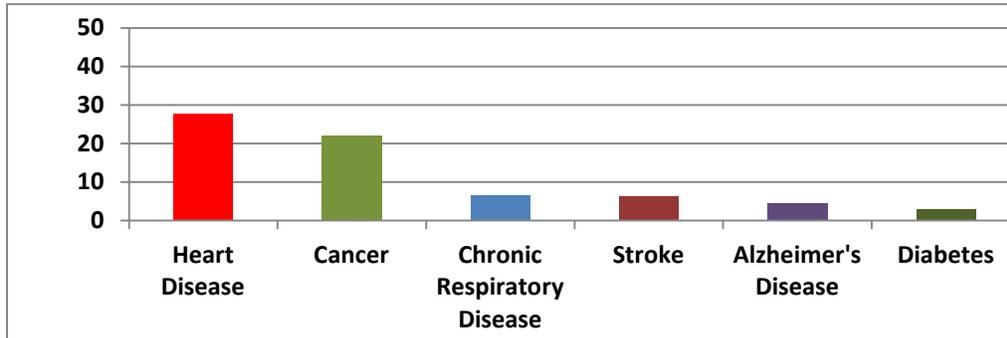
Not only are older women less likely to have support in the home, they are also less likely to be able to purchase needed assistance. Older women tend to have lower incomes, in part because of educational differences but also because of long-standing biases in employment practices. While the median income for households headed by persons 65 and older was \$48,538 in 2011 (AoA, 2012), individuals who were not classified as in "family households", many of who were women, did not fare as well. The median income for men 65 and older was \$27,707, and for women the median income was only \$15,362. Almost 10 percent of older adults are below the poverty level, which is an historic low. Poverty is, however, still a serious issue among older adults. If the poverty standard is raised slightly to 125 percent of the poverty threshold, 14.8% of the aged could be considered poor or "near poor"; 12.1 percent of those who are ages 65 to 74, and 17.8 percent of those who are 75 years of age and over could be considered poor or "near poor" (Gabe, 2012).

From a more positive perspective, almost 79 percent of older adults own their home as compared with only 64 percent of the entire U.S. population. This is a significant issue with respect to the long-term care continuum of services because housing is a key resource, both financially and in terms of maintaining one's ability to receive long-term care services within the home. For some, housing may also provide a source of revenue to pay for needed services.

### *Health Status of Older Adults*

Older adults, particularly the oldest-old, pose a number of challenges for our human service systems. Largely because of advances in public health and the development of antibiotics, there has been a 30 year increase in life expectancy over the last 100 years. This increase in life expectancy has, however, been accompanied by new issues. In the past, infectious diseases killed many people before they reached old age. Today, people are aging with a number of significant chronic conditions that may ultimately lead to death, but often result in years of disability before being fatal (Chart 1).

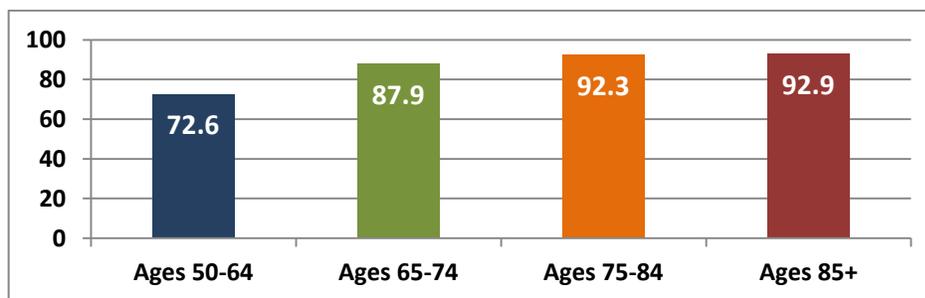
**Chart 1 Leading Causes of Death in U.S. Adults Aged 65 and Older**



**Source 1: CDC, National Center for Health Statistics. National Vital Statistics System, 2007–2009**

Within different age cohorts, there are marked variations in the prevalence of chronic disease and disability due to chronic disease or injury. For example, the incidence of disability from injury and chronic conditions such as multiple sclerosis and rheumatoid arthritis may begin at relatively young ages in the U.S. population. Diseases such as diabetes, hypertension, and high cholesterol may be seen in people in their fifties or younger, but are often not disabling until later ages. Chart 2 shows the percent of people with one or more chronic conditions beginning at age 50. The likelihood of developing at least one chronic condition increases with each decade of life. As people reach their 60s and beyond, the chances of having numerous chronic conditions multiplies. Sixty-three percent of those 65-74 years have two or more chronic conditions, and this percentage goes up to 78 percent of those between 75-84 years and 83 percent of those 85 and older (CMS, 2012). Chronic conditions increase the likelihood of disability and play a major role in the need for long-term care.

**Chart 2: Persons with One or More Chronic Conditions by Age Group in the U.S**

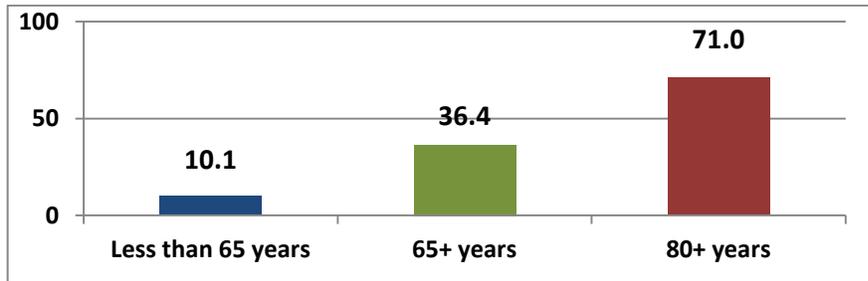


**Source 2: Johns Hopkins Bloomberg School of Public Health Analysis of Medical Expenditure Panel Survey**

Aging is a significant factor in disability and potential need for long-term care, but it is not only the elderly who may require long-term care services (Chart 3). Children born with developmental disabilities or the young who have acquired disabilities due to illness or injuries may require long-term care services throughout their lives. Only 10 percent of children and adults less than 65 years of age have a disability,

but their need for long-term care may span decades, while the elderly are likely to require long-term care for much shorter periods.

**Chart 3 Disability Rates by Age: United States**



Source 3: Cornell University, Disability Statistics, 2011 <http://disabilitystatisticsfigure1tics.org/reports/acs.cfm?statistic=1>

### *The Long-Term Care System in the US*

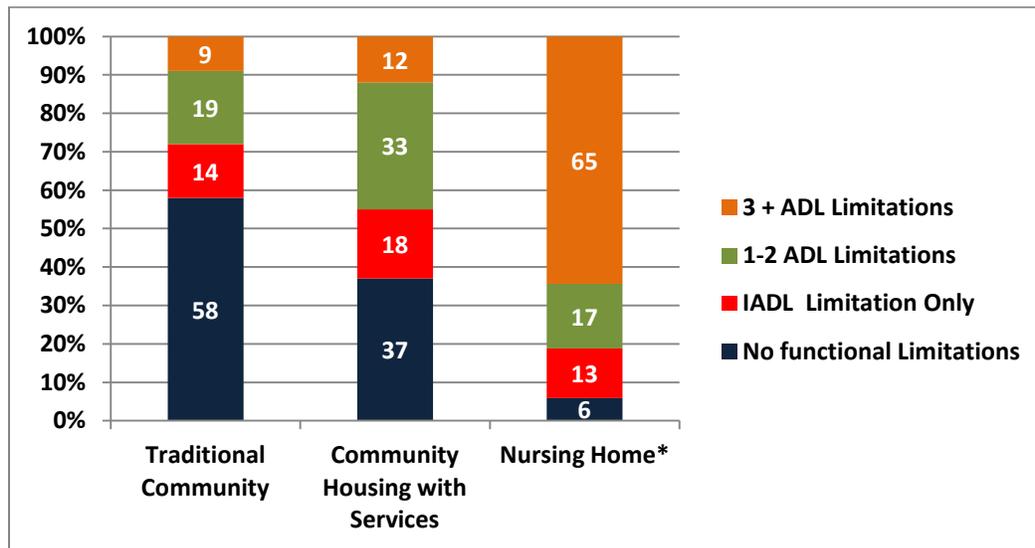
Long-term care services range from assistance with maintaining a home, transportation, and shopping to help with the most basic of care tasks, such as bathing, eating and dressing. Unpaid caregivers, including family, friends, neighbors, and church members, provide the bulk of long-term assistance to both younger and older people. While it is difficult to identify the exact number of informal caregivers, it is estimated to range from 20 to 50 million people. Policymakers generally do little to support the importance of informal services, viewing them as a “family responsibility” that should have no cost to the public. But this is not in fact the case. The provision of services by informal providers does come with a significant cost. Most of those providing care are in the workforce, and it is estimated they lose about \$660,000 in wages over their lifetime due to care giving responsibilities. Additionally, the productivity costs to businesses are estimated to be between \$11 billion to \$29 billion yearly (Day, 2012).

While the financial costs are substantial, the emotional and physical cost to informal caregivers can be enormous. It is not uncommon to see the relatively healthy older adult who is providing care to a spouse become ill and die earlier than the person for whom they are caring. A study by Schulz and Beach (1999) found that elderly spousal caregivers (ages 66-96) who experience care-giving-related stress have a 63% higher mortality rate than non-caregivers of the same age. Other studies have estimated that between 40 to 70% of caregivers have clinically significant symptoms of depression, with approximately one quarter to one half of these caregivers meeting the diagnostic criteria for major depression (Zarit, 2006).

Functional limitations from physical, cognitive, or mental conditions, are a defining feature of disability. As with children and younger adults, families contribute significant long-term care resources for older adults, but the severity of the limitation in older adults is more predictive of need for formal assistance than in other age groups. Chart 4 illustrates the relationship between functional limitation and residential location of Medicare recipients 65 years and older. Those with minimal or no functional limitations are most likely to live in traditional community housing, while those with higher levels of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) functional limitations are

likely to live in environments with services readily available. By the time an older adult acquires three or more ADL limitations, the chance of that person receiving care in a nursing facility goes up dramatically.

**Chart 4: Percent of Medicare Enrollees Age 65 and Over with Functional Limitations by Residential Setting, 2002**

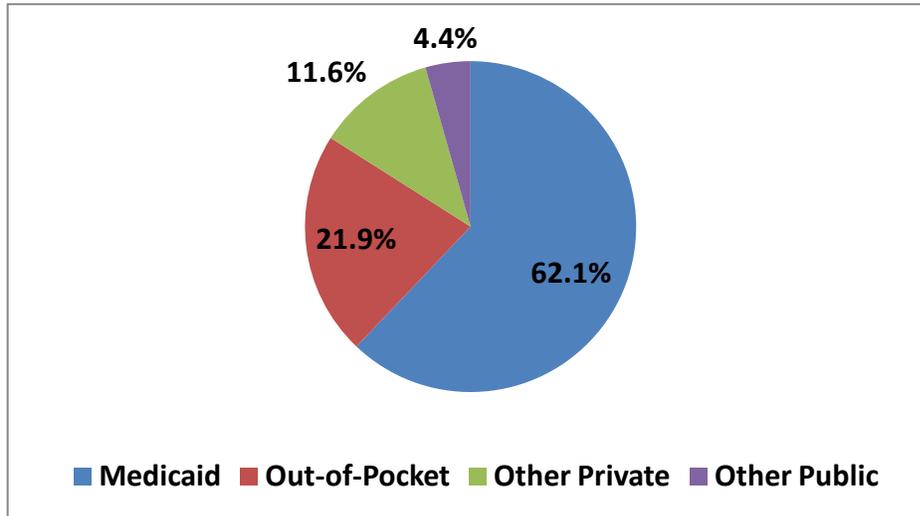


Source 4: Day, T. (2012). About Long Term Care, National Care Planning Council [http://www.longtermcarelink.net/eldercare/long\\_term\\_care.htm](http://www.longtermcarelink.net/eldercare/long_term_care.htm) \*total does not add to 100% due to rounding

When family, friends, and other informal resources for care are unavailable, insufficient, or exhausted, people must turn to programs provided by formal sources. The major forms of care available in the U.S. are home care services, adult day care, residential options providing various levels of care (i.e., group homes, board and care, assisted living) and, for those with the greatest needs, there are nursing facilities. These services are typically funded by personal resources, public programs such as Medicaid, and private financing options such as long-term care insurance. Medicare provides minimal support for custodial care, but does so only in the context of providing skilled care for recuperation or rehabilitation. Persons must have a minimum three day stay in the hospital to trigger Medicare coverage of short-term skilled care. Some examples of additional Federal funding sources for long-term care include: Veteran’s benefits, the Older American’s Act Programs and Social Security Block Grants (SSBGs).

In 2011, the total spending for long-term care (public, out-of-pocket and other private sources) in the US was \$210.9 billion (O’Shaughnessy, 2013). As shown in Chart 5, Medicaid is the dominant source of expenditures for long-term care, followed by out-of-pocket monies. When family caregivers no longer have personal strength or emotional resources to provide care, the care recipient and often the family contribute significant amounts financially to the provision of formal services. They provide more than one-fifth of long-term care coverage out-of-pocket and contribute another 11.6 percent through their long-term care insurance and other private resources. Additional public resources for long-term care amount to less than 5 percent.

Chart 5 Long-Term Care Expenditures by Source, FY 2010



Source 5: O’Shaughnessy, C. (2012). *The Basics: National Spending for Long-Term Services and Supports. Who Pays for Long-Term Care-Factsheet* The SCAN Foundation  
<http://thescanfoundation.org/publications/facts/national>

## B. THE OLDER POPULATION OF NORTH DAKOTA

### *Demographics*

When compared with national data, North Dakota is already an “old” state. In 2012, the year after the baby boomers, individuals born between 1946 and 1964, started turning 65, North Dakota ranked 12th in the nation for the proportion of the population 65+ (14.4 percent) and had the second highest proportion of persons 85 and older (2.5 percent) (NDSU, 2013). This proportion of the oldest old is much greater than the U.S. average and exceeds the anticipated percentage of persons 85+ in the U.S. population over the next 15 years.

North Dakota is also a very homogeneous state from a racial and ethnic standpoint. In 2012, North Dakotans age 65 years and older were predominantly non-Hispanic White (96.5 percent compared with 79.2 percent of older adults nationally) (US Census, 2012b) and ethnically very similar, with more than three-quarters being of German or Norwegian ancestry. The second largest racial group in North Dakota are American Indians, of which slightly more than 2 percent (approximately 2,120 people) are 65 years or older.

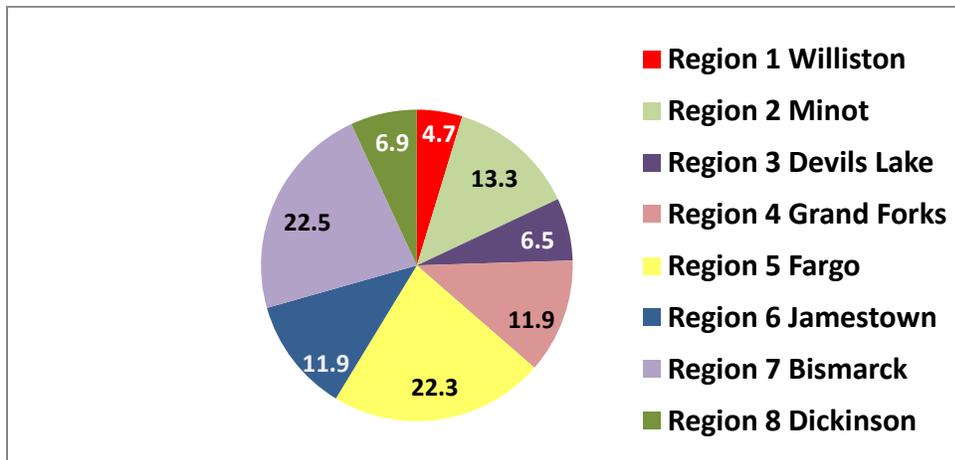
Almost 95.8 percent of older North Dakota residents live in households compared to 88.5 percent nationally. More North Dakota residents 65 years and older are married, 58.7 percent in North Dakota versus 54.7 percent nationally. Despite the higher percentage of older married North Dakotans, a higher percentage of this age group live alone, approximately 49 percent compared to 43.4 percent nationally (US Census, 2012b). This is due in part to the fact that older North Dakotans are less likely than older adults nationally to live with another family member or nonfamily member (4.2 percent versus 11.5

percent (US Census, 2012b). This may have significant implications for the availability of informal care to older north Dakotans in their own homes and reduce the likelihood that adequate formal services can be provided in the home to meet their need.

In addition, the ability of some older North Dakotans to purchase needed services may be compromised by their economic status. Poverty estimates among those 65 years and older are slightly higher for North Dakota (10.6 percent) than for a comparable age cohort nationwide (9.5 percent) (US Census, 2012b). Among older American Indians in North Dakota poverty levels are considerably higher, with 28 percent of those ages 65 to 74 years living below the poverty level. Poverty rates increase for those 75 years and older to 30 percent (US Census, 2011b).

Statewide averages do not, however, tell the whole story and North Dakota offers numerous examples of how population characteristics and resources can be vastly different across regions and counties, even those next to each other. For example, the more urban counties of Cass, Burleigh, Grand Forks and Ward have proportions of 65-plus and 85-plus below the national average (US Census, 2012b). Despite their low proportions of elderly in comparison to the total population, these four counties are home to 41 percent of all older adults (65+ years). Fifty-eight percent of older adults reside in Regions 2, 5, and 7, in which Ward, Cass and Burleigh are located (Chart 6). If Regions 4 and 6, with the counties of Grand Forks and Stutsman, are included, these five regions house 81.9 percent of the older population.

**Chart 6: Total Percentage of 65+ Population by Region**



Rural counties such as McIntosh and Divide currently have some of the highest proportions of persons 65 and older in the country, with the proportion of people age 85 and older being 3 to 4 times the national average at 7.5 and 6.5 percent respectively. Despite these high proportions of elders, the combined number of persons 65 and older in these two counties is 1,500, and the total 85 years of older is less than 350 (US Census, 2012b). These small numbers do not skew the statistics for the various regions. For example, Region 1 has a large proportion of people 85 and older in the total population of the county, but a relatively small proportion of all those 85 and older in the State. It has been predicted that the percentage of people age 65 plus in very rural counties will increase as the baby boomers age.

As will be discussed later, recent trends in some rural counties in North Dakota do not however appear to necessarily support this assumption.

Just as counties and groups of counties have unique characteristics, they can change rapidly in dramatic and unanticipated ways. Until recently, it was assumed that the North Dakota population would continue to decline and to age, particularly in rural counties, and predictions relating to service availability for the elderly were quite dire. At the beginning of this century, North Dakota was one of only a few states with a declining population. People were migrating out of rural counties and often out of the state altogether. The young were leaving to seek better job opportunities, leaving behind parents and aging adults who often had neither the means nor possibly the desire to leave. As decades of out-migration occurred, the median age of the population climbed from 25.7 years in 1940, to 35.3 years in 2000, and to 37.2 years in 2010 (NDSU, 2012).

In 2004 however, this demographic trend began to shift, particularly in the western, most rural sector of the state. The energy boom hit North Dakota; young adults began migrating into North Dakota seeking work in the oil fields, and more young North Dakotans stayed in the state because of the job opportunities. In 2000, there were about 2,000 workers in the oil region (which includes McKenzie and Divide counties), but this number grew to approximately 19,000 by 2011, an increase of 950 percent (State Population Center, 2011). It is estimated that the overall resident population increased by between 19,000 and 22,000 people in the last year, making North Dakota's population larger than at its peak in 1930. With a population increase of 7.5 percent, North Dakota is now the fastest growing state in the country (Glink, 2014).

This growth has resulted in an unexpected decrease in North Dakota's median age for the first time in decades. Between 2000 and 2008, the median age of North Dakota increased to 37.3 years, compared to the national average of 36.8 years. Between 2008 and 2014, the median age in North Dakota dropped to 36.1 years (MacPherson, 2014). This appears largely the result of a drop in the median age in three of North Dakota's 53 counties—Mountrail, McKenzie, and Williams (State Population Center, 2011). It has been projected that McKenzie and Williams along with Divide will more than double in the number of seniors from 2011 to 2025. While the influx of younger workers into these counties may reduce the proportion of older adults and lower the median age, it may or may not change the actual number of persons in the counties who will become 65+ over the next 10 years.

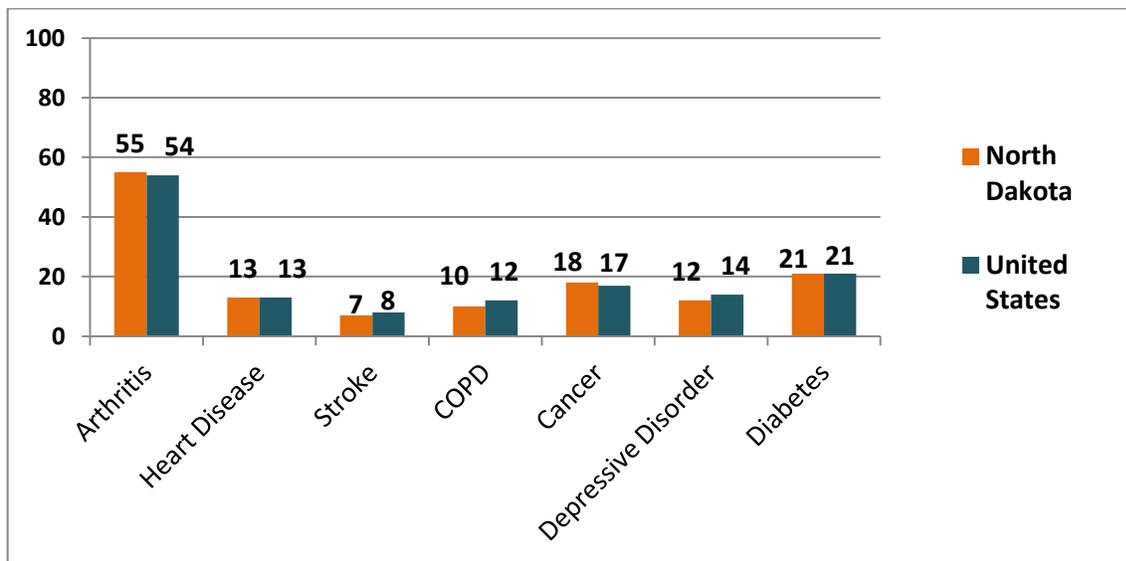
Predictions made in the mid-2000s of a dramatic increase in numbers and proportion of older adults in the most western sector counties was predicated on the assumption that those already over 65 years of age and those turning 65 over the next 10 years would continue to reside in these counties. In recent meetings with service providers, anecdotal evidence was presented indicating increases in the cost of living and in housing prices, particularly in the Bakken Oil Region and surrounding areas, was forcing some older residents out of the area and enticing some of the baby boom generation to sell their homes and move to more populated areas. This could have a significant effect on the most western energy boom counties, but may have little impact on other rural counties that do not benefit as directly from the energy boom. Likewise, this may mean a mere shifting of aging issues from one sector of the county

or state to another, as it appears current and future cohorts of older adults are primarily relocating within the same county or, at least, 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).

**Health Status and Disability among Older North Dakota Residents**

Older North Dakotans are fairly similar to their age cohorts nationally in relation to the health conditions and level of disability they experience. As shown in Chart 7, older North Dakotans have slightly higher rates of arthritis and cancer, but are below national averages for stroke, chronic obstructive pulmonary disease (COPD), and depressive disorders. There is no difference in their rates of diabetes and heart disease.

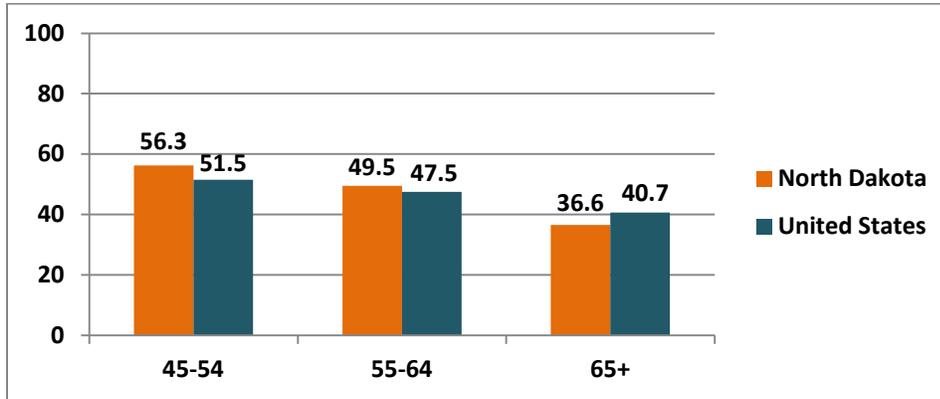
**Chart 7: Percentage of People With Chronic Conditions Among 65+: North Dakota Verses the United States**



According to the Behavioral Risk Factors Surveillance System (BRFSS), in 2012 North Dakotans between 45-54 years and 55-64 years were more likely to rate their health as “Very Good” or “Excellent” as compared with the same cohort nationally, although the gap begins to narrow in the 55-64 age group (Chart 8). Among the current age group 65+, the percentages rating their health as “Very Good” or “Excellent” dropped below the national median percent.

These findings are significant since it has been shown that self-rated health status is an independent predictor of development of morbidity, mortality, and disability in basic physical and instrumental daily life activities among elderly (Bjorner, J., 1996; Idler E., 1997). In other words, older persons’ evaluation of their health tends to be predictive of their likelihood of either dying or needing help in daily activities.

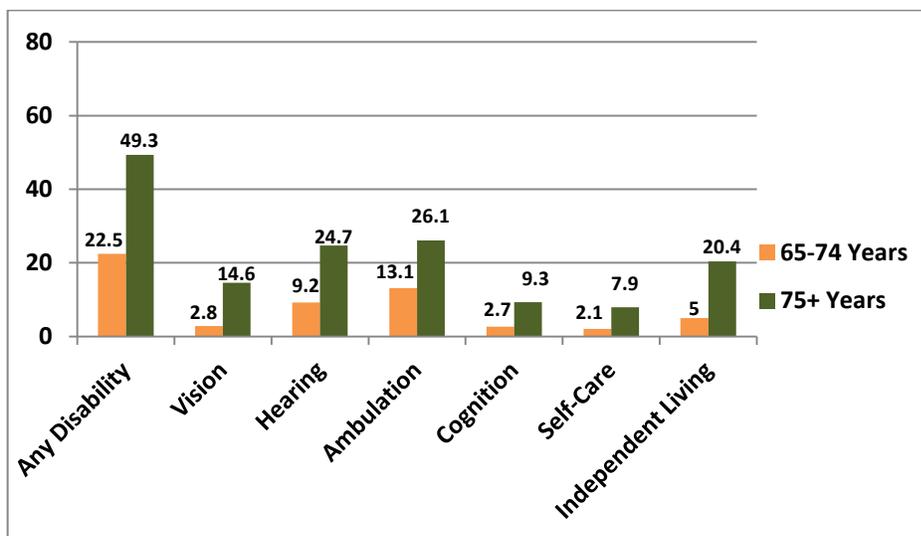
**Chart 8:-Self-Reported Health Status Ratings of “Very Good” or “Excellent” Among North Dakota and U.S. Age Cohorts**



Source 8: Centers for Disease Control. BRFSS Prevalence and Trend Data-2012 <http://apps.nccd.cdc.gov/brfss/>  
 The BRFSS is the largest telephone survey in the world. Data have been collect for over 30 years on health status indicators and currently are collected via telephone monthly in all 50 states. As of 2011, more than 500,000 interviews were done annually.

Ageing predisposes people to chronic diseases and injuries that are likely to result in disabilities requiring long-term care. In North Dakota, the prevalence of disability among those aged 21 to 64 years is 8.6 percent, as compared to a prevalence rate of 22.5 percent for those from 65 to 74 years and a rate of 49.3 percent for those 75 and older. Chart 9 shows some of the areas of function most affected by age, with ability to ambulate being most impacted.

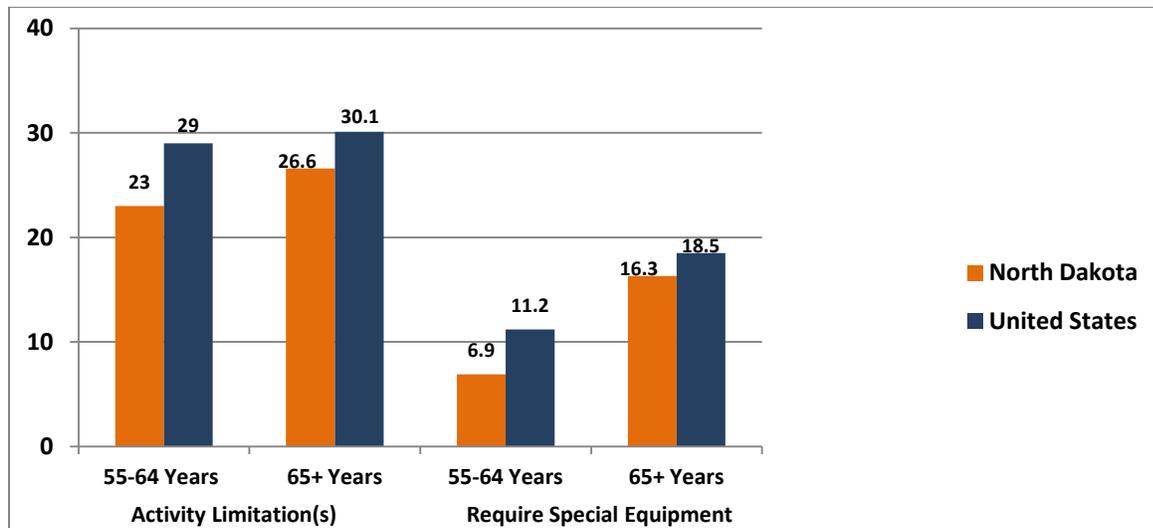
**Chart 9: Prevalence of Disability among Non-Institutionalized People in North Dakota: Ages 65 to74 and Ages 75 and Older**



Source 9: Cornell University (2011). 2011 Disability Status Report: North Dakota. <http://www.disabilitystatistics.org>

When compared with U.S. averages for “activity limitations” and “need for special equipment” to perform activities among older adults (65+ years), the population in North Dakota has lower proportions of older adults in both categories (Chart 10). In fact, North Dakotans across all age groups starting at 18 years have lower proportions of people with limitations. Depending on the age group, the differences range from 2.3 to 6 percentage points (BRFSS, 2012).

**Chart 10: Percentage of Persons 55-64 Years and 65+ Years with Activity Limitations and Those Needing Special Equipment: North Dakota and United States**

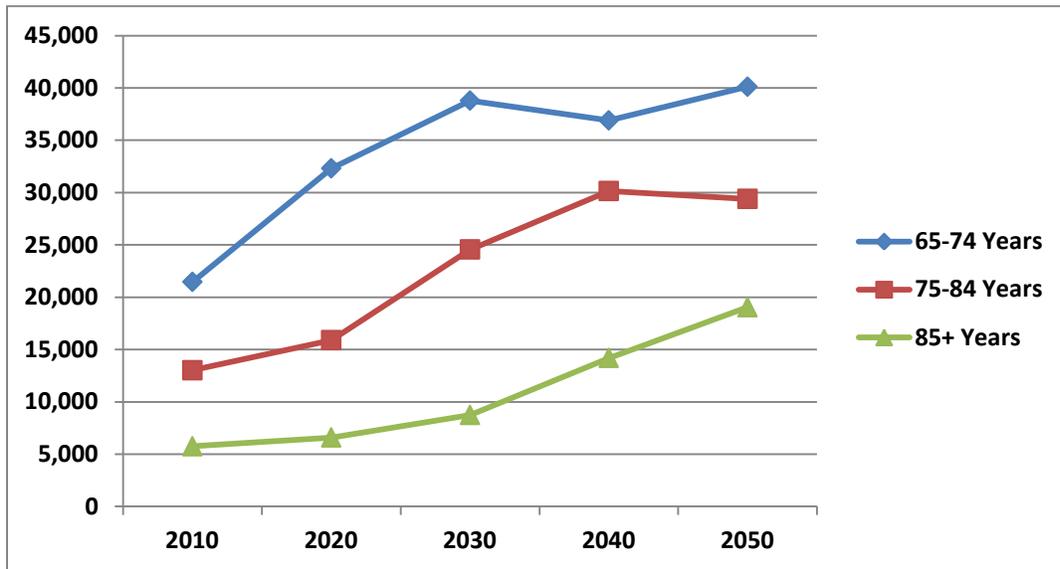


Source 10: Source: BRFSS, 2012

***The Future of Aging and Long-Term Care in the U.S. and North Dakota***

As North Dakota and other states plan for future long-term care services, it is important to anticipate potential changes in state demographics over the next five to ten years, as well as differences in the characteristics, resources, and preferences of future aged cohorts. With the baby boomers beginning to reach 65+ years, the graying of America will accelerate. As illustrated in Chart 11, the 60+ population is expected to soar from 2012 through 2030 and beyond. It is predicted that the 65-plus population will grow from the current 13.7 percent to 16.1 percent by 2020, and to approximately 20 percent by 2030 (U.S. Census Bureau, 2010). This means the population aged 65 and over is expected to double in the next 25 years, reaching 72 million people by 2030. The percent of the U.S. population age 85 and older was 1.6 percent in 2012, and it is not projected to increase significantly until 2030 when it will reach 2.3 percent. This is the time when the baby boomers will begin to enter the 85+ age group.

Chart 11: Aging of the U.S. Population: 2010-2050



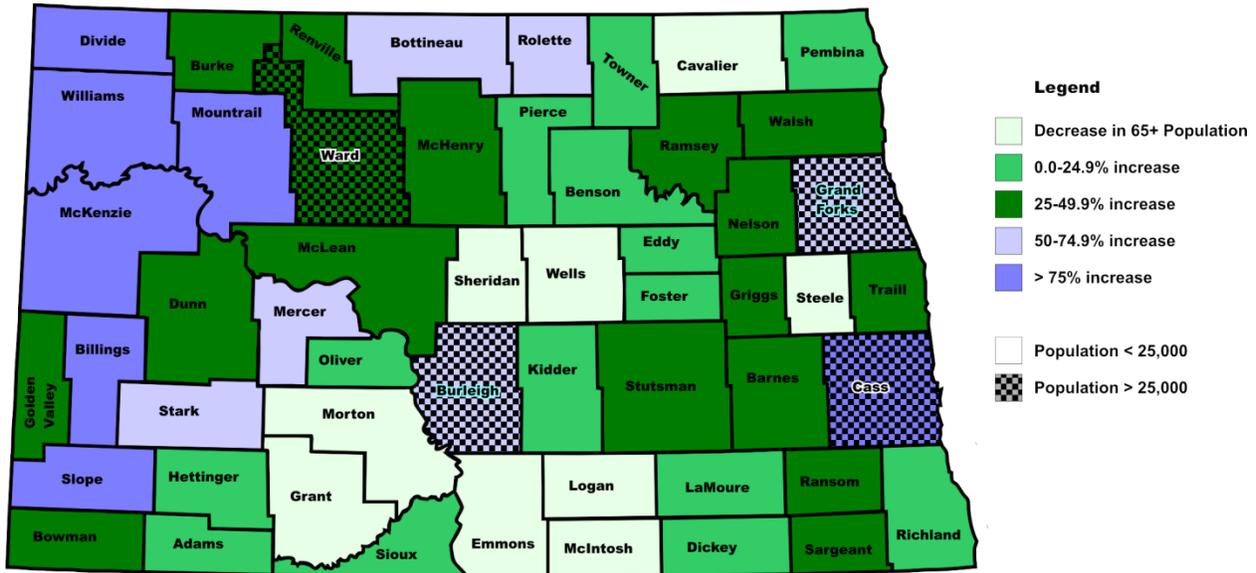
Source 11: Figure 5- U.S. Census Bureau, 2009 Projections

The aging of the population of North Dakota is expected to follow a similar trajectory. Despite the influx of younger people to the state, it is projected that the 65+ segment will remain a fast growing segment of the population. The number of persons 65 years and older is expected to increase 50% (from 98,595 in 2011 to 148,060 in 2025), with the proportion of older adults predicted to increase to 17.6 percent (Center for Social Research, 2012). The actual proportion of older adults will be contingent on the numbers of younger adults moving into the state. If movement of the younger population into the state maintains or increases, there will be lower proportions of older adults in relation to the total population of the state. However, the impacts of the younger population will likely not be felt evenly across the state. The young, who are moving into the state for jobs in the energy sector, are most likely to directly impact far western counties in the Bakken Oil Region far more than counties in other parts of the state. For some counties, the proportion of older adults in the population may increase to currently projected levels. Even in those rural counties with considerable increases in the proportion of older adults, this is not likely to translate to large numbers since 40 of North Dakota’s 53 counties have total populations less than 10,000 and 20 have populations less than 5,000. Still, for rural and frontier counties that experience significant increases in the number of older persons needing services and a likely concomitant decrease in the availability of younger formal or informal caregivers to provide services, those in need of long-term care may find choices for care limited or nonexistent.

Given the rapid changes in North Dakota demographics, predictions about the future are difficult to make with great certainty. It appears however, that in many rural counties the projections related to the aging of the population may not be as dramatic as once thought. Only 13 of North Dakota’s 53 counties are projected to meet or exceed the statewide predicted 50 percent increase in persons 65+ between 2011 and 2025. Three of these counties are the largest in the state, Cass, Burleigh and Grand Forks,

which comprise approximately 44 percent of the state’s population (See Map 1). This means that large increases in actual numbers of older adults will be in counties that are more urban and more likely to have the resources and workforce to provide needed services.

**Map 1: Increase in the Number of People Age 65+ by County in North Dakota: 2010-2025**



Source 6: NDSU, Center for Social Research (2013). *North Dakota’s Aging Population: Profile and Trend of Seniors Ages 65 and Over*, Prepared for the NDSU Extension Service, <http://www.ag.ndsu.edu/pubs/yf/famsci/ec1673.pdf>

The other counties with large projected increases in older adults are primarily in the western sector of the state. As noted previously, the demographic composition of the Bakken Oil Region is changing dramatically. Although the numbers of older adults may increase significantly in the far western counties, their proportion in the population is likely to be far less than anticipated (particularly in Williams, Mountrail, and McKenzie). It also remains to be seen whether a significant increase in numbers will occur if, as has been suggested, the baby boomers and current older adults leave these areas in significant numbers.

The influx of a young working age population into the western counties should provide a resource for services to the older population that does not leave. The opposite may be true as oil field jobs tend to attract workers who are unlikely to be qualified for or enticed by the lower pay and types of work that are typical in human service jobs. A more likely scenario is that higher paying jobs in the energy field and support services areas will attract workers out of the human services field. During focus groups with rural service providers, many noted they were forced to use outside short-term contract workers to provide long-term care services. With the shortage of qualified workers and focus on filling nursing facility positions, home care options tend to be quite limited. This is of particular significance since a

high percentage of North Dakota elders live alone; national data suggests that elders prefer to remain in their own homes or at least in a living environment more independent than a nursing facility.

Another factor that must be considered in looking to the future is that the jobs now fueling the migration of young into the state may not last. It is predicted that when drilling operations end in the next 10 to 15 years, the need for workers will drop dramatically. Since many of the workers now in the oil fields are transient and not establishing significant ties to the area, they are not likely to stay. It may be beneficial for the future to explore ways to keep some of these workers in the state and encourage them to relocate their families to North Dakota. This requires availability of adequate housing and schools, diversification of the economy, and an overall infrastructure to support a younger population. It may also require a willingness of communities to embrace diversity and welcome “outsiders” into the area. As with many rural states, the only source of growth for the state is immigration into the state, and often these immigrants are racially and ethnically different than current inhabitants.

A major challenge for North Dakota in delivering long-term care services is the geography and population density of the state. With an estimated population of only 700,000 people and 79,704 square miles of land mass, North Dakota is surpassed only by Montana, Wyoming and Alaska in the challenges of delivering long-term care services over vast, sparsely populated areas (World Population Statistics, 2013). With high proportions yet small numbers of the very aged population situated in what can be defined as frontier areas, North Dakota faces both distance and workforce resource challenges in the delivery of services. In addition, North Dakota currently faces a higher proportion of older adults at risk for needing long-term care than most of the country will experience for decades. How the state manages these challenges today may forecast the fate of long-term care services in the state over the next two decades.

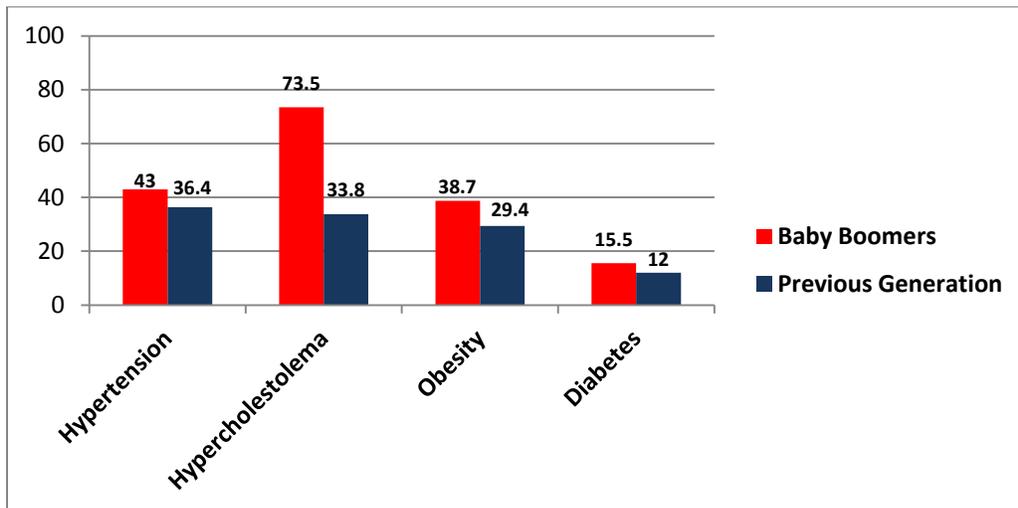
### *Projected Changes in the Older Population*

Can we assume that the baby boom generation will have the same needs and behave similarly to the current cohort of older adults? The data on health status and function discussed in the previous sections tell us about today’s elders. But making assumptions about the needs and expectations of the baby boomers based on the current senior population is problematic. As Dr. Mariah Tenamoc discusses in her paper, “Aging is Everyone’s Business: Changes in Population: Implication for the Data Use and Service Delivery”, the baby boom generation is very different from today’s 75+ population.

Differences in the older population today and the incoming baby boom generation range from health status to personal preferences. For example, a study by King et al. (2013) examined results from the National Health and Nutrition Examination Survey (NHANES) to compare the health of baby boomers to those born in the previous generation. Studies in the early 2000s showed declines in disability in incoming cohorts of older adults, but King’s study refutes this finding. King et al. examined data on current elders at the time they were 46 to 64 years old and the 46 to 64 year old cohort today. Overall, researchers found that baby boomers (current 46 to 64 year olds) have higher rates of chronic disease, more disability and lower self-rated health than the previous generation at the same age. They are more likely to be obese and less physically active than the previous generation (Chart 12). Baby boomers also

have greater rates of high blood pressure, high cholesterol and diabetes. On a more positive note, baby boomers are less likely to smoke cigarettes, and they have lower rates of emphysema and heart attack than the previous generation.

**Chart 12: Proportion of Baby Boomers versus Previous Generation with Significant Health Problems**



Source 12: From: King et.al. (2013). The status of baby boomers’ health in the United States: The healthiest generation? JAMA Internal Medicine online. <http://trends.psc.isr.umich.edu/pubs/abs.html?id=1498>

King et. al. (2013) also found that baby boomers are more likely to use an assistive device for walking, be limited in work, and report a functional limitation than the previous cohort at the same age (King et.al., 2013). This suggests that as baby boomers age they may experience more functional disability and need for long-term care than the current cohort of older adults, but more studies are needed to confirm whether these data represent real differences or merely differences between the cohorts in evaluating their health and in their willingness to report problems.

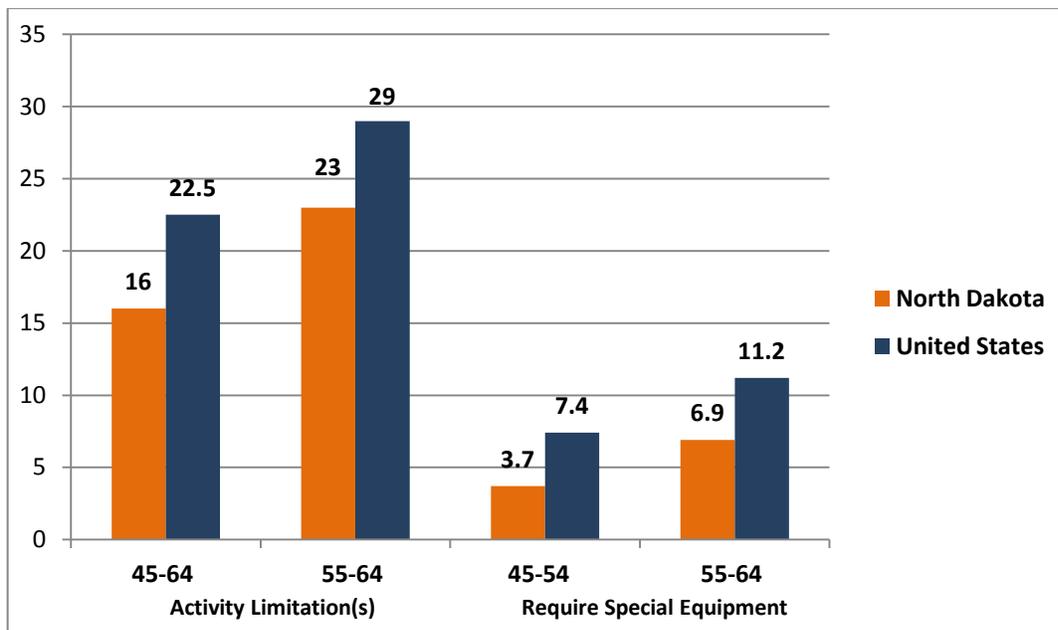
Additionally, it is unclear how much of the difference in prevalence of chronic illness and disability is due to recognition and diagnosis. It is also likely that baby boomers are being diagnosed and treated earlier and have access to more effective medications for hypertension, hypercholesterolemia, and diabetes than earlier cohorts. This may reduce their chances of adverse consequences from these conditions in the long term.

Another consideration in reports of disability among the baby boomers is whether the disability is permanent or amenable to current treatments. Large numbers of baby boomers can move in and out of the disability spectrum with knee or hip replacements, angioplasty or other medical treatments that are readily available today. It is also important to recognize that most of the chronic conditions we see today are avoidable and can be prevented or improved with positive lifestyle changes, such as improved diet and regular exercise. How we approach prevention in the near term will have a definite effect on future health status.

It will be important to monitor the impact of new therapies on lowering rates of disability even in the face of increasing rates of chronic disease. For example, we know that better control of hypertension and use of anticoagulant and anti-arrhythmic drug therapies have reduced the incidence of stroke and disabling heart conditions. Better treatments or a cure for Alzheimer’s disease and other dementias would dramatically lower the need for nursing home care. While such treatments increase acute care costs, they can substantially reduce the need for or amount of time people will spend in long-term care.

Even without new therapies, North Dakota’s baby boomers enjoy relative good health. A higher percent of North Dakotans aged 45-64 rate their health as “Very Good” or “Excellent” as compared with the same age group nationally (refer to Chart 8). North Dakotans aged 45-54 and 55-64 are also less likely to report activity limitations or need for special equipment as compared to their age cohorts nationally (Chart 13).

**Chart 13: Percentage of Adults Ages 45-54 and 55-64 with Activity Limitation and/or Need for Special Equipment**



***Other Factors Influencing Long-Term Care Services for Baby Boomers***

Health and disability alone do not predict use of the long-term care service system. Factors such as availability of family and other informal support, financial resources, accessible and age-friendly homes and communities, and personal preferences play a decisive role in behavior relating to demand for specific services and the use of services.

If current demographic trends continue, it is predicted there will be a caregiver shortage. Whether unpaid family and friends or paid caregivers, the availability of caregivers is projected to decrease dramatically over the next 30 years. Recent estimates by AARP showed that there are currently seven people aged 45-64 years to care for each person who is 80 or older. By 2030, there will only be four

(Redfoot et.al, 2013). This is, in part, due to the baby boom generation having fewer children than their parent's generation (2 versus 3.1), as well as the fact they were more likely to have no children. In 2010, one in nine women 80-84 years of age had no children. By 2030, it will be one of every six women (Glickman, H., 2013). Therefore, fewer family members will be available to provide care and there will be a much smaller working age population to provide paid care.

This shortage of workers is forecast based on dependency ratios. Dependency ratios are calculated based on the numbers of working age adults as compared with the population on both ends of the dependency spectrum, children under age 19 and adults 65 years and older. The projected dependency ratios in many studies suggest there will be far fewer people to care for those needing care on both ends of the spectrum. One problem with some ratio calculations is the assumptions used. Some assume people 65 and older are no longer working and that they need long-term care. In fact, many older adults will continue to work far beyond age 65 and most will not need long-term care until at least age 80 or older. Actual dependency ratios will depend on how these and other variables affecting care needs change as baby boomers age (Knickman and Snell, 2002).

### **SUMMARY**

North Dakota is demographically an "old" state today. High proportions of persons 85 years and older living in relatively remote areas pose significant challenges to the delivery of services. Distance is a significant variable in the organization and payment for services, but workforce availability is also a critical issue. 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.

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.

### III. North Dakota Continuum of Care

#### A. Background

Ideally, an integrated system of long-term care will improve access, choice, quality of care and quality of life while also containing cost and achieving positive health outcomes. The LTC system should balance the state's limited health care funds between consumer preference and cost-effective services.

Long-term care presents one of the greatest policy challenges facing state governments across the nation. With the baby boomer generation approaching retirement and more people living past the age of 85, the number of citizens needing long-term care is expected to double by 2030. North Dakota, like many states is grappling with issues surrounding the provision of long-term care.

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. Among the challenges facing the state are the following:

- An aging population, coupled with geographic mismatch between the places where services exist today and the places where the elderly population is expected to grow over the next 20 years
- Historically low rates of availability and utilization of home and community based services that can help seniors fulfill their desire to remain independent and in their homes
- Skilled nursing facilities that are outdated and in need of capital improvements
- Shortages of front-line health care workers

In 2011, a report titled: "Raising Expectations" was completed by AARP, The Commonwealth Fund and SCAN, and provides the first state scorecard that measures state-level performance of long term services and supports (LTSS). The Scorecard examines state performance across four key dimensions of LTSS system performance: 1) affordability and access; 2) choice of setting and provider; 3) quality of life and quality of care; and 4) support for family caregivers. Within the four dimensions, the Scorecard includes 25 indicators. It also underscores the need for states to develop better measures of performance over a broader range of services and collect data to more comprehensively assess the adequacy of their LTSS systems.

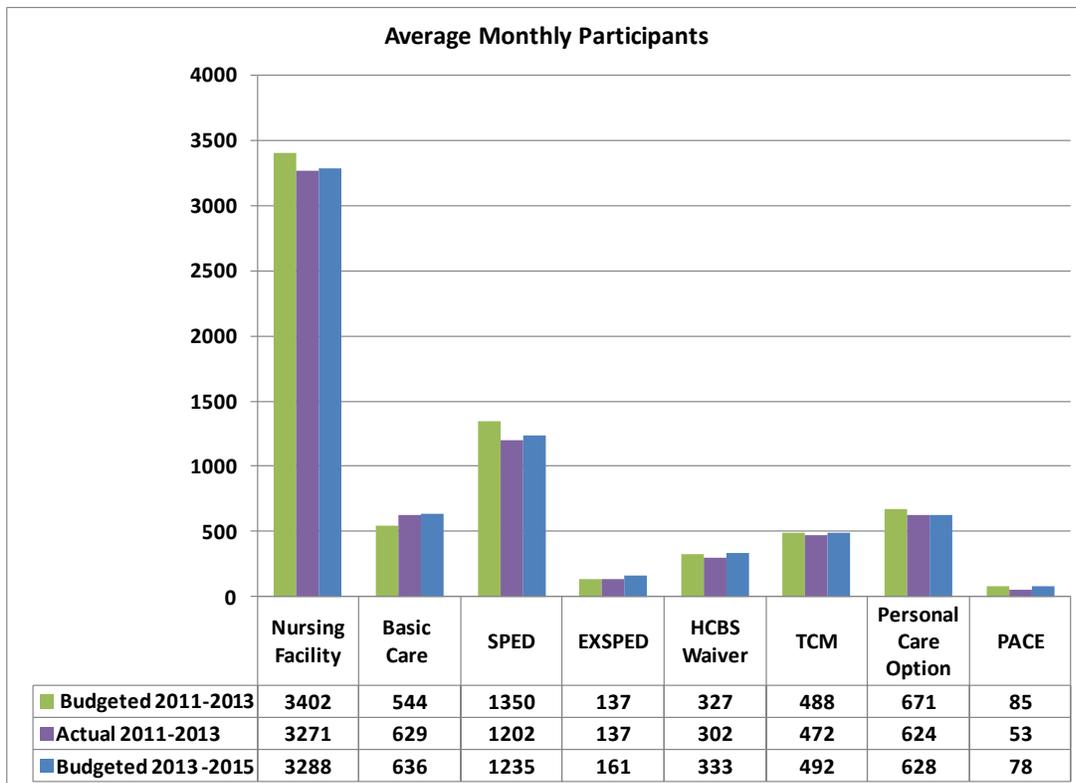
The Scorecard is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in all states can exercise choice and control over their lives. The states that ranked the highest across all four dimensions were Minnesota, Washington, Oregon, Hawaii, Wisconsin, Iowa, Colorado and Maine, with North Dakota ranking 18th. In the Affordability and Access Dimension, one of the indicators measured is the Aging and Disability Resource Centers (ADRC)/Single Entry Point functionality with North Dakota ranking 45th. One has to take into consideration that the

Scorecard findings were reported in 2011 and the State implemented a statewide ADR-LINK in 2013. A second Scorecard report is scheduled to be released in 2014, and North Dakota’s progress in this indicator should be reflected in the next report.

Generally speaking, with the increasing numbers of aging baby boomers there has also been a growing desire among elders to remain in their own homes and independent for as long as possible. This desire for community-based services rather than traditional services provided in institutional settings can represent a win-win situation for both the aging and disabled population and for the states, since those being served can receive services much less expensively and in their own homes.

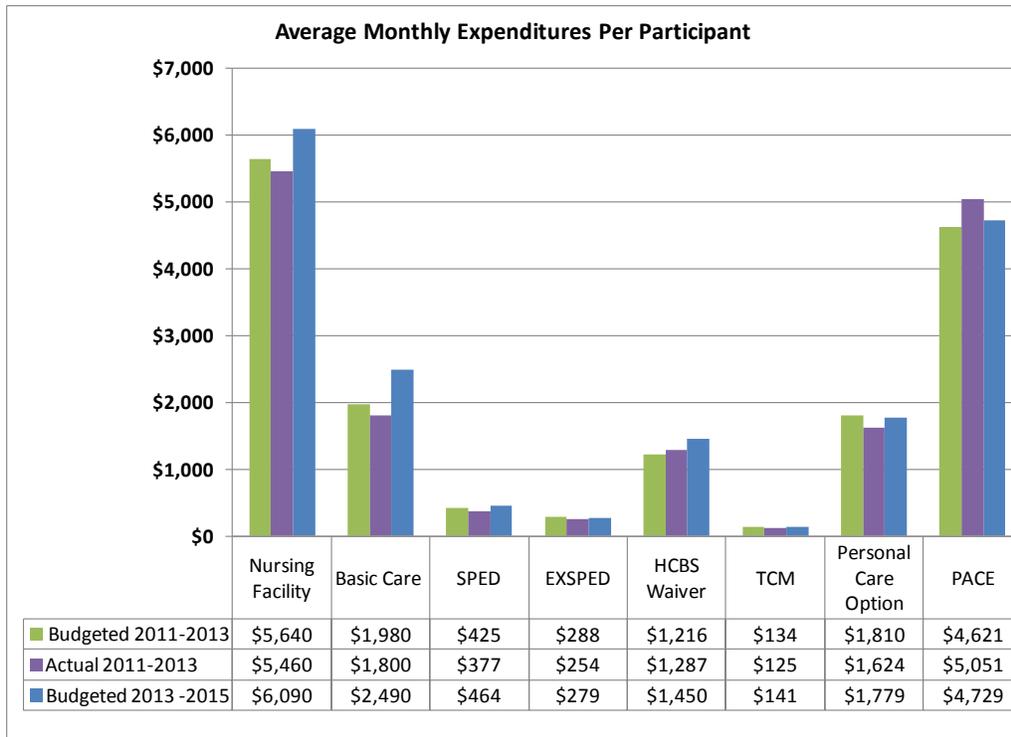
The long-term care continuum budget for the 2013-2015 biennium is \$607 million compared to the 2011–2013 biennium of \$552 million, or an increase of approximately 10%. Charts 14 and 15 provide details of the average monthly number of participants and average monthly cost of North Dakota’s long-term care programs. This includes the numbers budgeted for the 2011-2013 biennium as well as budgeted data from the 2013-2015 Quarterly Budget Insight through September 2013. Budgeted participant numbers are down for all services except expanded service payments for the elderly and disabled (Ex-SPED), home and community based services (HCBS) and targeted case management (TCM), which may just be an artifact of a shorter period for comparison.

**Chart 14: Average Monthly Number of Participants in the Long Term Care Programs**



Note: Participant numbers for nursing facility and basic care were calculated by Myers and Stauffer from per diem units for comparison purposes.

**Chart 15: Average Monthly Expenditures of North Dakota’s Long-Term Care Programs**



**Note:** Average Expenditures per Participant numbers for nursing facility and basic care were calculated by Myers and Stauffer from per diem unit expenditures for comparison purposes.

## B. Institutional Services

During the 2011-2013 biennium, nursing facilities comprised 49% of the monthly average people served in North Dakota, (3, 271 out of 6,690) and 84% of the long term care continuum expenditures, (\$427 million out of \$508 million).

The monthly average people served in nursing facilities in the 2013-2015 biennium through September 2013 was 49% of the total (3,333 out of 6, 775). The expenditures for nursing facilities represented 83% of the total.

The following section briefly discusses the description and reimbursement methods for nursing facilities in North Dakota.

### 1. Nursing Facility

#### *Description*

A nursing facility is an institution or distinct part of an institution established to provide twenty-four hour continuous nursing care. A nursing facility participating in Medicaid must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. These services include:



- Nursing and related services
- Specialized rehabilitative services
- Medically-related social services
- Pharmaceutical services
- Dietary services individualized to the needs of each resident
- Professionally directed program of activities to meet the interests and needs for well being of each resident
- Emergency dental services (and routine dental services to the extent covered under the state plan)
- Room and bed maintenance services
- Routine personal hygiene items and services

Nursing facilities must be certified by the Centers for Medicare & Medicaid Services (CMS) and be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To become certified, a state surveyor must complete at least a Life Safety Code (LSC) survey, and a Standard Survey.

Typically the State Department of Health has the responsibility for certifying nursing facility compliance or non-compliance (except for State-operated facilities), which is subject to CMS' approval. "Certification of compliance" means that a facility's compliance with Federal participation requirements is ascertained. In addition to certifying a facility's compliance or noncompliance, the State recommends appropriate enforcement actions to the State Medicaid agency for Medicaid and to the regional office for Medicare.

The CMS regional office determines a facility's eligibility to participate in the Medicare program based on the State's certification of compliance and a facility's compliance with civil rights requirements.

Nursing facilities in North Dakota are licensed by the North Dakota Department of Health and certified by the CMS to participate in the Medicare and Medicaid programs. As of September 2013 North Dakota had 80 nursing facilities providing a total of 6,029 beds. The nursing facilities ranged in size from 20 beds to 255 beds. The occupancy rate for North Dakota was 92.51%.

### *Reimbursement*

In the early 1990's several states were involved with CMS in the multistate case mix demonstration. The demonstration states worked with CMS to finalize the MDS assessment tool, conduct time studies to collect data for the development of the Resource Utilization Groups (RUGs) Classification system and assist in the collection of the MDS data. North Dakota had implemented an early version of a case mix system that utilized a state developed assessment instrument and a 16-group classification system. In 1999 the state implemented a RUG III case mix system that utilized the federally mandated MDS Assessment and the 34 group RUG III classification system.

The MDS has been updated several times, and currently all states are required to complete the MDS 3.0 version and submit the data directly to a CMS repository. States are able to utilize the MDS data for

their Medicaid case mix payment systems. The RUG III classification system was also updated to a new RUG IV version, and North Dakota implemented the new RUG IV 48 classification system in 2012. Medicaid reimbursement rates for nursing facilities in North Dakota are case mix adjusted using the MDS 3.0 and Resource Utilization Group, Version IV (RUG-IV) 48 grouper. Per-diem rates are established for each Resource Utilization Group and provider. While RUG case-mix methodologies are commonly applied across the country, states typically use a facility average system rather than establishing rates for each RUG category.

North Dakota's case mix adjusted rates are based on historical facility costs. Each nursing facility must file an annual cost report with the Department of Human Services. Reports for the period from July 1 through June 30 are due by October 1 of that year. All cost reports are desk reviewed and may be field audited. Annual rate changes take place on January 1. Using various adjustment factors, rate limits are applied to the direct care, other direct care, and indirect care cost categories. In cases where a facility's actual rate is below the limit rate for indirect care costs, incentive payments may be applied to the facility's rate component for indirect care costs. In addition, the Department compares the actual Direct Care and Other Direct Care rates to the limit rate and applies an operating margin payment add-on when the actual costs are less than the limit rate.

A minimum occupancy of 90% is used when calculating rates for Indirect Care and Property, although there are some conditions for waiving the 90% occupancy application. Occupancy limits are used to control the Medicaid nursing facility payment associated with costs that do not vary with the facility's occupancy.

The case-mix classification determined by the MDS is applicable to any resident in the facility, regardless of payment source, for funding of the resident's care. The rate payable for a given classification covers all required nursing facility services and is based on semiprivate accommodations. Residents may be charged separately for services and items that are not part of this daily rate, such as charges for a private room, cable television, transportation outside of the facility's medical community, telephone or long distance service, requested brand name supplies or items, or other non-routine services that are requested by the resident and supplied for personal comfort. These additional charges are not subject to rate equalization and are not payable by the Medicaid program.

The Department of Health requires minimum staffing requirements for all nursing facilities in the State. At least one registered nurse (RN) must be on duty eight consecutive hours per day, seven days a week. Also, at least one licensed nurse must be on duty 24 hours a day, seven days a week. These standards mirror the federal staffing requirements for nursing facilities.

Although North Dakota does not require additional staffing beyond what's mandated by federal regulations, the State does have a high national ranking in quality of care surveys. According to a 2013 report published by Families for Better Care, North Dakota is one of only 12 states that scored an above average grade in every staffing category. Furthermore, 88% of the state's nursing facilities scored an above average direct care staff rating, which resulted in the third best nationally.

Despite achieving high quality marks for staffing, North Dakota still has room for improvement. Nearly 98% of nursing facilities were cited with deficiencies during the calendar year 2012 surveys, resulting in a rank of 48 of the 50 states and District of Columbia. North Dakota ranked near the middle (27) for Health Inspections above average. (Centers for Medicare and Medicaid Services Nursing Home Data Compendium, 2012 Edition).

Evaluation of North Dakota’s nursing facility services and reimbursement policies reveals some unique characteristics, which are likely to influence some aspects of the LTC continuum. These are briefly described as follows:

**NURSING FACILITY OWNERSHIP** North Dakota has a much higher percentage of not-for-profit providers than most states. According to the Kaiser Family Foundation, 92.9% of the state’s nursing facilities were identified as not-for-profit in 2011, 4.8% were for profit, and 2.4% were government-owned.<sup>1</sup> This is significantly higher than the national average of 25.5% not for profit facilities reported by the same source for 2011.

The relationship of nursing facility ownership with respect to quality of care has been studied extensively. According to the Kaiser report, “Research indicates that for-profit, or proprietary, facilities may have poorer performance on quality measures or lower staffing levels than non-profit or government facilities.” Therefore, it would be expected that, given the very large percentage of not-for-profit nursing facilities in North Dakota, quality of care should be above the national average, and staffing would be higher as well. This is affirmed by a GAO report in 2011 that reported that for-profit nursing facility chains had the lowest staffing levels, the highest number of deficiencies identified by public regulatory agencies and the highest number of deficiencies causing harm or jeopardy to residents. Research in the quality of nursing home care has reported that not-for-profit nursing faculties have higher nurse staffing levels and fewer health care deficiencies than their for-profit counterparts. For-profit facilities, particularly those owned by multi-state chains, are more likely to reduce spending on care for the residents and to divert spending to profits and corporate overhead. While research findings do not necessarily apply to an individual nursing facility, clearly there are for-profit nursing facilities that give excellent care and not-for-profit nursing facilities that give poor care, the general rule is documented in study after study: not-for-profit nursing facilities generally provide better care to their residents (GAO, July 2012).

**CASE MIX RATE EQUALIZATION** North Dakota’s reimbursement methodology for nursing facility services is based on a twofold requirement: 1.) That rates for services are to be based on resident needs and conditions (case mix); and 2.) That nursing facility rates for Medicaid residents must also be applicable to all residents in the facility, regardless of funding source.

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<sup>1</sup> <http://kff.org/medicaid/fact-sheet/overview-of-nursing-facility-capacity-financing-and-ownership-in-the-united-states-in-2011>

This rate equalization provision is utilized in only one other state, Minnesota. The primary concept of this provision is to allow private-pay residents to better preserve their assets and thereby delay “spending down” and becoming Medicaid eligible.

While there are a number of arguments that can be made for maintaining rate equalization or eliminating the requirement altogether, the practical effect of this provision in North Dakota is as follows:

- The State’s goal in implementing rate equalization, to reduce discrimination due to payment source and prevent cost shifting from Medicaid residents to private pay residents is still a valid goal.
- Changes in nursing facility funding for all residents (Medicaid and private pay) are dependent upon requests made to the Legislature.
- Nursing facilities do not have efficiency standards by which they can compete. Costs never go down, and rates continue to increase, year after year.
- Local private markets have little influence on private rates. Nursing facilities are not allowed to charge private pay residents less than a Medicaid resident.

Rate equalization is only employed in Minnesota and North Dakota. It is not a reimbursement policy that is universally adopted by other State Medicaid Programs primarily because of concerns related to efficiency standards and cost growth.

## **C. Residential Services**

In North Dakota residential services are provided in two service settings; basic care, and assisted living. During the 2011-2013 biennium, basic care facilities comprised 9.4% of the monthly average people served (629 out of 6,690) and \$27 million out of \$508 million (5.4%) of the long term care continuum expenditures.

The monthly average people served in basic care facilities calculated based on data in the 2013-2015 Quarterly Budget Insight report through September 2013 was 9.7% of the total, (656 out of 6, 775). The expenditures for basic care facilities were 5.6% of the total.

The following sections briefly discuss the description and reimbursement methods for basic care and assisted living in North Dakota.

### **1. Basic Care**

#### ***Description***

Basic care facilities offer a long-term care service option and licensure category within North Dakota’s LTC continuum that is lower than nursing facilities but higher than independent living. Basic care facilities are Medicaid and state-funded and licensed by the North Dakota Department of Health to provide room and board and health, social, and personal care that will assist the residents to attain or maintain their highest level of functioning, consistent with resident assessment and care plan to five or

more residents not related by blood or marriage to the owner or manager. Basic care facilities are not certified by CMS and do not participate in the Medicare program. As of November 2013, North Dakota had 68 basic care facilities with a total of 1,785 beds. Not all licensed basic care facilities participate in the Medicaid program. According to the 2012 cost reports, the occupancy rate was 83%.

In order to receive basic care assistance, elderly, blind and disabled individuals must be Medicaid-eligible and meet the following criteria:

- Be in need of a supervised environment;
- Not be severely impaired in any of the activities of daily living, such as toileting, transferring to or from a bed or chair, or eating; and
- Be impaired in three of four IADLS.

Basic care facilities must offer the following:

- Personal care services
- Pharmacy and medication administration services
- Social services
- Nursing services
- Dietary services
- Activity services
- Housekeeping and laundry services

These services must be provided on a twenty-four-hour basis within the facility, either directly or through contract, and include assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL); provision of leisure, recreational, and therapeutic activities; and supervision of nutritional needs and medication administration. North Dakota defines ADL as those personal, functional activities required by an individual for continued well-being, including eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management. IADL is defined as preparing meals, shopping, managing money, housework, laundry, transportation, use of telephone, and mobility outside the basic care facility.

### ***Reimbursement***

Basic care rates are prospective, cost-based rates calculated from fiscal year end cost reports filed annually. The costs are divided into categories for direct care, indirect care, property, and food and plant costs. For each cost category, the actual rate is calculated using allowable historical operating costs plus adjustment factors, divided by in-house resident days for the direct care and indirect care cost categories and resident days for the food and plant and property cost categories. The adjustment factor is determined by the State Legislature.

The per diem rate components are compared to upper limits set at the 80th percentile of each cost component array based on licensed beds in all facilities reporting historical costs, excluding specialized facilities for individuals with mental disease. The lesser of the actual rates or the limit rates for the direct

personal care and indirect personal care costs and the operating margin are added to establish the facility's personal care rate. The operating margin is three percent based on the lesser of the actual direct care rate, exclusive of the adjustment factor, or the direct care limit rate, exclusive of the adjustment factor, established for the rate year.

The rates for property costs, food and plant costs, the operating margin for room and board, and the lesser of the actual rates or the limit rates for direct room and board and indirect room and board costs are added to establish the facility's room and board rate. The sum of the personal care rate and the room and board rate is the facility's established rate. As with nursing facility cost reports, all basic care facility cost reports are desk reviewed and may be field audited. The room and board portion of the rate is paid with 100% state funds, and the personal care portion of the rate is paid by Medicaid.

A moratorium on basic care beds was implemented in 1995 and remains in effect. New basic care beds are only allowed under the following three situations: if nursing facility beds are converted to basic care beds; if it can be proven that basic care services are not readily available; or if existing basic care beds within a 50-mile radius are at least 90% occupied. Under the moratorium beds can be sold and transferred from one provider to another allowing occupancy capacity to shift across the state while the overall capacity remains unchanged.

Basic care facilities must undergo a routine survey process conducted by the Department of Health, and the facilities must be in compliance with both the standard health survey and the life safety code survey.

## 2. Assisted Living

### *Background*

Assisted living facilities typically provide the lowest level of residential care within the long-term care continuum of services. They offer an apartment-like setting to residents who are fully independent or semi-independent and who do not require continuous nursing care. Assisted living facilities do not have to be staffed on-site 24 hours a day, but staff must be available at all hours in order to meet the needs of the residents. These facilities also offer personal care and medication management services to their residents.

Regulatory and licensing requirements for assisted living facilities vary widely among states, but assisted living continues to be a service option that is paid primarily with private funds. Although most states offer an assisted living option through their 1915 (c) Medicaid Waiver programs, participation is quite limited among states, primarily because the Medicaid Program is prohibited from paying for room and board expenses in a non-institutional setting. According to the North Dakota Long-Term Care Association, 94% of funding for assisted living comes from private funds and public assistance covers just 3% of the costs. The remaining 3% was classified as other and includes Housing and Urban Development (HUD) funds.<sup>2</sup>

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<sup>2</sup> NDLTCA Assisted Living Facilities fact sheet <http://www.ndltca.org/data/Assisted%20Living%20facilities.pdf>

### *Description*

Assisted living facilities in North Dakota are defined as five or more living units that are operated as one entity and that provide services to five or more individuals who are not related to the owner or manager. They provide or coordinate individualized support services to accommodate the individual's needs and abilities to maintain as much independence as possible.

Assisted living residents must be capable of self-preservation in an emergency and cannot require continual or 24 hour nursing care. Direct care staff must be available 24 hours a day but do not have to be on site at all times. Unlicensed staff may distribute medication except those prescribed "as needed." As of November 2013, there were 73 assisted living facilities in North Dakota providing a total of 2,672 living units.

Currently, North Dakota requires assisted living facilities to be licensed for operation by the Department of Human Services (DHS), and licensed for sanitation and safety standards by the Department of Health. A 1987 task force recommended in that the Department of Health and DHS consolidate the licensure functions for all long term care facilities. The September 2000 "Task Force on Long Term Care Report"<sup>3</sup> recommended that assisted living facilities be required to register with DHS and be licensed by the Department of Health.

Regulations require facilities to address certain aspects of staffing, training, and customer satisfaction. Changes were made to assisted living regulations in 2009 prompted by the advocacy of the assisted living profession. Assisted living facilities are required to conduct reference checks on prospective employees and must screen those candidates using applicable registries. Assisted living administrators are required to complete at least twelve hours of continuing education per year and all direct care staff are required to receive training on residents rights, accident prevention, mental and physical health needs of tenants, behavior problems and interventions, and infection control. The regulations require each assisted living facility to maintain and fully disclose tenancy requirements, and each facility must conduct at least one satisfaction survey every 24 months and must share the results with tenants.

Medicaid funding is available for services such as personal care and homemaker, which are reimbursed to assisted living providers through Medicaid waiver programs and the SPED and ExSPED programs. Residents must have an approved individual plan of care, subject to a maximum cap for services.

The State does not have a moratorium on assisted living facility beds. New facilities are allowed to be built and opened without restrictions on timing or location.

Unlike nursing facilities and basic care facilities, assisted living facilities are not subject to a formal survey process. However, each assisted living facility is required to perform satisfaction surveys every two years and share the results with its residents.

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<sup>3</sup> <http://www.nd.gov/dhs/info/publicnotice/2013/11-27-medicaid-sp-amendments.pdf>

## D. Medicaid Home and Community-Based Programs

The Medicaid Program provides funding to states that support an array of long-term care services, both institutional and non-institutional. The Medicaid Program was enacted in 1965 and initially limited coverage of long-term care to a nursing facility setting or hospital setting for individuals who were ventilator-dependent. That ended however, when the family of a ventilator-dependent child fought to move services for the child out of the hospital and into her own home. They argued that this “waiver” of funding requirements for delivery of acute care services from the institutional setting to the child’s home would be less expensive and would add a quality of life component that would be immeasurable. Their fight was successful, and authorization to fund traditionally institutional long-term care services in the home was made available through section 1915(c) of the Social Security Act, which was authorized in the Omnibus Budget Reconciliation Act of 1981 and has become widely recognized as the origin of the Medicaid Waiver Program.

Over the next several years, similar flexibility was extended to states to cover populations other than children, but funding and regulatory reliance on traditional institutional settings for long-term care rendered states slow to adopt waiver programs on a wide scale.

In 1999, the Supreme Court ruled in *Olmstead v. L.C.* that Americans with Disabilities had the right to receive services “...in the most integrated setting appropriate.” This decision interpreted Title II of the Americans with Disabilities Act (ADA), which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications.

The *Olmstead* decision had a significant impact on State Medicaid Agencies and the Federal government, providing the impetus for considerable growth in waiver program availability and in the number of Medicaid recipients served through waiver programs nationwide.

The Deficit Reduction Act of 2005 further and substantially extended waiver program flexibility by allowing states the option to add HCBS to their Medicaid state plans, which among other things extends waiver service availability to all Medicaid recipients who qualify.

Then on May 20, 2010, CMS issued a State Medicaid Director (SMD) Letter to provide information on new tools to support community integration, as well as to remind states of existing tools that remain strong resources in states' efforts to support community living. With the issuance of this letter, CMS reaffirmed its commitment to the policies identified in previous *Olmstead* guidance. In the May 20, 2010 letter, CMS expressed an interest in working with states to continue building upon earlier innovations and a hope that the letter will help states identify new strategies to improve community living opportunities.

On January 10, 2014, CMS published a final rule on Medicaid HCBS waivers, which further expands state waiver program authority to enhance quality and to add protections for individuals receiving services. This final rule is part of the Affordable Care Act. Highlights include:

- Defining home and community-based settings
- Implementation of the Section 1915(i) home and community-based services State Plan option, which, includes new flexibility that gives states additional options for expanding home and community-based services and to target services to specific populations
- Amends the 1915(c) home and community-based services waiver program to add new person-centered planning requirements, allows states to combine multiple target populations in one waiver, and streamlines waiver administration.

These combined efforts have contributed to significant growth in the number of people receiving needed care in their setting of choice, rather than strictly in institutions.

Currently, the Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. In addition to offering states the ability to deliver traditional services in community settings, waivers are tools that states can use to test new or existing ways to deliver and pay for health care services in Medicaid. There are four primary types of waivers and demonstration projects:

- Section 1115 Research and Demonstration Projects, which allow states to test approaches to financing and delivering Medicaid and CHIP.
- Section 1915(b) Managed Care Waivers, which allow states to provide services through managed care delivery systems.
- Section 1915(c) Home and Community-Based Services Waivers, which allow states to provide long-term care services in home and community settings rather than institutional settings.
- Concurrent Section 1915(b) and 1915(c) Waivers, which allow states to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities.

According to CMS, total federal and state spending on Section 1915(c) programs totaled nearly \$38 billion, accounting for 59 percent of all non-institutional LTSS spending. The remaining 41 percent of non-institutional services was provided through Medicaid State Plan options including personal care, home health, rehabilitation, PACE, private duty nursing, Money Follows the Person and HCBS under Sections 1915(i) and (j).<sup>4</sup>

### **1. Medicaid 1915(c) HCBS Waivers**

The 1915(c) HCBS waiver programs are the oldest and most common and highly utilized by states to deliver cost-effective long-term care services and supports to its recipients/consumers in the community, rather than through traditional institutional settings, such as nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and in some cases hospitals. CMS

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<sup>4</sup>“Medicaid Expenditures for Section 1915(C) Waiver Programs In FFY 2011”, Steve Eiken, Brian Burwell, Lisa Gold, Kate Sredl, Paul Saucier, October 2013, pp. 2-3] in FFY 2011

reports that for FFY 2011, Section 1915(c) waiver programs account for nearly 30 percent of all Medicaid LTSS spending, including institutional and non-institutional services.

Under the 1915 (c) Home and Community-Based Waiver authority states have the option to cover a variety of services, both medical and non-medical, to one or more targeted populations, although eligible individuals must meet the minimum level of care required for a comparable institutional setting.

Each State 1915(c) HCBS waiver program must meet several basic criteria.

- The program must be cost-effective in the aggregate
- The program must ensure each participant's health and welfare
- The program must include reasonable and adequate provider standards for participation
- The program must ensure that services are provided according to a clearly- established and person-centered plan of care for each individual

The 1915 (c) HCBS waiver program also authorizes states to waive certain Medicaid program requirements. These include the following:

- State-wideness
- Comparability of services
- Income and resource rules applicable in the community

1915 (c) HCBS waiver programs are typically established to offer community services to persons who are elderly, chronically ill, physically disabled, and/or intellectually / developmentally disabled. Waiver programs may also be targeted to persons with specific diseases or conditions.

Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

### *Medicaid 1915(c) Waivers in North Dakota*

North Dakota has the following Section 1915(c) waivers.

- ND Medicaid Waiver HCBS (0273.R04.00)
- ND Children's Hospice (0834.R01.00)
- ND Autism Spectrum Disorder Birth through Four (0842.R01.00)
- ND Traditional MR DD HCBS (0037.R06.00)
- ND Technology Dependent Medicaid Waiver (0468.R01.00)
- ND Medicaid Waiver for Medically Fragile Children (0568.R01.00)

The focus of this study is on the North Dakota Medicaid Waiver HCBS 0273.R04.00, which helps eligible individuals who would otherwise require nursing facility services to obtain the services they need in

their homes and communities. Services are provided to individuals age 65 or older and individuals with physical and other disabilities ages 18 to 64. The waiver was originated in 1994 and most recently renewed in 2012 for five years.

Services provided include:

- Adult day care – program of non-residential activities, both health and social services, provided at least three (3) hours per day one or more days per week to ensure optimal functioning of the individual
- Adult family foster care – 24-hour care in a home environment ( 4 or less individuals) with adults who are unable to function independently or who may benefit from a family home environment
- Adult residential care – personal care, therapeutic, social and recreational programming services provided in a facility with at least 5 unrelated adults with 24 hour on site response staff
- Case management - assessment of needs and arrangement, coordination and monitoring of services
- Chore services – heavy housework, cleaning, professional extermination, snow removal, etc.
- Emergency Response Systems – electronic devices that enable the client to secure help in an emergency
- Environmental modifications – Physical adaptations to the home to enable a client to function with greater independence and safety in his or her home
- Extended personal care – hands on medical care provided by a Qualified Service Provider (QSP) trained by a nurse licensed to practice in the State
- Family personal care – provides extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services
- Home delivered meals – provides meals that assure a minimum of one third of the recommended dietary allowances
- Homemaker services – housekeeping, laundry and shopping services
- Non-medical transportation - enables individuals to access essential community services
- Respite care – temporary relief to a primary caregiver for a specified period of time
- Specialized equipment and supplies – devices, controls, or appliances specified in the plan of care to improve ADL performance or to increase an individual’s ability to perceive, control or communicate with the environment in which they live.
- Transitional living services – training, supervision, or assistance with self care, communication skills, socializations, sensory motor development, reduction or elimination of maladaptive behavior, community living and mobility

## **2. State Plan Waiver Options 1915(i), 1915(j) and 1915(k)**

The Deficit Reduction Act of 2005 established two additional Medicaid state plan options for states to cover HCBS. These include the 1915(i) Waiver that allows states to offer HCBS under their state plan,

and the 1915(j) Waiver that permits states to provide self-directed personal care/personal assistant services (PAS).

1915(i) state plan HCBS options include:

- Targeting the HCBS benefit to one or more specific populations
- Establishing separate additional needs-based criteria for individual HCBS
- Establishing a new Medicaid eligibility group for people who get State plan HCBS
- Defining the services included in the benefit
- Allowing any or all HCBS to be self-directed

For Section 1915(j) a state must stipulate that beneficiaries would otherwise be eligible to receive agency-directed PAS under the state's Medicaid plan and ensure that beneficiaries choosing to self-direct:

- Receive choice counseling
- Are allowed to manage their own budgets, planning and purchasing services of their own choosing
- Have their needs, strengths, and preferences assessed before services are designed and initiated
- Have an individual service plan developed on their behalf
- Have access to financial management services (FMS) to assist them in paying providers, tracking costs, and filing required reports

The "Community First Choice Option" 1915(k) was established under the Affordable Care Act of 2010 and became available on October 1, 2011. It allows states to provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan and provides a 6% increase in Federal matching payments to states for expenditures related to this option.

North Dakota is not currently participating in any of these State Plan Waiver Options.

### **3. Medicaid State Plan Personal Care**

All State Medicaid Agencies have the option to amend their State Medicaid Plans to add personal care services to the array of Medicaid-covered services available to individuals in non-institutional settings. Unlike personal care services that are offered through a state's 1915(c) and 1915(j) Home and Community-Based Services Waiver programs however, State Plan Personal Care cannot be limited through the use of first-come, first-served funded or with a waiting list, but must instead be available to every individual who meets state-established eligibility criteria for the service. It is this open-ended approach to personal care services that is likely the reason that many states do not include this service option within their LTC continuum; namely, because Medicaid State Plan Personal Care is a service similar to hospital, physician, and nursing facility in which adequate funding must be available to meet the needs of all who qualify.

North Dakota implemented a Personal Care service option through its state Medicaid Plan in 2003. According to the Kaiser Family Foundation website on Medicaid Personal Care Services Expenditures, North Dakota was one of only 32 states in 2008 that offered personal care through their State Medicaid Plans. Two additional states were approved by CMS but did not have expenditures.

In North Dakota, Medicaid State Plan – Personal Care Services, or MSP-PC, are defined as services that help people with daily living activities such as bathing, dressing, transferring, toileting, cooking meals, housework and laundry to help them continue to live independently in their homes and communities.

Personal Care services in North Dakota have three eligibility criteria.

1. Level A Personal Care Services

Individuals may be eligible for this level of services and receive up to 120 hours of personal care per month if they meet the following guidelines:

- Be impaired in at least one ADL or three IADLs;
- Must be on Medicaid; and
- Have needs that are expected to last 30 days or more.

A case manager will assess how much assistance is needed with activities such as bathing, transferring, toileting, dressing, laundry, and housework.

2. Level B Personal Care Services

Individuals may be eligible for this level of services and receive up to 240 hours of personal care per month if they meet the following guidelines:

- Be impaired in at least one ADL or three IADLs;
- Meet nursing facility level of care;
- Must be on Medicaid; and
- Have needs that are expected to last 30 days or more.

A case manager will assess how much assistance is needed with activities such as bathing, transferring, toileting, dressing, laundry, and housework to determine whether this level of care is needed.

3. Level C Personal Care Services

Individuals may be eligible for this level of services and receive up to 300 hours of personal care per month if they meet the following guidelines:

- Be impaired in at least five ADLs;
- Meet nursing facility level of care;
- Must be on Medicaid; and

- Have needs that are expected to last 30 days or more.

A case manager will assess how much assistance is needed with activities such as bathing, transferring, toileting, and dressing to determine whether this level of care is needed.

#### **4. Service Payments for the Elderly and Disabled (SPED) Program**

The Service Payments for the Elderly and Disabled (SPED) program is a state program that was created to provide a variety of services that allow people to stay in their homes rather than going to a nursing facility. Covered services include:

- Adult Day Care
- Adult Family Foster Care
- Case Management
- Chore Service
- Emergency Response System (Lifeline )
- Environmental Modifications (Limited)
- Extended Personal Care
- Family Home Care
- Homemaker
- Home Delivered Meals
- Non-Medical Transportation
- Non-Medical Transportation - Escort
- Personal Care
- Respite Care

Individuals may qualify for SPED if they have liquid assets less than \$50,000, an inability to pay for services, and impairments in four ADLs or in five IADLs that have lasted or be expected to last three months or longer.

Individuals younger than age 18 may be eligible for services if they:

- Have been screened for nursing facility level of care
- Are not eligible for services under the Medicaid waiver program or the Medicaid State Plan for personal care services
- Are living in what is commonly considered a private family dwelling
- Have a need for service that is not due to mental illness or mental retardation
- Are capable of directing their own care or have a legally responsible party
- Have needs within the scope of covered services

During the 2011 – 2013 biennium, an average of 1,202 individuals received SPED services per month at an average cost of \$377. According to the 2011-2013 Quarterly Budget Insight, total expenditures for the SPED Program the biennium were \$10,870,112.

## 5. Expanded Service Payments for the Elderly and Disabled (Ex-SPED) Program

Ex-SPED is a state program that pays for in home and community based services for people who would otherwise receive care in a basic care facility. The covered services are the same as for the SPED program with the exception of personal care and extended personal care services, which are not included. To receive funding through this program, individuals must meet the following criteria:

- Be eligible for Medicaid
- Be eligible for Social Security Income (SSI) or have income that does not exceed SSI
- Not be severely impaired in toileting, transferring and eating
- Be impaired in three of four IADLs or have health, welfare or safety needs including need for supervision or a structured environment
- Live in what is commonly considered a private family dwelling.
- Have needs within the scope of services

During the 2011–2013 biennium, an average of 137 individuals per month received Ex-SPED services at an average cost of \$254. State expenditures listed on the 2011-2013 Quarterly Insight Budget Report totaled \$834,214.

## E. Program of All-Inclusive Care for the Elderly (PACE) Program

The Program of All-Inclusive Care for the Elderly (PACE) is by definition a self-contained care continuum of services and programs that function separately from but parallel to other Federal and State programs.

The PACE model of care originated in the early 1970s, when the Chinatown North Beach community of San Francisco saw the need for long term care services for families whose elders had immigrated from Italy, China and the Philippines. On Lok Senior Health Services, a nonprofit corporation was formed to create a community based system of care.

In 1990, the first PACE program received Medicare and Medicaid waivers to operate. The Balanced Budget Act of 1997 established the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs. By 2013 there were 98 PACE programs operating in 31 states.<sup>5</sup>

The PACE philosophy is that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. Therefore, an interdisciplinary team of health professionals determines the services necessary to improve and maintain the individual's overall health, and coordinates those services to provide the needed care.

PACE providers receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide the entire continuum of patient-centered and coordinated care and services to frail elderly individuals with chronic care needs and who live in the community.

PACE provides the following care and services, including but not limited to:

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<sup>5</sup> [http://www.npaonline.org/website/article.asp?id=12&title=Who,\\_What\\_and\\_Where\\_is\\_PACE?#History](http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_is_PACE?#History)



- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing facility care when necessary

PACE is a long term care delivery and financing innovation. The PACE delivery system is comprehensive, uses an interdisciplinary team for care management, and integrates primary and specialty medical care. The Journal of American Directors Association (JAMDA 2009) reported that PACE programs have seen steady census growth, good consumer satisfaction, reduction in use of institutional care, controlled utilization of medical services, and cost savings to public and private payers of care, including Medicare and Medicaid.

The evolution of PACE and its regulatory and reimbursement model have changed over time, but the principles of care have remained unchanged. Nationally PACE programs are dealing with some of the same challenges they had 30 years ago, and yet PACE programs continue to expand and provide care to an ever wider distribution of populations. The growing number of older people in the United States challenges healthcare providers and policy makers alike to provide high quality care in an environment of shrinking resources. The PACE model's comprehensiveness of health and social services, its cost-effective coordinated system of care delivery, and its method of integrated financing have wide applicability and appeal. Providers across the United States have successfully replicated the PACE model, demonstrating the value of high quality and individualized care.

For consumers, the PACE program provides:

- Caregivers who listen to and can respond to their individualized care needs
- The option to continue living in the community for as long as possible
- One-stop shopping for all health care services

For health care providers, PACE provides:

- Capitated funding arrangement that rewards providers that are flexible and creative in providing the best care possible
- Ability to coordinate care for the individuals across settings and medical disciplines
- Ability to meet increasing consumer demands for individualized care and supportive service arrangements

For those who pay for care, PACE provides:

- Predictable expenditures
- Comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care
- A model of choice for older individuals focused on keeping them at home and out of institutional settings

To be eligible for PACE an individual must:

- Be 55 or older
- Live in the service area of a PACE organization
- Be eligible for nursing facility care
- Be able to live safely in the community

Once enrolled, the PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

### *PACE in North Dakota*

PACE was established in North Dakota in September of 2008 and currently has two sites operated by Northland PACE in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

Effective on or after January 1, 2014, the 2013 House Bill 1360 approved an expansion of the PACE program into one additional community. As reported in a public notice dated November 27, 2013, PACE plans to expand into Minot and the estimated cost of this expansion for twelve months is \$927,000.

The 2011-2013 Quarterly Budget Insight Report shows there was a monthly average of 53 persons receiving PACE services at a monthly cost of \$5,051 per person. This is less than the budgeted number of individuals and at a slightly higher than budgeted expense. Through the date of the report, it represents spending of a little over 68% of the biennium appropriation. As reported on the Quarterly Budget Insight Report for the first quarter of the 2013-2015 biennium, the actual monthly average enrollment was 78 individuals. This is about 1% of the total number of Medicaid LTC beneficiaries.

Although limited in location and capacity, the PACE program nevertheless provides an important service within North Dakota's LTC continuum. It is an all-inclusive program that provides for the total needs of an individual while maintaining the individual's desire to continue to live at home.

Costs should be contained because the PACE program sponsors receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide the entire continuum of patient-centered and coordinated care. All PACE participants must be certified to need nursing facility care to enroll in PACE, however only about seven percent of PACE participants nationally reside in a nursing facility.

Because individuals can leave the program at any time, voluntary disenrollments have the potential to undermine the PACE reimbursement structure. For example, if participants regularly disenroll when they



begin using nursing facility services, then the PACE organization may not be providing the full continuum of care that the rates were intended to cover, reducing cost effectiveness.

## IV. Accessing Long Term Care Services

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.

### A. System Entry

Unfortunately for many Americans, long-term care is not typically something that is planned in advance or fully considered before the need presents itself. In most situations, the need to understand and access long term care services is done in an emergency or crisis situation, such as after an inpatient hospital stay, surgery, or some other health care crisis. These are issues that challenge every state Medicaid agency and other programs that administer publicly-funded LTC services and supports. Making sure that all consumers and their families and caregivers know how to access needed services and programs and obtain information on available services is essential to a successful long term care system.

A long term care continuum can be confusing and difficult to navigate. Single point of entry systems allow consumers to access services through a coordinated, standardized entry process that includes screening, assessment and case management.

Since the early 1990s, states across the U.S. have been implementing or considering single points of entry for long term care. These points of entry (POE) vary greatly in scope, implementation, and process. They generally however, involve the development of a single entity or process through which consumers must enter to access, understand, arrange for, and receive the care they need. Functionally, a POE provides an entity who consumers can contact to obtain information and referral, apply for services, evaluate and provide service recommendations. POE systems are generally founded on one or both of the following philosophies:

- “One-Stop Shop” – A consumer-centered information system that provides comprehensive information and support to encourage informed decision making on long term care services, support and benefits. Coordination, integration, and linkages of care services, supports and benefits, which are seen as necessary to service the diversity of consumers; and
- “No Wrong Door” - An approach that evolved from one-stop shop and is focused on the delivery of information to consumers regardless of where they first enter or encounter the system. This type of system tends to rely heavily upon technology that brings together services and funding streams. Today’s POE programs combine these philosophies in varied amounts and create systems that provide information and

assistance, streamline the application process, address eligibility and monitor or oversee services.

North Dakota has two main points of contacts in the point of entry system. Consumers can call the county social service office and receive information on support services or they can contact an Options Counselor through the Aging and Disability Resource LINK and obtain information, referral and assessment.

The ADRL Options Counselors will refer consumers to the county social service office if the person needs to be assessed for eligibility for Medicaid, home and community based services (HCBS) or basic care. The State has a memorandum of understanding with the county social services offices to conduct these assessments. The ADRL has the authority to assess consumers and determine eligibility for programs that include the Older Americans Act Services, such as: congregate meals, transportation, family caregiver support program, home delivered meals, health maintenance and legal assistance.

Both county social workers and ADRL Options Counselors can also go to the hospital and assess the needs of an individual and assist with determining the appropriate services needed. When a consumer needs nursing facility services, the level of care screening tool (LOC) is completed by a nurse or social worker from the hospital or the receiving nursing facility. LOC eligibility is then determined by the state contractor.

## **1. County Social Services Offices**

The county social services offices are a point of contact for families, children, the elderly and disabled to help locate resources and support programs. North Dakota has county social services offices located throughout the State. They offer a variety of services, including eligibility determinations and assistance with the following programs and services:

- Medicaid
- Basic care assistance
- Home and community-based services and supports for elderly and disabled individuals
- Personal care assistance
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Children's health services, including CHIP
- Child care assistance
- Child welfare, including foster care, child protection services, child care licensing, and related services
- Heating assistance
- Referrals to other local resources and programs

The majority of the services/programs offered by the county are administered in conjunction with state and federal agencies, particularly the North Dakota Department of Human Services.

## 2. Aging Disability Resource LINK - ADRL

In 2009, the North Dakota Department of Human Services received a three-year grant from the Administration on Aging to pilot an Aging and Disability Resource Center (ADRC) in the Bismarck region. The project used a “no wrong door” model offering a “virtual single point of entry for accessing public and private health and human services on-line, by phone, or through face-to-face contact.”

In 2013, the Department implemented a state-wide ADRC system. Options Counselors are located in each of the eight regions of the state. The system also includes a toll-free number (1-855-Go2 LINK) offering information and assistance to callers and maintains a database accessible at [www.carechoice.nd.gov](http://www.carechoice.nd.gov).

The purpose of the ADRL is to make it easier for older individuals, adults with disabilities, and their family members to learn about the choices they have and determine whether they qualify for long-term care and supportive services. The service also helps to link the individuals and families to needed services and supports, and be a resource for people who do not qualify for publicly funded case management and support services.

The three main functions of the ADRL are:

1. To promote information and awareness through public education and information on long-term support options
2. To provide assistance through long-term support options counseling, referral, crisis intervention, and planning for future needs
3. To facilitate access for private and public pay services, through comprehensive assessment

ADRL services and functions appear to be limited in ways that adversely impact the ease and success of which North Dakota’s elderly and disabled are able to receive and maintain services in the community. Stakeholders report that the Options Counseling has no provision for assisting individuals with completing application forms or for performing extended case follow-up. This appears to be inconsistent with the federal description of the ADRC responsibilities.

The ADRLs together with the county offices work together to serve as North Dakota’s entry points for accessing publicly-funded LTC services.

## B. Description of Process

### 1. North Dakota Stakeholder Perceptions / Experiences

As part of this long term care study, a questionnaire was developed and distributed to more than 404 stakeholders identified by the Department of Human Services.; responses were received from 94 (23%) stakeholders.

The first two questions were intended to identify the respondent’s familiarity with ND LTC services and programs respectively, while the third question asked the stakeholder to rank how efficient and

effective are the point of entry and needs assessment for determining consumer eligibility and arranging appropriate services. Stakeholder responses to the third question were as follows (the percentages do not total to 100% due to rounding):

**Question 3a: How efficient and effective are the point of entry and needs assessment for determining consumer eligibility and arranging for appropriate services?**

- Very: the process is user friendly and person-centered, eligibility determinations are made timely, and a service plan is quickly established and implemented-**15%**
- Somewhat: the process works but is somewhat complicated and cumbersome-**65%**
- Not at all: the process is difficult and includes numerous barriers and/or obstacles-**9%**
- No response-**12%**

Stakeholders were also requested to explain their responses to this question. Common themes expressed included:

- Need a single point of entry
- Process is burdensome and confusing
- Paperwork is intimidating and takes a long time to complete
- Regulations are burdensome
- Need education on programs and what services are available
- Assessment process is inefficient, cumbersome and needs to stand up to appeals
- Screening process is subjective and based on person submitting the responses
- Discharge planners and physicians need education on point of entry process and what services are available to elderly individuals
- Hospitals and physicians offer nursing facility as the only option to families many times
- State is not offering enough options to keep people at home
- Point of entry and needs assessment process are inefficient
- The number of agencies serving individuals causes confusion with services and coordination
- Entry into system is best provided face-to-face rather than electronic method
- It takes approximately 6 hours to complete eligibility assessment
- Lack of county social workers makes scheduling assessment difficult
- Assessment does not accurately reflect what the individual truly needs to keep them home
- Consumers commented they were not offered any options to nursing facility as they were private pay
- Discharge planner was not aware of the process and what services were available but would like some information
- Legislators need education

Stakeholders who attended one or both of the public meetings in Bismarck (January 14, 2014) and Fargo (January 15, 2014) and/or who submitted written testimony expressed similar issues and concerns regarding the point-of-entry and needs assessment process.

## **2. Level of Care Determination**

All state Medicaid programs have two requirements that determine eligibility for individuals seeking to obtain Medicaid and other publicly funded services. These two requirements are: 1.) Categorical eligibility, which for long-term care services is based primarily on physical disability, chronic illness, age, or a combination of these factors; and 2.) Financial eligibility. Although both of these eligibility requirements are federally mandated, states have considerable discretion within the Federal framework to establish more specific and often stricter eligibility requirements.

State Medicaid Agencies are also required to establish a preadmission screening process, which includes a needs assessment, for persons seeking a skilled nursing level of services in either an institutional setting such as a nursing facility or a community setting through an HCBS Waiver Program. Again, states have discretion in adopting their own procedures and setting their own criteria when assessing needs for long-term care services, although the screening criteria for community-based care can be no less strict than that for institutional care. This assessment of functional eligibility and care needs is often referred to as a level of care determination, or LOC.

States are not required to perform annual re-determinations of level of care on the state Medicaid nursing facility residents; however, Federal law requires that Medicaid funds are made available to states only for persons who meet the state's institutional LOC criteria. For this reason, and to assure that individuals truly receive care in the least restrictive setting possible, many states require annual and often more frequent level of care determinations to be made in response to changes in an individual's care needs. North Dakota requires annual redeterminations of individuals who receive HCB services, but does not require redeterminations for persons in a nursing facility.

There are many assessment tools that have been developed to address a wide variety of programs and population needs and no one universal assessment tool adopted by all states, all programs, and populations. In 1987, following the Nursing facility Reform Act, the mandate for the MDS 2.0 to be used across all nursing facilities in the country was one of the first times that a specific tool was standardized across a service setting.

North Dakota contracts with ASCEND, a Nashville, Tennessee healthcare management support service to conduct nursing facility level of care reviews. The North Dakota Level of Care assessment tool is used to determine level of care for nursing facility, swing bed and waiver services. A level of care determination form must be completed on all clients who receive or apply for Medicaid when entering a nursing facility, swing bed or when beginning waiver services. The level of care determination must be approved prior to admission to the nursing facility.

According to the N.D.A.C. Section 75-02-02.1-04 annual screening is required only for recipients who require care in an intermediate care facility for individuals with intellectual disabilities or through home



and community based services (HCBS). In other words, individuals residing in nursing facilities are not reviewed on an annual basis to determine/affirm that their care needs continue to meet the nursing facility level of care. The nursing facility can however request a level of care screening to be completed if they believe that the individual residing in a nursing facility, and paid for by the Medicaid agency, no longer meets nursing facility level of care. This arguably represents a conflict-of-interest since the nursing facility is the primary provider of service and not an unbiased, third party reviewer.

## V. Rebalancing Programs

### A. Institutional Bias

#### 1. Historical Origin

As stated previously, institutional services within Medicaid are specific benefits authorized in the Social Security Act. These include hospital services, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), nursing facility (NF), inpatient psychiatric services for individuals under age 21, and services for individuals age 65 or older in an institution for mental diseases.

According to CMS, all must share the following features:

- Are residential facilities
- Provide comprehensive care including room and board.
- Bill for a single bundled service
- Must be licensed and certified by the state
- Are subject to surveys at regular intervals

Although state Medicaid agencies define the need for services through nursing facility level or care criteria, they are required to provide nursing facility services to individuals age 21 or older (under age 21 is an optional benefit). States cannot limit access to any eligible individual.

Prior to 1981, the only comprehensive long-term care that was reimbursed by Medicaid was care in an institutional setting. Nursing facilities were by and large the only service provider available in both urban and rural communities, making them the primary provider of services for most Americans with skilled nursing care needs. For these reasons, nursing facilities have collectively been one of the primary recipients of Federal, state and local funding for health care services. Until Congress enacted section 1915(c) of the Social Security Act as part of the Omnibus Reconciliation Act (OBRA) of 1981, comprehensive long-term care services through Medicaid were available only in institutional settings. In 1991 only 14% of Medicaid expenditures were for community based services.<sup>6</sup>

#### 2. Present

Institutional care is now and has long been widely recognized as a very expensive care option for taxpayers and private citizens. Additionally, it is a health care option that is typically not the service of choice for most individuals who have or develop skilled care needs. In addition, Federal funding and policies for long-term care have been slow to recognize and support various ways to implement non-institutional forms of care, making change very difficult and very challenging to implement.

Additionally, home and community-based services do not offer the level of supervision, continuous availability of qualified professional staff, program oversight, monitoring and review, and various other safety net features that are inherent within highly-regulated institutional services. It is this aspect that

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<sup>6</sup> [http://www.nhpf.org/library/background-papers/BP\\_HCBS.Waivers\\_03-03-06.pdf](http://www.nhpf.org/library/background-papers/BP_HCBS.Waivers_03-03-06.pdf)

further contributes to the challenges that state Medicaid agencies must overcome to implement and operate non-institutional care options, overcome historical perceptions of safety and service delivery, and determine the extent to which one's personal choice must be considered.

In the years since 1981, numerous legislative and regulatory changes and legal decisions have contributed to the evolution of Medicaid home- and community-based waiver programs. They have grown in availability, accessibility, and utilization in all states, significantly broadening the long-term care continuum of services options for individuals who would otherwise receive services in an institutional setting. In its publication, "Medicaid Expenditures for Long Term Services and Supports in 2011", CMS reports that Medicaid spending for older adults and people with physical disabilities continues to be heavily reliant on institutional care, with only 38% of spending for non-institutional care. This is in stark contrast with services for persons with developmental disabilities, where 68% of national expenditures went to non-institutional services.

CMS reports that in 2011, North Dakota ranked 43rd among all states in per capita 1915(C) spending for the aging and disabled. Total spending was just over \$4.5 million. This calculates to \$6.65 per person and shows an increase of 9.4% over 2010.

## **B. Rebalancing**

"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.

States have demonstrated that the services delivered in a more natural environment are often more cost effective and more comfortable than services provided in an institutional setting. Waiver programs enhance recipient choice and flexibility. Rebalancing benefits can include:

- Control Medicaid payments for institutional facilities
- Quality improvement in the state's LTC programs, services and supports
- Increased consumer choice in selecting LTC providers by stimulating HCBS service growth

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.

Finally, it is very important to point out that the overall success of long-term care rebalancing is highly dependent upon extensive stakeholder education, outreach, and training, which is not similarly required for institutional forms of care which are already well-known and understood. Most states fare poorly in this category, committing only a fraction of the resources needed to fully achieve the desired level of awareness needed to achieve program objectives. In this context, stakeholder is a global term used to refer not only to consumers and providers, but also to state and county agency staff, legislators, and other key decision-makers, many of whom do not fully understand and appreciate the complexity of the long-term care service delivery system.

### C. Diversion

“Diversion” is another important aspect of LTC rebalancing and generally refers to programs and initiatives that identify individuals who are at risk of institutional placement and expedite development of an individual care and service plan that establishes community-based services and supports prior to or shortly after being placed in a nursing facility. States with the most effective rebalancing outcomes not only provide transitioning opportunities out of institutional facilities and back into the community, but also proactively divert consumers to alternative services when long-term care needs are initially identified. These diversion programs are valuable tools for states in preventing inappropriate institutional admissions. In order for diversion programs to be successful however there must be adequate home and community based service capacity. Also individuals who are responsible for assisting in the long term care service decisions must have sufficient knowledge and understanding of available service alternatives.

Diversion efforts in North Dakota include work done during the Real Choice Systems Change Grant awarded in September 2004, the Money Follows the Person Grant (MFP), and the Aging and Disability Resource LINK (ADRL). The efforts have included evaluation of the hospital discharge process, education about alternative services, and development of a new information and referral resource.

In 2004, 73% of North Dakota nursing facility admissions originated from a hospital setting<sup>7</sup> In response to this finding, the Real Choice Grant focused on hospital discharge planners. A questionnaire was developed and distributed in January of 2006 to 46 hospital discharge planners across North Dakota. Twenty six were returned with three from urban areas, twenty from rural and frontier areas and three that did not designate location. Eight percent had participated in discharge planning for less than a year,

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<sup>7</sup>Issue Data Book for Long Term Care 2005

35% from one to five years, 23% for from six to ten years and 35% had eleven or more years of experience (these percentages do not total to 100% due to rounding).

After collection and evaluation of the questionnaire responses, the following conclusions and recommendations were reported:

- Hospital discharge planners, physicians, hospitals and clinics should be the target of training on available long term care options.
- Resources should be provided to assist the discharge planners.
- A single point of entry system should be developed.
- The developed single point of entry system should be marketed to discharge planners as a resource tool.
- Any perceived pressure to fill nursing facility beds should be eliminated.

A separate diversion effort is funded through the MFP grant. This includes education to providers and consumers about alternative services that could potentially help a person avoid an institutional placement. Through this effort staff has provided education to providers at professional conferences and to consumers at senior centers and other venues. The program also paid for television advertising to educate stakeholders about available services.

A more current diversion initiative is the Aging and Disability Resource LINK (ADRL), in which individuals age 60 and older and adults age 18 and older with physical disabilities are eligible to obtain information and referral assistance when seeking long-term services and supports. The initiative focuses on:

- Improving access
- Minimizing confusion
- Enhancing individual choice
- Supporting informed decision-making

Services include:

- ADRL Options Counseling – A person-centered, interactive, decision support process whereby consumers, family members and/or significant others are supported in determining appropriate long-term care choices based on the consumer’s needs, preferences, values and individual circumstances.
- ADRL Benefits Counseling – The provision of information designed to help consumers learn about public and private benefits with referral to appropriate entities for access to needed benefits. ADRL Benefits Counseling is considered part of the ADRL Options Counseling service.
- ADRL Futures Planning – The process of assisting consumers in planning for their future long-term care needs with referral to appropriate entities for retirement planning, long-term care insurance, etc. ADRL Futures Planning is considered part of the ADRL Options Counseling service.

- ADRL Information & Referral/Assistance - A one-on-one service that (a) provides consumers with information on opportunities and services available within their communities; (b) assesses problems and capabilities of the individuals; (c) links the consumers to the services and opportunities that are available; and (d) to the maximum extent practicable, establishes adequate follow-up procedures.

The ADRL Options Counseling service was implemented statewide on January 1, 2013, replacing the previous outreach program.

#### **D. Transition / Money Follows the Person (MFP)**

The Money Follows the Person (MFP) Rebalancing Demonstration Grant was established by Congress in the Deficit Reduction Act of 2005 as an initiative to help states rebalance their Medicaid long-term care systems. Program goals include:

- Increase the use of home and community-based services (HCBS)
- Eliminate barriers that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Put procedures in place to provide quality assurance and improvement of HCBS

The Affordable Care Act of 2010 strengthened and expanded the MFP program by allowing more states to apply and extending the program through September 30, 2016. It also expanded the definition of eligible individuals. The program is available to individuals who have lived in an institution for more than 90 consecutive days, exclusive of short-term rehabilitation services reimbursed by Medicare, and who have a desire to move back into community living.

The Money Follows the Person Program pays up to \$3,000 for one-time transition costs, which may include, but are not limited to:

- Health and safety technology
- Security and utility deposits
- Home modifications
- Adaptive equipment
- Home/apartment furnishings
- Assistive technology devices
- One-time vehicle modifications

According to CMS, 44 states plus the District of Columbia participate in this program.<sup>8</sup>

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<sup>8</sup><http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/StateMFPGrantSummaries-All.pdf>

### *Money Follows the Person in North Dakota*

As part of its ongoing efforts to support community-based services and community inclusion of individuals with disabilities, the North Dakota Department of Human Services applied for and received a federal Money Follows the Person Rebalancing Demonstration Grant. The federal Centers for Medicare and Medicaid Services awarded North Dakota the \$8.9 million grant in May 2007 to help move eligible individuals from institutions to community settings over the next five years. The grant is administered by the Department's Medical Services Division.

Mathematica compiles reports summarizing the progress in key indicators of the MFP grantee states.<sup>9</sup> The most current report available was for the six-month period from January 1 to June 30, 2013, based on information self-reported by state grantees in their semiannual progress reports, which were submitted on August 30, 2013.

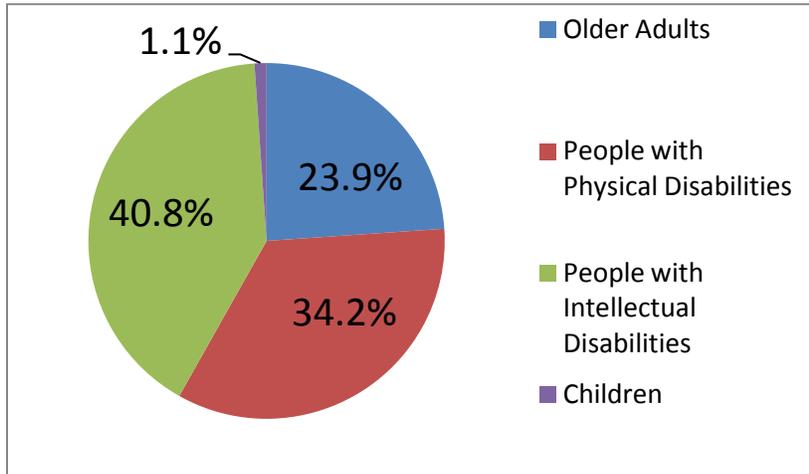
North Dakota's transition goals for 2011 were 39 individuals and the actual attained was 32, or 82.1%, while the goals for 2012 were 39 individuals, and the actual attained was 47, or 120.5%. The goals for 2013 were to transition 47 individuals. During the January to June reporting period there were 22 individuals transitioned, or 46.1%. The target spending level for the grant through 2012 was \$142,246,815, with actual qualified expenditures of \$169,246,963 or 119%. Spending levels were not included in the most current report.

Of the 22 transitions, two were to private homes, nineteen to apartments and one to apartments in qualified assisted living units. According to numbers provided by DHS, the cumulative number of transitions from the start of the grant until current for North Dakota is 184, with the following distribution.

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<sup>9</sup> [http://www.mathematica-mpr.com/publications/pdfs/health/MFP\\_2012\\_Annual.pdf](http://www.mathematica-mpr.com/publications/pdfs/health/MFP_2012_Annual.pdf)

**Chart 16: Cumulative Number of MFP Grant Transitions 2008-2014**



**Source17: Medical Services Division Department of Human Resources**

For the period from July 1 to December 31, 2012, there were two re-institutionalizations in North Dakota, both were older adults, and for the January 1 to June 30, 2013 period, there was one re-institutionalization of an individual who was physically disabled.

Section Q of the Minimum Data Set includes a question where residents are asked if they would like information about moving out of the nursing facility and back into the community. The Mathematica report shows that during the six month period from July 1 to December 31, 2012, four individuals were referred to the MFP program through MDS section Q, and of those, two were transitioned to alternative services. For the January 1 to June 30, 2013 period there were no transitions identified through the MDS.

## VI. Summary of Assessment of Capacity

One of the specific requirements for this project is to analyze the capacity and disbursement of nursing facility, basic care and assisted living beds. This section reviews capacity and disbursement of these three different settings across the eight service regions of North Dakota. The adequacy of this capacity and disbursement is also evaluated by comparing population statistics to bed counts for each setting.

### *Occupancy of Facilities*

Based on a North Dakota Department of Health report published in September 2013, there are 80 nursing facilities in the State and 6,029 certified beds. Nursing facilities are located in most counties in the State; of the 53 counties in the State, 11 counties do not have a nursing facility located within the county. According to the most recent data collected by DHS, the average nursing facility occupancy during 2013 was 93%. North Dakota appears to have a higher occupancy rate than most of the nation, as a 2011 Kaiser Family Foundation fact sheet listed the national average at 83% and showed North Dakota at 90%.

Cost report data from 2013 shows that the average occupancy rate for nursing facilities is 92.51%, with a low of 68.66% and a maximum of 99.88%. As demonstrated below, further review of the facility cost reports by region shows that the beds are rather evenly occupied throughout the State, with a range of 88% to 96%. The Williston and Minot regions have the largest percentage of open beds on average (12%) and the Bismarck region has the highest average occupancy rate (96%).

**Table 1: Nursing Facility Occupancy Rates by Region**

Region	Average Occupancy
<b>I - Williston</b>	88%
<b>II - Minot</b>	88%
<b>III - Devils Lake</b>	90%
<b>IV - Grand Forks</b>	93%
<b>V - Fargo</b>	94%
<b>VI - Jamestown</b>	92%
<b>VII - Bismarck</b>	96%
<b>VIII - Dickinson</b>	90%

Based on a North Dakota Department of Health report published in November 2013, there are 68 basic care facilities in the State and 1,785 certified beds. Basic care facilities are located in most counties in the State; of the 53 counties in the State, 17 do not have a basic care facility located within the county. According to a January 2013 fact sheet published by the North Dakota Long Term Care Association, the average occupancy of basic care facilities is 85%.

Cost report data from 2012 shows that the average occupancy rate for basic care facilities is 83%. As demonstrated below, further review of the facility cost reports by region shows that the basic care occupancy varies throughout the State, with a range of 71% to 91%. The Minot region has the largest percentage of open beds on average (29%), and the Dickinson region is the region that has the highest occupancy rate (91%). This data reflects only those basic care facilities that participate in the North Dakota basic care assistance program and are therefore required to file cost reports. There were 52 of the 68 basic care facilities that were participating in the Basic Care Assistance Program in 2012.

**Table 2: Basic Care Facility Occupancy Rates by Region**

Region	Average Occupancy
<b>I - Williston</b>	83%
<b>II - Minot</b>	71%
<b>III - Devils Lake</b>	90%
<b>IV - Grand Forks</b>	81%
<b>V - Fargo</b>	88%
<b>VI - Jamestown</b>	72%
<b>VII - Bismarck</b>	88%
<b>VIII - Dickinson</b>	91%

Based on a North Dakota Department of Human Services report published in November 2013, there are 73 assisted living facilities in the State and 2,672 living units. Assisted living facilities are located in most counties in the State; of the 53 counties in the State, 18 counties do not have an assisted facility located within the county. According to a January 2013 fact sheet published by the North Dakota Long Term Care Association, the average occupancy of assisted living facilities is 94%.

Cost report data is not available for assisted living facilities as they are not required to submit cost reports, therefore the assisted living occupancy rates for each region could not be calculated.

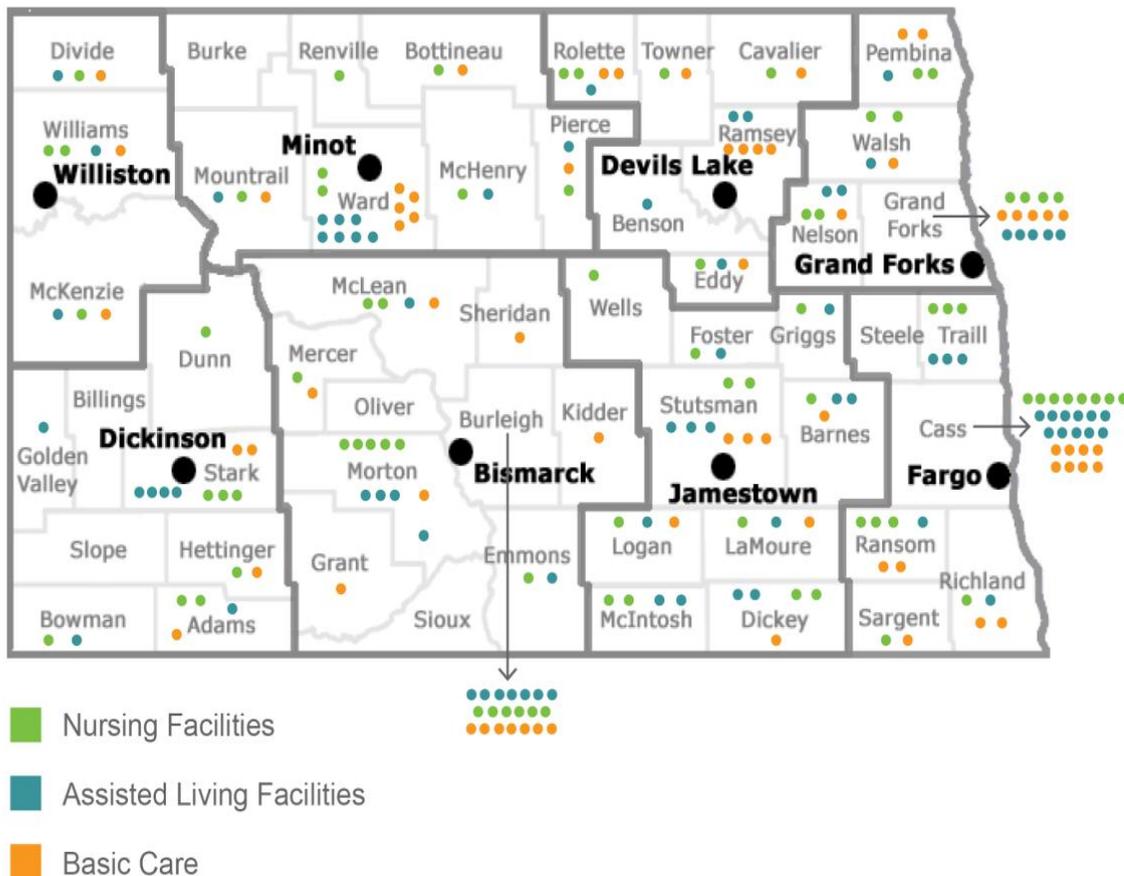
### *Location of Facilities*

Map 2 illustrates the distribution of nursing facilities, basic care facilities and assisted living facilities across North Dakota’s 53 counties and eight service regions. Chart 17 shows the population distribution between the eight regions. As would be expected, the number of facilities in each region is proportional to its population. One deviation from this correlation is apparent though as the Williston region does not contain as many providers as other regions (Region 3 – Devils Lake and Region 8 – Dickinson) with comparable populations.

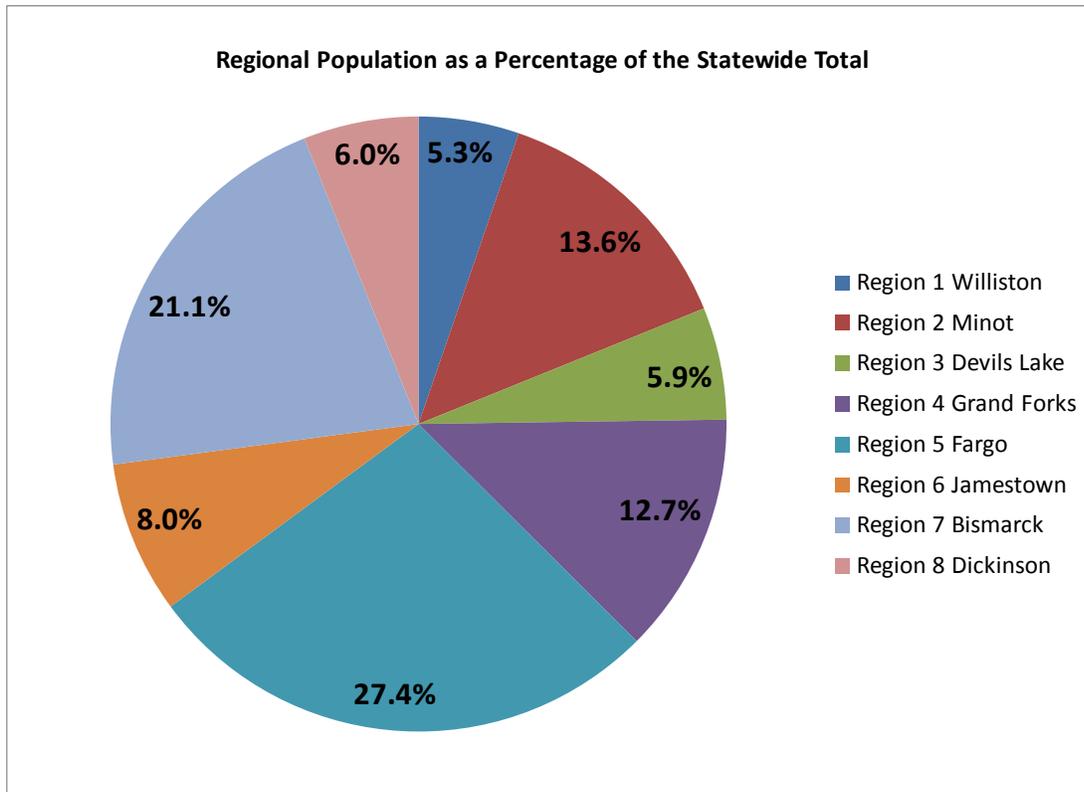
There are six counties within four of the regions that do not have any nursing facilities, assisted living facilities, or basic care facilities. They are Billings, Burke, Oliver, Sioux, Slope, and Steele. According to 2010 census figures, the total population of these counties is approximately 12,000 with Sioux County

being the most populous at just over 4,000 residents. For each of these counties, nursing facilities, basic care facilities, and assisted living facilities can be found in one or more of the adjacent counties making access to these services generally within 60 miles of most residents.

**Map 2: Distribution of Nursing Facilities, Basic Care Facilities and Assisted Living Facilities Across North Dakota**



**Chart 17: Regional Population as a Percentage of the Statewide Total**



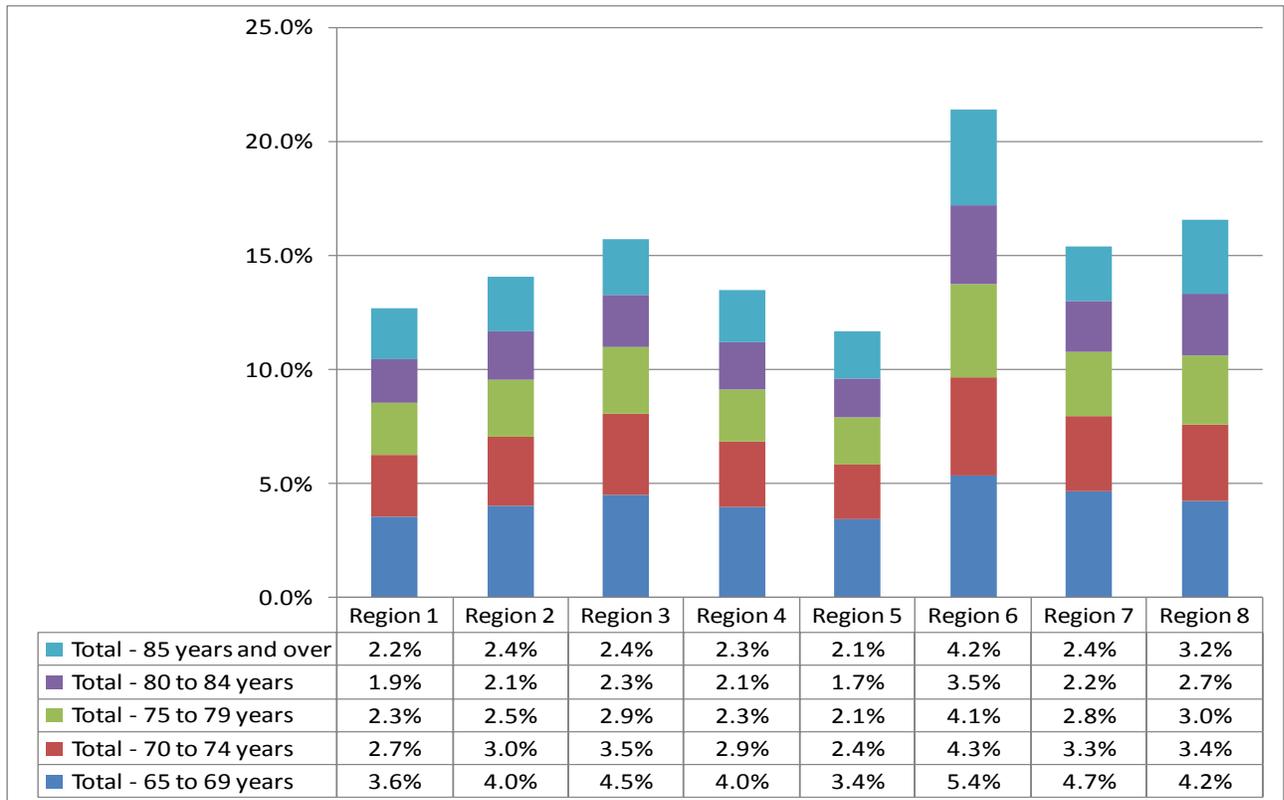
Charts 18 and 19 provide additional information to consider regarding the lower number of providers in the Williston region. Both charts show that Region 1, Williston, has a smaller percent of its population in the 65+ and 85+ age groups than other regions of comparable population (Region 3 – Devils Lake, and Region 8 – Dickinson). Since these are the age groups that are most likely to utilize long-term care services, this may explain why the Williston region has fewer nursing facilities, basic care facilities, and assisted living facilities. Conversely, the lack of facilities may be the reason the Williston region has a smaller proportion of residents age 65 and older. It is also noteworthy that the Williston region includes three of the seven counties in North Dakota where the 65+ population is projected to grow by 75% or more between 2010 and 2025 (see Map 1). Therefore, the State may benefit from investigating this circumstance further before developing long-range capacity targets and policies. Of course, there are other factors such as the oil boom’s impact on demographics, workforce and regional economies that may complicate this evaluation. For example, DHS recently learned that some facilities in the Williston region may be reducing admissions below capacity because they do not have enough staff to provide adequate care for full capacity.



**Chart 18: Population Distribution by Age Groups and Regions**



**Chart 19: Population Distribution by 65 and Over Age Groups and Regions**



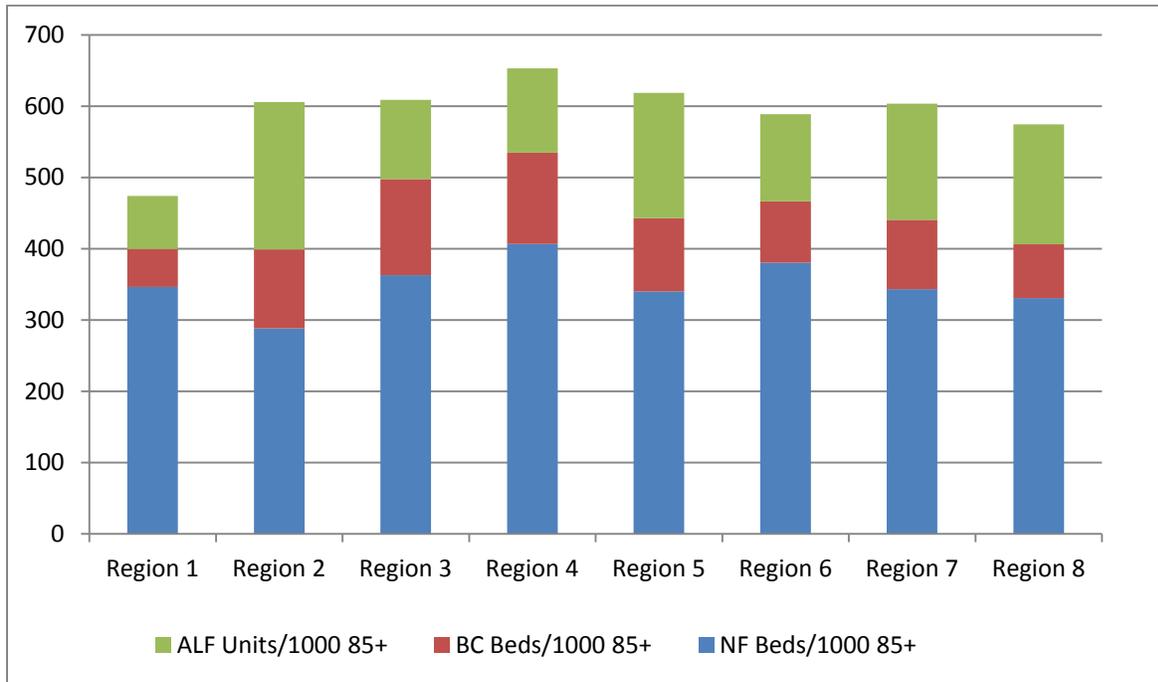
This analysis of facility disbursement compared to total population distribution and 65+ age group weighting identifies that Williston, Region 1, differs from other regions of similar size (Region 3 – Devils Lake and Region 8 – Dickinson). The difference merits further analysis.

Included in the Appendix is a table that provides a deeper look at access to long-term care services by analyzing the distribution of long-term care beds and the senior population across the eight regions of North Dakota. For nursing facilities and basic care facilities, available data was used to calculate the number of beds per 1,000 people age 65+ and also per 1,000 people age 85+. It was also possible to calculate the average vacancy rates for these two care settings for each region. This calculation was also computed as a rate per 1,000 people age 65+ and per 1,000 people age 85+.

Looking at just the data for people age 85 and over provides a clearer picture of service capacity and how it varies across the State’s regions. By combining the number of nursing facility beds and basic care beds with the number of assisted living units per 1,000 people over age 85 in each region, some observations about capacity become clear. First, the total number of nursing facility beds, basic care facility beds and assisted living units per 1,000 people over age 85 is relatively consistent across the State at about 600. However, Region 1, Williston, trails the rest of the State by a significant amount with less than 500 total beds and units per 1,000 people over age 85. There are distinct differences in the distribution of beds/units between the three care settings with the more rural areas of Williston, Devils

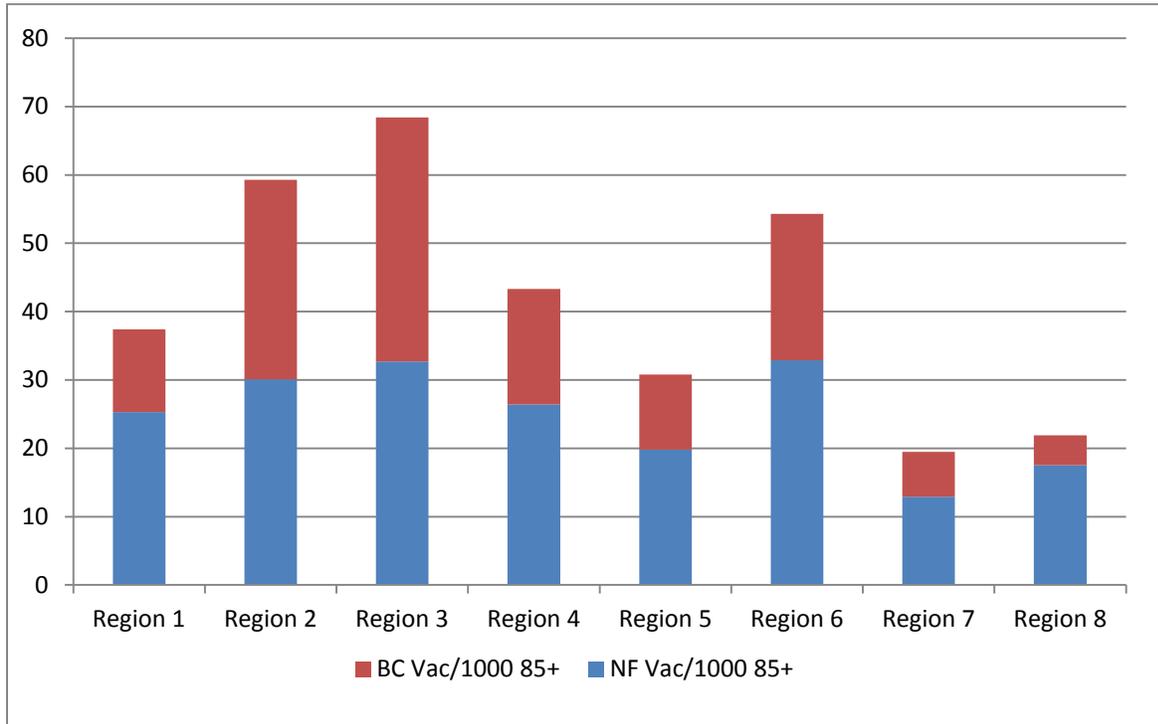
Lake, and Jamestown showing the smallest proportion allotted to assisted living units. Chart 20 illustrates this information.

**Chart 20: Distribution of Beds/Units by Regions**



This analysis of long-term care bed capacity per 1,000 people age 85+ appears to indicate that Region 1, Williston, is under-developed in terms of long-term care beds, compared to the other regions of the State. However, another piece of information seems to contradict this observation. When occupancy rates for nursing facilities and basic care facilities are compared to the over age 85 populations across all regions, the Williston area actually falls near the middle of the data. Assuming that this average vacancy rate or average number of available beds is indicative of demand, this finding shows that the need for nursing facility and basic care beds is not as great in the Williston region as it is in other areas of the State, specifically regions 5, 7, and 8 (Fargo, Bismarck and Dickinson). The observation about vacancy rates may be explained by reduced admissions in the Williston region due to staffing shortages. This analysis also does not factor in assisted living units since vacancy rates could not be calculated by region for that facility type. The vacancy rates for nursing facilities and basic care facilities are shown by region in Chart 21.

Chart 21: Nursing Facility and Basic Care Facility Vacancy Rates



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.

## VII. Primary Cost Drivers to Public Funded LTC Services

### A. Nursing Facility Cost Drivers

Another task required by this study is defining the primary cost drivers to publicly funded long-term care institutional services. This section examines cost data from North Dakota's long-term care facilities that participate in the Medicaid program. This includes all of the state's nursing facilities and 52 of the state's 68 basic care facilities. For both of these provider types, Medicaid reimbursement is determined from facility-specific cost data used to calculate per diem rates. Cost center limits are imposed on the per diem rates and incentives are included to encourage efficiency. This report does not provide a detailed analysis of the reimbursement system but rather focuses on analysis of the cost data used to determine rates. Additional information about facility rates and the reimbursement methodology is available on the Department of Human Services website.

A review of North Dakota nursing facility data reveals that per diem costs increased by 5.53% from 2012 to 2013. This occurred during a time when a national nursing facility specific market basket index predicted annual cost increases of less than three percent. This disparity may be due to differences between the national economy and the economy of North Dakota, but it certainly provides a reason to look closely at the State's nursing facility expenses and trends.

The North Dakota nursing facility reimbursement methodology includes limits that are applied to expenses that are grouped into cost centers. Despite these limits that are used to restrict cost outliers, less than 10% of providers have their direct or other direct costs limited and only 27% of providers have their indirect costs limited. This likely is because limits are also inflated between rebasing years. Regardless of the reason, because costs are seldom limited, cost increases are generally carried through to rate calculations and thus drive nursing facility program expenditures. There are many factors that may contribute to cost increases. The following analysis explores nursing facility costs in detail.

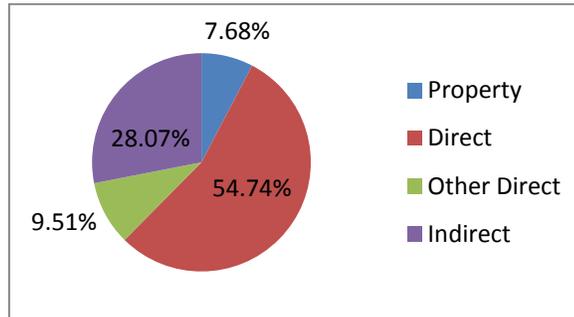
Typically nursing facility costs are driven by direct care costs, and specifically by labor. This is certainly the case in North Dakota as allowable direct care costs comprise approximately 55% of the total allowed nursing facility costs, with 85% of those costs coming from direct care nursing staff (includes registered nurses, licensed practical nurses and nursing aides) salaries and fringe benefits.

The following table and chart detail the breakdown of nursing facility costs between the cost centers used in establishing rates. Property costs include ownership or lease expense. Direct costs include therapies, nursing, and nursing supplies. Other Direct costs include food and dietary supplements, laundry, social services, and activities. Indirect costs include administration, chaplain services, pharmacy, plant operating, housekeeping, dietary, and medical records. Direct costs make up the majority of expenses followed by Indirect, Other Direct, and Property.

**Table 3: Allowed Costs by Cost Center**

Allowed Costs by Cost Center		
	Costs	%
<b>Property</b>	\$34,274,499	7.68%
<b>Direct</b>	\$244,298,625	54.74%
<b>Other Direct</b>	\$42,465,282	9.51%
<b>Indirect</b>	\$125,287,553	28.07%
<b>Total</b>	\$446,325,959	100.00%

**Chart 22: Distribution of Allowed Costs by Cost Center**



To identify more specific cost-drivers, the cost centers were divided into smaller categories. Costs were grouped into ten specific categories and one general catch-all category (All Other Costs) for remaining non-allocated costs. The property cost center was not sub-divided and when referring to property the report speaks to the cost center. As noted, the largest cost driver in the direct cost center is nursing staff salaries and fringe benefits, at 85% of total direct costs. This represents about 46.4% of total allowable costs. Administration costs are the only other cost category that exceeds 10% of total costs, coming in at 11.5% of all costs. This was the largest cost driver in the Indirect Cost Center and includes administration salaries and fringe benefits, malpractice insurance, and anything reported as other administration costs. Other notable costs that comprise two percent or more of total costs (and the cost center they are reported in) include Property, Dietary Labor (Indirect), Plant Operating (Indirect), Food/Dietary Supplements (Other Direct), Housekeeping (Indirect), Other Nursing (Direct), Nursing Drugs/Supplies (Direct), Activities (Other Direct), and Laundry (Other Direct). This list also illustrates the significance of nursing labor costs.

**Table 4: Percent of Total Costs by Line Items**

Percent of Total Costs by Line Items	
<b>Nursing Salaries/Fringe*</b>	46.4%
<b>Administration</b>	11.5%
<b>Property</b>	7.5%
<b>Dietary</b>	7.0%
<b>Plant</b>	5.6%
<b>Food/Dietary Supplements</b>	3.7%
<b>Nursing Other</b>	3.0%
<b>Nursing Drugs/Supplies</b>	2.5%
<b>Activities</b>	2.3%
<b>Laundry</b>	2.0%
<b>All Other Costs</b>	8.5%

\*Note 1: Includes RN, LPN and aides

One of the cost drivers that received notable concern through our input gathering process is contracted nursing labor, a sub-category of the nursing labor costs. Several respondents to the questionnaire

pointed to the increased reliance on contracted staffing as a significant factor in their cost increases. This concern was similarly raised during the stakeholder meetings that were conducted in Bismarck and Fargo.

Contracted labor does account for about 6.0% of the total expenditures for nursing staff (2.9% of all costs) in North Dakota, while only contributing about 3.3% of the total hours of care. This disparity may seem small but the average rate per hour paid for contracted staff is nearly twice the average wage paid for each of the nursing staff categories. Nursing facilities pay a considerable premium for contracted staff, which is the difference the average nursing facility pays for contracted labor compared to their own nursing staff. This is true even when the additional costs of fringe benefits are included. It is important to point out that the average hourly compensation for all contracted staffing for the report period ending June 30, 2013 was \$37.80, while the average hourly compensation for facility staff was \$22.09. That difference represents a premium of over 70%. While the total expenditures for contracted labor are not currently great compared to total nursing labor costs, the premium paid for this labor adds over \$5 million to total annual costs. If dependence on contracted labor were to grow, it would certainly translate into significant cost increases. Note: Data used for analysis is from a nursing facility cost report schedule that is not desk reviewed or field audited.

**Table 5: Compensation Comparisons between Facility Staff and Contracted Staff**

<b>Nursing Staff Category</b>	<b>Average Hourly Wage for Facility Staff</b>	<b>Average Hourly Rate for Contracted Staff</b>
<b>RN</b>	\$28.94	\$49.81
<b>LPN</b>	\$20.89	\$38.87
<b>Aide</b>	\$14.99	\$33.66

**Table 6: Calculation of Premium Paid for Contract Labor**

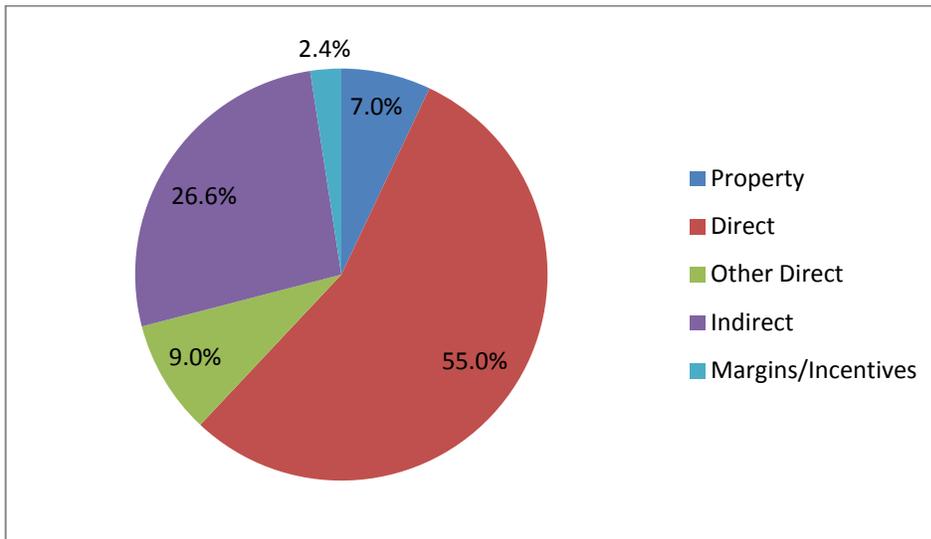
<b>Contract Labor Compensation</b>	<b>Compensation at Facility Rate</b>	<b>Premium Paid for Contract Labor</b>	<b>Premium Percentage</b>
<b>\$12,757,322</b>	\$7,454,906	\$5,302,416	71.13%

There is one set of cost drivers that only affects the reimbursement rates and does not contribute to the cost of operating the nursing facilities. This includes the Indirect Cost Center Incentive and the Direct and Other Direct Margins. These add-ons to the per diem rate calculations allow providers to share the difference between the cost center limits and their actual per diem costs. The contribution to the total rate from the incentive and margins is small, coming in at just 2.4% of the total rate, but it is a unique cost driver of reimbursement rates and expenditures. Because this is not a cost providers incur, North Dakota could redirect this spending without diminishing the nursing facility reimbursement system's recognition of provider costs. These expenditures could be redirected toward rate components that are tied to quality rather than simply rewarding efficiencies that most providers already achieve.

### 1. Rate Composition by Cost Centers

As noted above, the incentives and margins contribute about 2.4% to the total per diem rate. The remainder of the per diem rate is divided across the cost centers very similarly to how costs breakdown (Chart 22). The chart below illustrates the contribution of each component to the total rate.

**Chart 23: Rate Components' Contribution to the Total Rate**



Another aspect to consider is how costs change from year to year. The majority of cost increases from 2012 to 2013 appear to be driven largely by increases in labor costs. The largest increase in costs per resident day between these two years was for administration at 6.67%. The second leading cost increase was for nursing salaries and fringe, which rose by 5.48%. Overall per diem costs increased by 3.94% from 2012 to 2013. Table 7 shows the change in per diem costs for each of the top eleven expense categories between 2012 and 2013.

**Table 7: Per Cent Change in Per Diem Costs Top Eleven Expense Categories**

	2012 Per Diem Cost	2013 Per Diem Cost	Percent Change
Nursing Salaries/Fringe	\$96.23	\$101.51	5.48%
Administration	\$23.59	\$25.17	6.67%
Property	\$16.84	\$16.85	0.05%
Dietary	\$14.94	\$15.30	2.40%
Plant	\$11.75	\$12.23	4.16%
Food/Dietary Supplements	\$7.91	\$8.01	1.26%
Nursing Other	\$6.53	\$6.50	1.41%
Nursing Drugs/Supplies	\$5.53	\$5.46	-1.22%
Activities	\$5.09	\$5.11	0.27%
Laundry	\$4.31	\$4.33	0.48%
All Other Costs	\$18.31	\$18.75	2.40%

Because some costs are increasing at a faster rate than others, the distribution of costs across the different rate categories is changing. The percent of total resources each nursing facility devotes to nursing salaries and administration is rising while the portion of those resources devoted to nursing supplies and property is declining. Table 8 lists the percent of total costs allocated to each expense category for 2012 and 2013 and then shows the change in that percent between the two years.

**Table 8: Comparison between 2012 and 2013 Expense Categories**

	2012 Percent of Costs*	2013 Percent of Costs*	Percent Change
Nursing Salaries/Fringe	45.63%	46.30%	1.49%
Administration	11.19%	11.48%	2.59%
Property	7.98%	7.69%	-3.63%
Dietary	7.08%	6.98%	-1.41%
Plant	5.57%	5.58%	0.18%
Food/Dietary Supplements	3.75%	3.65%	-2.67%
Nursing Other	3.04%	2.96%	-2.63%
Nursing Drugs/Supplies	2.62%	2.49%	-4.96%
Activities	2.41%	2.33%	-3.32%
Laundry	2.04%	1.97%	-3.43%
All Other Costs	8.68%	8.55%	-1.50%

\*The total of these percents does not add to exactly 100.00% due to rounding.

The increases in costs are reflected in the components of the per diem rates but in a little different light. Because nursing salaries are only a portion of the total direct care rate component, that rate component does not mirror the same increase as nursing salaries alone. The same is true for the administration costs when compared to the indirect rate component where those expenses are reimbursed. Overall, each of the rate components is increasing, with Margins/Incentives increasing the most at 7.13%. The

Indirect rate component showed the next highest increase at 4.41%. The other rate components are increasing at about 1% or less, and the overall rate increase was 2.17% from 2012 to 2013. The table below lists the average per diem for each rate component in 2012 and 2013 and shows the percent change for each between the two years.

**Table 9: Comparison between 2012 and 2013 Per Diem Rates by Rate Component**

Per Diem Rates by Rate Component			
	2012 Per Diem	2013 Per Diem	% Change
<b>Property</b>	\$16.42	\$16.56	0.82%
<b>Direct</b>	\$127.76	\$129.45	1.32%
<b>Other Direct</b>	\$20.95	\$21.09	0.66%
<b>Indirect</b>	\$60.06	\$62.71	4.41%
<b>Margins/Incentives</b>	\$5.33	\$5.71	7.13%
<b>Total Per Diem</b>	\$230.52	\$235.52	2.17%

The changing distribution between the rate components illustrates a changing emphasis within the rate calculation. When considering the percent of the total rate allocated to each rate component, analysis reveals a shift in the rate calculation towards Margins/Incentive and Indirect costs and away from Direct, Other Direct, and Property. Table 10 illustrates this point showing the percent of the rate comprised by each rate component for 2012 and 2013 and also the change in that percent between the two years.

**Table 10: Comparison between 2012 and 2013 Distribution of Per Diem Rates by Rate Component**

Distribution of Per Diem Rates by Rate Component			
	2012 Percent	2013 Percent	Percent Change
<b>Property</b>	7.1%	7.0%	-1.32%
<b>Direct</b>	55.4%	55.0%	-0.82%
<b>Other Direct</b>	9.1%	9.0%	-1.47%
<b>Indirect</b>	26.1%	26.6%	2.20%
<b>Margins/Incentives</b>	2.3%	2.4%	4.86%

As was noted earlier, nursing salaries comprise the largest share of all costs. Not surprisingly the hourly rates for nursing positions increased between 2012 and 2013. The largest change in rates was for registered nurses, which jumped 4.22%. However, the rates for licensed practical nurses and nurse aides increased by almost as much. Table 11 shows the increase in hourly rates for each category of nursing staff.

**Table 11: Comparison between 2012 and 2013 Average Hourly Wage Rates**

Facility Staff Wage Changes			
Nursing Staff Category	2012 Average Wage	2013 Average Wage	Percent Change
RN	\$27.77	\$28.94	4.22%
LPN	\$20.26	\$20.89	3.12%
Aide	\$14.40	\$14.99	4.06%

Contracted hourly labor rates also increased for the most part between 2012 and 2013, although the average contracting rate for licensed practical nurses actually fell. The contracted hourly labor rate for registered nurses showed the greatest increase, rising 9.9%. The hourly contracted rate for nurse aides increased 7.49%, while the hourly contracted rate for licensed practical nurses fell by 7.29%. This information and the average contracted hourly labor rate for each nursing staff category are listed in the following table.

**Table 12: Comparison between 2012 and 2013 Average Contracted Hourly Labor Rates**

Contracted Hourly Labor Rates			
Nursing Staff Category	2012 Average Hourly Wage	2013 Average Hourly Wage	Percent Change
RN	\$45.32	\$49.81	9.90%
LPN	\$41.93	\$38.87	-7.29%
Aide	\$31.31	\$33.66	7.49%

The use of contracted labor was a concern raised by several stakeholders throughout the data gathering process, and contracted labor costs did increase by 3.4% between 2012 and 2013. In 2012 providers spent about \$12.3 million on contracted nursing labor based on reported cost data, and in 2013 that figure grew to \$12.8 million. The premium facilities pay for contracted labor also increased slightly between 2012 and 2013. The premium rose from 69.0% in 2012 to 71.13% in 2013. Table 13 shows how contracted labor payments changed between 2012 and 2013. Again it is noteworthy that the wage data is from a nursing facility cost schedule that is not desk reviewed or field audited.

**Table 13: Change in Contracted Labor Payments between 2012 and 2013**

	Contract Labor Compensation.	Percent Change from Previous Year	Premium	Percent Change from Previous Year
<b>2012</b>	\$12,336,829	NA	69.00%	NA
<b>2013</b>	\$12,757,322	3.41%	71.13%	3.09%

A separate cost driver that is only meaningful when compared to data across years is census. Based on cost report data, between 2012 and 2013 the total number of nursing facility days of care decreased about 3%. The largest percent of decline occurred in Medicare days. The declines in Medicare and

Medicaid resulted in a slight shift in caseload towards private pay. The tables below show the changes in census and the distribution of census between payer sources.

**Table 14: Comparison between 2012 and 2013 Census Distribution**

	Total Days	Private	Medicare	Medicaid	Other*
<b>2012</b>	2,096,130	772,751	163,215	1,141,562	18,602
<b>2013</b>	2,034,185	750,658	154,268	1,092,967	36,292
<b>% Change</b>	-2.96%	-2.86%	-5.48%	-4.26%	NA

\*In 2012 one provider did not report the distribution of days between payer sources; therefore all their days were reported as other distorting this statistic. Other could include payments from the Veterans Administration, long-term care insurance or other sources.

**Table 15: Comparison between 2012 and 2013 Private, Medicare, and Medicaid Census**

	Private	Medicare	Medicaid
<b>2012*</b>	37.20%	7.86%	54.95%
<b>2013</b>	37.57%	7.72%	54.71%
<b>% Change</b>	1.01%	-1.71%	-0.44%

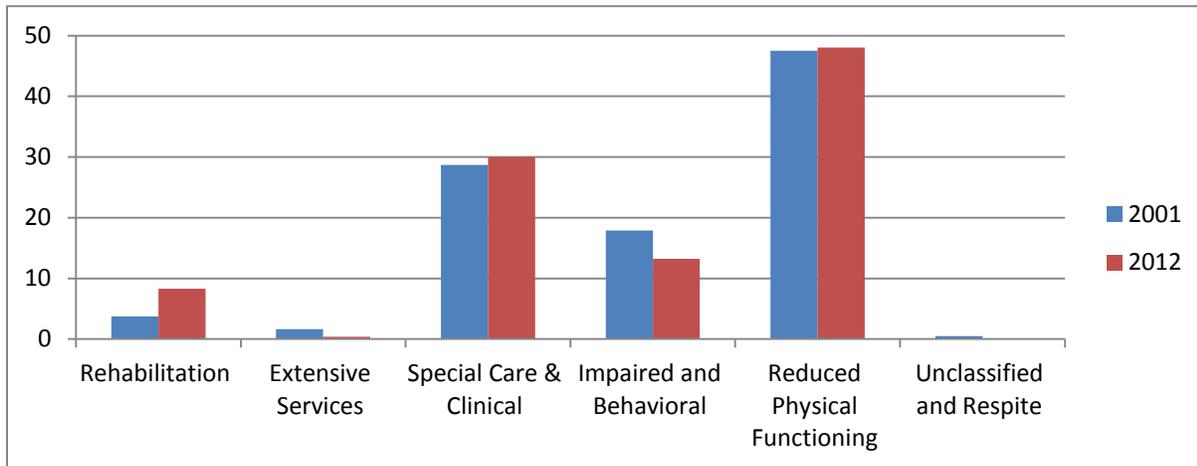
\*The total of these percents does not add to exactly 100.00% due to rounding.

Another potential cost driver that is not evident from simply looking at cost data is the shifting acuity of nursing facility residents. Data from previous reports illustrates that North Dakota is experiencing a decline in nursing facility utilization. In his 2007 report, David Zentner<sup>10</sup> indicated that Medicaid nursing facility days had decreased from 1,346,963 to 1,261,774 by 2005. He also noted that licensed nursing facility beds decreased by about 10% over this same period. An earlier report by Myers and Stauffer from 2002 showed that total nursing facility census for 2001 was approximately 2.25 million. This downward trend has continued as demonstrated by 2013 cost report data, which included a total of just less than 2 million days. This decline in nursing facility utilization is a common and intentional trend largely reflective of the continuing development and evolution of community-based care alternatives.

Nursing facility administrators often say that their residents are coming to their facilities later and with greater care needs. Evaluation of North Dakota's case mix data indicates that the latter part of this assertion appears to be confirmed by case mix data. By analyzing census records showing the distribution of residents across the Resource Utilization Groups (RUGS), Myers and Stauffer identified a slight shift in the percentage of residents that are classified in the higher resource categories. This shift is small but has a significant impact on cost increases. Chart 24 demonstrates these findings. In order to make this comparison, differences in the RUG systems used during each period had to be reconciled. This was accomplished by combining several RUG categories to create more general RUG groups.

<sup>10</sup> An Overview and Recommendations: Long-Term Care in North Dakota  
[http://www.nchsd.org/libraryfiles/StrategicPlanningResourceMapping/ND\\_LTC\\_Report2007.pdf](http://www.nchsd.org/libraryfiles/StrategicPlanningResourceMapping/ND_LTC_Report2007.pdf)

**Chart 24: Comparison of Resource Utilization Groups Distributions 2001 - 2012**



There is one more factor that may be reducing pressure for providers to contain costs. As noted earlier, the cost center limits impact only a small number of providers. This is likely due to increases in limits. These limits are rebased every four years and are increased annually with an inflation factor. The average increase in limits per year since 2006 (excluding adjustments for moving to the RUG IV system) is about 4.3% even though annual inflation calculated from the Global Insight Skilled Nursing Facility Market Basket Index (GII) is only about 2.59% for this period. The result is that total limits have increased by about 45.85% since 2006, while cost increases were only projected to be about 22.73% based on the GII. The table below shows the change in limits between January 1, 2006 and January 1, 2014 and compares these to the rate of inflation calculated from the GII. It is notable that the GII is a national index and does not account for differences between the North Dakota economy and the rest of the nation. However, it does provide an index that is specific to nursing facilities and is widely used.

**Table 16: Limit Changes Compared to Inflation 2006 – 2014**

Limit/Index	1-Jan-06	1-Jan-14*	Annual Percent Change	Total Percent Change
Direct	\$95.57	\$139.61	4.30%	46.08%
Other Direct	\$18.27	\$26.17	4.07%	43.24%
Indirect	\$45.23	\$66.22	4.33%	46.41%
Total	\$159.07	\$232.00	4.28%	45.85%
Global Insight Index	1.0690	1.312	2.59%	22.73%

\*For comparison the January 1, 2014 limits do not reflect the RUG IV adjustment implemented January 1, 2013

## 2. Summary of Findings from Nursing Facility Cost Driver Analysis

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.

## **B. Basic Care Facility Cost Drivers**

The other group of long-term care services that is funded through Medicaid and state programs is basic care. About 75% (52 of 68) of these providers participate in North Dakota's basic care assistance program. Basic care residents are less acute than nursing facility residents, and this is reflected in the average cost for these facilities. During the 2011-2013 biennium, state expenditures averaged \$1,800 per month for each basic care resident, compared to \$5,460 per month for nursing facility residents. In 2012, the average per diem cost for basic care facilities participating in the basic care assistance program was \$103.75.

Per diem costs for basic care facilities increased slightly less than 5% between 2011 and 2012, with the greatest cost increases occurring in direct care. Costs are divided into cost centers during the rate setting process, similar to nursing facilities, but the cost centers are somewhat different. The property cost center includes the costs of facility ownership. The room and board cost center includes food and dietary supplements and utilities. The direct care cost center includes resident care staffing costs and supplies, licensed health care professional (LHCP) staffing costs, laundry expenses, social services expenses, and activities expenses. Indirect cost center expenses include administration, plant operating, housekeeping, dietary staffing, pharmacy and medical records. Direct care costs and indirect care costs are further divided between personal care and room and board. Costs are divided much more evenly between these cost centers than with the nursing home cost centers. The tables below show the per diem costs for each cost center, the increase in per diem costs between 2011 and 2012 and the distribution of costs between the cost centers.

**Table 17: Basic Care Per Diem Costs**

Basic Care Per Diem Costs			
Cost Center	2011 Per Diem	2012 Per Diem	% Change
Property	\$11.89	\$12.23	2.84%
Room & Board	\$14.60	\$14.95	2.41%
Direct Personal Care	\$20.65	\$22.40	8.46%
Direct Room & Board	\$16.66	\$17.86	7.23%
Indirect Personal Care	\$20.08	\$20.81	3.62%
Indirect Room & Board	\$14.98	\$15.50	3.47%
<b>Total Per Diem Costs</b>	<b>\$98.86</b>	<b>\$103.75</b>	<b>4.94%</b>

**Table 18: Distribution of Basic Care costs**

Distribution of Basic Care Costs			
Cost Center	2011 Percent	2013 Percent*	% Change
Property	12.03%	11.79%	-2.00%
Room & Board	14.77%	14.41%	-2.42%
Direct Personal Care	20.89%	21.59%	3.35%
Direct Room & Board	16.85%	17.22%	2.18%
Indirect Personal Care	20.31%	20.06%	-1.26%
Indirect Room & Board	15.15%	14.94%	-1.40%

\*The total of these percents does not add to exactly 100.00% due to rounding.

Similar to nursing facility costs, basic care facility costs are largely driven by labor expenses. However, basic care facilities do not utilize as much direct care labor as nursing homes. Total direct care staffing (resident care staff and LHCP staff) comprised about 30.5% of all basic care facility costs in 2012. Only three other cost areas exceeded 10% of the total costs; administration, dietary staffing and property costs. The table below lists the total reported expenses and percent of total costs for the eleven cost categories that exceeded 2% in 2012.

**Table 19: Total Reported Expenses and the Percent of Total Costs for the Eleven Cost Categories**

<b>2012 Basic Care Costs Breakdown</b>		
<b>Cost Category</b>	<b>2012 Costs</b>	<b>2012 Percent*</b>
<b>Resident Care Salaries/Fringe</b>	\$6,961,291	20.30%
<b>Administration</b>	\$4,859,875	14.17%
<b>Dietary</b>	\$4,237,282	12.35%
<b>Property</b>	43,985,876	11.62%
<b>LHCP Salaries/Fringe</b>	43,510,927	10.24%
<b>Food &amp; Dietary Supplies</b>	\$2,662,613	7.76%
<b>Housekeeping</b>	\$1,673,712	4.88%
<b>Utilities</b>	\$1,541,432	4.49%
<b>Activities</b>	\$1,377,240	4.02%
<b>Plant</b>	\$1,064,445	3.10%
<b>Other Room &amp; Board</b>	\$930,734	2.71%
<b>All Other Costs</b>	\$1,491,345	4.35%

\*The total of these percents does not add to exactly 100.00% due to rounding.

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 LHCP staff), which is about 30.5% of all costs.

### *Summary of Cost Drivers*

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.

## VIII. Identify LTC Quality and Access Measures/Provide Sample Data Indicators or Surveys

In 2002, the Centers for Medicare and Medicaid Services (CMS) began a national Nursing facility Quality Initiative (NHQI). CMS released the first set of quality measures in 2002 with the intention of using them on their public reporting system called the Nursing Home Compare (NHC). Over time, the quality measures have gone through several revisions. The current quality measures were revised and implemented in 2012 and include short stay and long stay quality measures. The Nursing Home Compare website allows consumers to compare information about nursing facilities. It contains quality of care information on every Medicare and Medicaid certified nursing facility in the country, including over 15,000 nationwide. Many nursing facilities have already made significant improvements in the care being provided to residents by taking advantage of this information.

Nursing facilities regularly collect assessment information on all their residents using a form called the Minimum Data Set (MDS), which includes an assessment of the residents' health, physical functioning, mental status, and general well-being. Nursing facilities self-report this resident-specific information to CMS.

CMS uses some of the assessment information to measure the quality of certain aspects of nursing facility care, like whether residents have gotten their flu shots, are in pain, or are losing weight. These measures of care are called "quality measures." Comparison of scores helps to evaluate how nursing facilities may differ from one another.

The Nursing Home Compare website includes information on the following:

- Five-Star Quality Ratings of overall and individual star performance on health inspections, quality measures, and hours of care provided per resident by staff performing nursing care tasks.
- Health inspections results and complaints give detailed and summary information about deficiencies found during the three most recent state inspections and any recent complaint investigations.
- Nursing facility staffing information about the number of registered nurses, licensed practical or vocational nurses, physical therapists and nursing assistants in each nursing facility.
- A set of quality measures that describe the quality of care in nursing facilities including percent of residents with pressure sores, percent of residents with urinary incontinence and more.
- Penalties against a nursing facility.

The current quality measures were selected because they can be easily measured without requiring nursing facilities to prepare additional reports. They are considered to be both valid and reliable but are

not intended to be used as benchmarks, thresholds, guidelines, or standards of care. The QMs are guides to assist nursing facilities improve their quality of care.

The current Quality Measures available on the Nursing Home Compare website are a set of short stay and long stay measures. The short stay quality measures include all residents in an episode whose cumulative days in the facility are less than or equal to 100 days. The long stay quality measures include all residents in an episode whose cumulative days in the facility are greater than or equal to 101 days.

#### Short Stay Quality Measures

- Percent of Residents Who Self-Report Moderate to Severe Pain
- Percent of Residents with Pressure Ulcers That Are New or Worsened
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication

#### Long Stay Quality Measures

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Residents Who Self-Report Moderate to Severe Pain
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents with a Urinary Tract Infection
- Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
- Percent of Residents Who Lose Too Much Weight
- Percent of Residents Who Have Depressive Symptoms
- Percent of Long-Stay Residents Who Received an Antipsychotic Medication

Several states and the federal government have implemented pay for performance programs which recognize nursing facilities that achieve a high level of performance or exceptional improvement based on some of the quality measures. States that have implemented a pay for performance program utilize the long stay quality measures since these measures recognize the Medicaid chronic care population. Using the Nursing Home Compare website the State of North Dakota is compared to the national average in each of the quality measures. The following table compares North Dakota long stay measures to the national average.

**Table 20: Long-Stay Quality Measures Comparing North Dakota to National Average**

<b>Long-Stay Quality Measures Comparing North Dakota to National Average</b>		
	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%

As shown in Table 20, 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. Although the statewide average is lower than the national average, there is variability among the eight regions in the state as illustrated in the following chart.

Chart 25: Selected CMS Quality Measures



According to the AARP Scorecard, North Dakota ranks in the top quartile of states in quality of care. The 2011 Scorecard compared the percentage of nursing facility residents with pressure ulcers, restraints, staff turnover rates, and hospital readmissions, and again North Dakota ranked high in quality of care. This indicates that the State's nursing facilities are working hard to provide quality of care and assessing care needs of their residents and planning appropriate care. The challenge will be to maintain these standards. The State is exploring a quality incentive program that will recognize nursing facilities that are providing exceptional care.

### *Performance Measures*

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.

**STAFFING AND RELATED MEASURES** – In the states with pay for performance (P4P) programs, quality measures tied to direct care staffing levels have been a significant part of the programs. Staffing level (hours per resident day), turnover and retention rates, use of pool or contract 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. Three states (GA, OH, and OK) conduct employee satisfaction surveys. Direct care staff satisfaction relates broadly to care quality; 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.

**MDS-BASED QUALITY MEASURES** –Quality Measures (QMs) derived from the MDS have been applied widely in public reporting and quality assessment. They have been critiqued from both clinical and methodological perspectives. Most states rely on the CMS QMs reported on Medicare's Nursing Home Compare web site. In 2012, CMS implemented the new Minimum Data Set 3.0, and as a result of the change in the assessment tool, the quality measures were re-defined and implemented in October 2012.

**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 have been criticized because of inconsistency in survey practices and rates of citations between states and regions within states.

**RESIDENT AND FAMILY SATISFACTION** – Several states conduct surveys to gather data on resident or family satisfaction. They rely on established instruments. Minnesota also conducts a resident quality of life survey. 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; with only 15 percent of residents 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, which is the type of information that can be collected in a resident satisfaction survey. Today’s technology can also evaluate these issues. Nursing homes 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 support 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 private rooms, and dispute resolution. Minnesota is developing a measure of facility discharge rates from nursing home to community in order to emphasize community transitions and re-balancing between nursing home 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 their 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 of 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.

## **IX. Stakeholder Perceptions of North Dakota Long-Term Care**

### **A. Identification of Stakeholders**

A comprehensive evaluation of North Dakota’s LTC continuum includes identification of program and service stakeholders and state staff, and solicitation of feedback regarding their experiences and perceptions with respect to long-term care.

For the purposes of this study, the following list of stakeholders was identified:

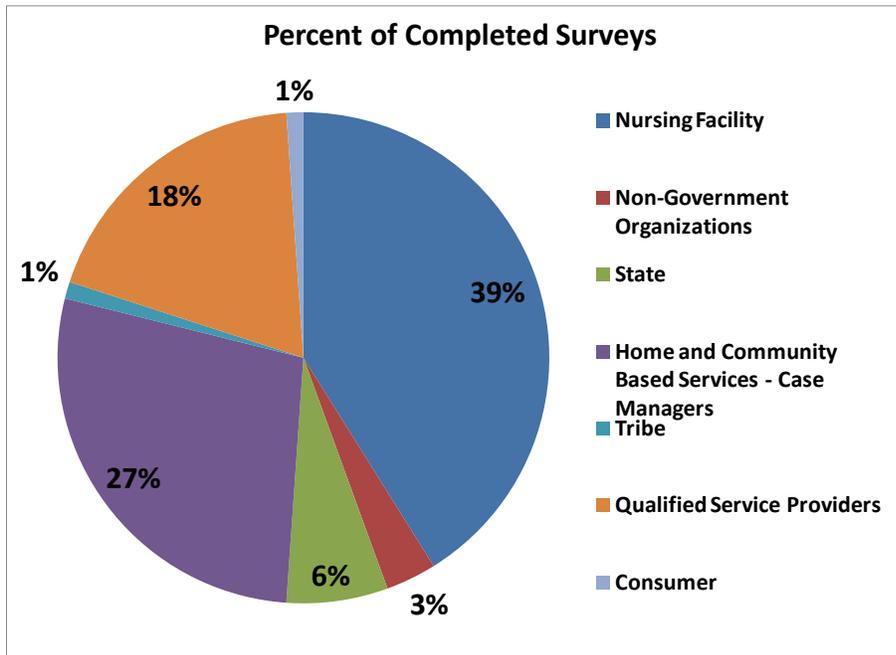
- AARP – ND
- ASCEND
- Consumers
- Dakota Center for Independent Living
- Facilities – Nursing, Basic Care, Assisted Living
- Freedom Resource Center
- HCBS Case Managers
- Independence, Inc.
- Northland PACE
- ND Indian Affairs Commission
- ND Association of Home Care
- ND Healthcare Review
- ND Hospital Association
- ND Housing Finance Agency
- ND Medical Association
- ND LTC Association
- Options Resource Center for Independent Living
- Qualified Service Providers
- Discharge Planner
- State Ombudsman
- State staff from the Department of Human Services and the Department of Health
- Tribal Health Directors
- Tribal Chairmen

### **B. Development of Questionnaire**

Given the short time allotted for the evaluation of programs and services, it was determined that solicitation of a brief questionnaire would be the most efficient and effective way to obtain necessary stakeholder input from most areas throughout the State. Therefore, a questionnaire specific to North Dakota was developed and approved for distribution.

Four hundred four questionnaires were sent out by email and by regular mail during the first week of November. A follow-up/reminder request was sent out two weeks later, and the due date for all responses was extended to December 20, 2013 to optimize participation. A total of 94 (23%) responses were received by the middle of February. Please refer to Chart 26 for distribution of responses received by stakeholder category.

**Chart 26: Responses Received by Stakeholder Group**



A copy of the North Dakota Stakeholder Questionnaire and an Analysis of the Responses are located in Appendix B.

### C. Stakeholder Meetings

Two public meetings were held in North Dakota to obtain public comment on the State’s Long-Term Care Continuum of Services. The first meeting was held in Bismarck on January 14, 2014 from 1-3 pm and was followed by a separate meeting with representatives of the North Dakota AARP office and the North Dakota Long Term Care Association. The second public meeting was held in Fargo on January 15, 2014 from 1-3 pm. Both public meetings were well-attended, with a combined 57 persons present.

Written testimony was received both at the public meetings and immediately after. Public input was carefully recorded and reviewed with the Department.

A summary of the issues raised at the public meetings in Bismarck and Fargo, and of written testimony received after the meetings is included in Appendix C.

## **X. Program/Service Gaps**

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.

Rather, the real variation among states with respect to these universal program and services gaps can be attributed to four main aspects: namely, the degree of legislative and/or executive priority to which long-term care is given; the extent to which states have committed resources, both in terms of staffing and administrative resources and funding; the system/process approaches taken to address the significant issues; and the involvement and commitment of consumer and provider stakeholders.

It is also important to point out that a more realistic goal may not be to eliminate the gaps altogether, but to instead diminish their effects to the fullest extent possible. States that have been at the forefront of re-aligning long-term care services to better meet the needs and desires of their aging and disabled populations have worked hard to fully identify issues and problems, involve stakeholders, to develop solutions, prioritize resolution, and adapt to unexpected circumstances as they arise.

Many program /service gaps are imbedded within a complicated system and cannot be easily addressed without also systematically tackling other programs and services. Others, in contrast, are relatively simple to address but may have limited value unless linked to other changes made within the continuum. With that said the true implications of program and service gaps on each state extend far beyond their initial identification. It is in this context that the following gaps in North Dakota’s programs and services have been identified.

While stakeholders identified numerous program, service, and process issues within North Dakota’s LTC continuum, this section is limited to the identification of several high-level gaps which are systemic and have significant implications on LTC service availability, accessibility, quality, processes, and/or rebalancing. In this context, we define a gap 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. In accordance with the defined scope of this project, some of the gaps that we identify in this section will be further analyzed and addressed within a final report prepared for this Study. That final report will include recommendations, implementation issues, and potential costs of remediating these gaps.

### **1. Consumer Education and Outreach**

Consumer and provider groups 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.).

This gap is identified primarily through oral and written stakeholder feedback, and supported by navigation of the DHS's web site and review of consumer outreach materials and provider and other manuals prepared by the Department.

The Department of Human Services website is not clear about the single point of entry contact or how to navigate within the LTC system. Individuals can access service information by calling the county social services offices or by contacting the Aging and Disability Resource-LINK (ADRL). Under the Direct Service Locations option, county offices are described as the first point of contact for families who need economic assistance, child welfare services, supportive services for the elderly and disabled individuals, etc. In contrast, by clicking on the Adults and Aging Services option, the first link to information is for reporting abuse and neglect in vulnerable adults. Farther down in the Services section there is a link for Information and Assistance which then links to the Aging and Disability Resource-LINK. This link goes to the ADRL-LINK site and an explanation of the services provided. Consumers can explore service options, obtain the toll free number to contact an individual or send an email with their questions or request. A separate link called "Informational Materials" provides more information on ADRL services. This link includes a useful video about the ADRL, an ADRL Fact Sheet and the ADRL Brochure.

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.

## **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. This 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.

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

One primary gap has been identified in this area.

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.

In North Dakota, LOC determinations are performed by ASCEND, the Department's contracted medical reviewer. LOC forms may be completed on-line or submitted via facsimile or through regular mail.

### **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 service.

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.

### ***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.

### ***6. Transportation and Support***

Two primary gaps in transportation have been identified. The first is 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 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.

### ***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. Since Federal funding sources generally prohibit any payment for room and board other than for institutional services, the State should establish a priority to further develop and foster the services needed to promote the ability of seniors to maintain their own homes and to age in place for as long as possible.

With respect to the very high percentage of elderly who reside in nursing facilities, the lack of affordable and accessible senior congregate and other publicly-subsidized housing represents a significant challenge to any efforts 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. According to “LTC across the States”, a 2012 AARP study, North Dakota had 58 people living in a nursing facility for every 1,000 people over age 65. The national average is 35 per 1,000 and this study ranked North Dakota number one among the states<sup>11</sup>.

Furthermore, the oil boom communities in North Dakota have seen drastic increases in demand created by the influx of workers, as well as dramatic increases in housing expenses and cost of living. While this obviously impacts the entire community, it also adversely impacts the pool of community-based providers such as QSPs, since their housing and cost of living expenses increase as well, rendering them more likely to seek higher paying employment or to relocate altogether.

#### **8. Service / Program Review**

Many states employ review protocols to continuously evaluate quality of care, provider compliance, service delivery, and to assure overall accountability for program performance and funding. 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).

Some common areas for LTC program review are as follows:

**LOC REVIEWS** – Many states require LOC reviews to be performed by state or contracted staff at the time of nursing facility/HCBS Waiver placement and at least annually. This assures that consumers continue to meet minimum institutional LOC criteria. These reviews also provide a needed check and balance to ensure that nursing facilities clearly understand LOC criteria and self-initiate resident transfers to less restrictive settings as soon as improvements in condition occur. This also assures that funding continues to be made available in the appropriate setting and at the appropriate level for each consumer. North Dakota requires initial LOC determinations unless there is potential for medical improvement for persons who are eligible for nursing facility services, but performs initial and annual LOC determinations only for individuals who are on the HCBS Waiver Program.

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<sup>11</sup>AARP Across The States Profiles Of Long-Term Services And Supports  
[http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf)



**MDS REVIEW** – Because so much funding is involved with nursing facility care, several states have implemented and maintain MDS record reviews, which are performed on-site and at all facilities over a period of time. This is an important compliance tool for states that case-mix adjust their rates. As with annual LOC reviews, MDS reviews also provide 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 time lines. North Dakota performs these reviews on a limited basis.

**COMMUNITY BASED PROVIDER REVIEWS** – Some states perform on site Waiver Program reviews to validate that services are delivered according to individual care plans and that provider billings are documented properly and can be validated. North Dakota has two individuals who perform this type of review.

**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. To address these issues, states may implement consumer interviews and satisfaction reviews either independently or as part of a broader on-site provider performance and documentation review.

North Dakota does not have a comprehensive compliance approach for its LTC providers (both institutional and HCBS), which represents a significant gap within the LTC Continuum. 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.

## XI. Closing Summary

### A. A Brief Overview of Findings

For this report, we carefully studied the Department’s objectives with respect to this Interim Report and then sifted through a wide variety of state and national resources to develop an accurate and relevant presentation of North Dakota’s Long-Term-Care Continuum of services and supports. We also met with State staff and solicited stakeholder feedback to augment our understanding of the service array and delivery systems that are currently in place, and to help identify stakeholder priorities, systematic issues, and concerns.

Within this report specifically, we present relevant national and State-specific demographic information with respect to the aging and disabled population and their caregivers. Some of the highlights with respect to North Dakota are as follows:

- North Dakota is already an “old” state. In 2012, the year after the baby boomers started turning 65, North Dakota ranked 12th in the nation for the proportion of the population 65+ (14.4 percent) and had the second highest proportion of persons 85 and older (2.5 percent).
- Almost 95.8 percent of older North Dakota residents live in households compared to 88.5 percent nationally.
- The more urban counties of Cass, Burleigh, Grand Forks and Ward have proportions of 65-plus and 85-plus below the national average. Despite their low proportions of elderly in comparison to the total population, these four counties are home to 41 percent of all older adults (65+ years).
- Fifty-eight percent of older adults reside in Regions 2, 5, and 7, in which Ward, Cass and Burleigh counties are located. If Regions 4 and 6, with Grand Forks and Stutsman counties are included, 81.3 percent of the older populations reside in these five regions.
- Rural counties such as McIntosh and Divide currently have some of the highest proportions of persons 65 and older in the country with the proportion of people age 85 and older being 3 to 4 times the national average at 7.5 and 6.5 percent respectively.
- Despite the large proportions of older adults in many rural North Dakota counties, the actual numbers are often relatively small. For example, the combined number of persons 65 and older in McIntosh and Divide is 1500 and the total 85 years or older is less than 350.
- It is estimated that the overall resident population increased by between 19,000 and 22,000 people in the last year, making North Dakota’s population larger than at its peak in 1930. With a population increase of 7.5 percent, North Dakota is now the fastest growing state in the country.
- Older North Dakotans are fairly similar to their age cohorts nationally in relation to chronic health conditions. Older North Dakotans have slightly higher rates of arthritis



and cancer, but are below national averages for stroke, chronic obstructive pulmonary disease (COPD), and depressive disorders. There is no difference in their rates of diabetes and heart disease.

- North Dakota’s baby boomers enjoy relative good health. A higher percent of North Dakotans aged 45-64 rate their health as “Very Good” or “Excellent” as compared with the same age group nationally. North Dakotans aged 45-54 and 55-64 are also less likely to report activity limitations or need for special equipment as compared to their age cohorts nationally.
- North Dakota currently faces a higher proportion of older adults at risk for needing long-term care than most of the country will experience for decades.

Within this paper, we also analyze long-term care service capacity and distribution, describe key home and community-based programs, define access to services, and describe rebalancing initiatives. We examine primary cost drivers of ND’s long-term care systems and identify quality and access measures that can be used to promote desired outcomes. We also carefully review and summarize stakeholder perspectives obtained from responses to a targeted questionnaire, public meetings, and written testimony.

Finally, we identify and define gaps within North Dakota’s Long-Term Care Continuum and present them within the following eight categories.

- Consumer Education and Outreach
- Service Point-of-Entry
- Systems Bias toward Institutional Care
- Mental/Behavioral Health Programs
- Workforce Shortage and Retention Issues
- Transportation and Support
- Housing
- Service/Program Review

In conclusion, the findings presented in this report are intended to provide the background necessary to prepare the Final Report, which is due on July 1, 2014, and will consist of recommendations specific to North Dakota’s Long-Term Care Continuum.

## **B. The Final Report**

### **1. Purpose**

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.

This long term care study was designed to assist the North Dakota Department of Human Services Medical Services Division 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.

Evaluation of the current LTC system will be continued between delivery of this interim report and the final report. In addition several selected programs from other states will be evaluated to assess their LTC structure and the range of services provided.

## 2. Contents

The final report will focus on the analysis and development of findings and recommendations needed to complete a comprehensive assessment of North Dakota's current and future long-term care service delivery system. The final report will include:

- A summary of the findings from the Interim Report and a description of the purpose and content of the Final Report
- 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
- Recommend policy considerations to help eliminate service gaps in the long-term care continuum

Given the diverse interests of the various stakeholders, our focus will be to develop recommendations that best meet competing requirements. Each recommendation will be evaluated for its impact on the Medicaid program and state funded services. We will also identify any needed state plan amendments, waiver amendments, and regulatory changes when applicable.

## XII. Appendices

### Appendix A: Regional Capacity Table

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Totals
<b>Age 65 and Older</b>	4690	13405	6503	11972	22444	11980	22669	7003	100666
<b>Age 85 and Older</b>	829	2293	1009	2010	3988	2338	3493	1370	17330
<b>Licensed Nursing Facility Beds</b>	287	661	366	817	1356	889	1198	453	6027
<b>Vacancies</b>	21	69	33	53	79	77	45	24	401
<b>Occupancy Percentage</b>	93%	90%	91%	94%	94%	91%	96%	95%	93%
<b>Basic Care Beds</b>	44	254	136	257	409	201	340	103	1744
<b>Vacancies</b>	10	67	36	34	44	50	23	6	270
<b>Occupancy Percentage</b>	77%	74%	74%	87%	89%	75%	93%	94%	85%
<b>Assisted Living Units</b>	62	473	112	238	701	286	569	231	2672
<b>NF Beds per 1000 Age 65 and Older</b>	61.2	49.3	56.3	68.2	60.4	74.2	52.8	64.7	59.9
<b>NF Beds per 1000 Age 85 and Older</b>	346.2	288.3	362.7	406.5	340.0	380.2	343.0	330.7	347.8
<b>NF Vacancies per 1000 age 65 and Older</b>	4.5	5.1	5.1	4.4	3.5	6.4	2.0	3.4	4.0
<b>NF Vacancies per 1000 age 85 and Older</b>	25.3	30.1	32.7	26.4	19.8	32.9	12.9	17.5	23.1
<b>Basic Care Beds per 1000 Age 65 and Older</b>	9.4	18.9	20.9	21.5	18.2	16.8	15.0	14.7	17.3
<b>Basic Care Beds per 1000 Age 85 and Older</b>	53.1	110.8	134.8	127.9	102.6	86.0	97.3	75.2	100.6
<b>Basic Care Vacancies per 1000 age 65 and Older</b>	2.1	5.0	5.5	2.8	2.0	4.2	1.0	0.9	2.7
<b>Basic Care Vacancies per 1000 age 85 and Older</b>	12.1	29.2	35.7	16.9	11.0	21.4	6.6	4.4	15.6
<b>Assisted Living Units per 1000 Age 65 and Older</b>	13.2	35.3	17.2	19.9	31.2	23.9	25.1	33.0	26.5
<b>Assisted Living Units per 1000 Age 85 and Older</b>	74.8	206.3	111.0	118.4	175.8	122.3	162.9	168.6	154.2

Compiled by Myers and Stauffer 2014

## Appendix B: Aging Service Questionnaire

	<b>Medical Services (701) 328-2321</b> <b>Toll Free 1-800-755-2604</b> <b>Fax (701) 328-0376</b> <b>ND Relay TTY 1-800-366-6888</b> <b>Provider Relations (701) 328-4030</b>
	Jack Dairymple, Governor Maggie D. Anderson, Executive Director

North Dakota LTC Study Stakeholder Questionnaire	
<b>Name of person completing form:</b>	
<b>Organization completing form: (If applicable)</b>	
<b>Title of person completing form:</b>	
<b>Email address:</b>	
<p>This informal Stakeholder Questionnaire is an important part of the Department's evaluation of North Dakota's Long-Term Care (LTC) continuum. You / your organization has been identified as an integral LTC Stakeholder; therefore, we request your assistance in helping us to thoughtfully and objectively assess the current status of our programs, identify opportunities to improve, and consider how and where best to focus limited resources. This is not intended to be a scientific questionnaire but rather an information-gathering mission to help identify and better understand the perspectives of those most impacted by our programs. Individually identifiable information will not be shared in any published report.</p> <p style="text-align: center;"><b>Instructions:</b> Please return your completed questionnaire by email to  <a href="mailto:NDLTCstudy@mslc.com">NDLTCstudy@mslc.com</a>            no later than November 22, 2013.</p> <p style="text-align: center;">If you have questions about the study please feel free to contact:            Carol Job, Project Manager or Kathy Wade, Project Director            Telephone: (800) 255-2309</p>	

### Questionnaire

<b>1. I am most familiar with the following ND LTC service(s). Check all that apply .</b>	FALSE
<input type="checkbox"/> Nursing facility <input type="checkbox"/> Home health <input type="checkbox"/> Hospital <input type="checkbox"/> Personal care <input type="checkbox"/> Basic care facility <input type="checkbox"/> Case management <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Transportation	

<b>2. I am most familiar with the following North Dakota LTC program(s). Check all that apply.</b>	FALSE
<input type="checkbox"/> Medicaid Waiver HCBS <input type="checkbox"/> PACE <input type="checkbox"/> State Plan Personal Care <input type="checkbox"/> Service Payments for the Elderly and Disabled (SPED) <input type="checkbox"/> Money Follows the Person <input type="checkbox"/> Expanded Service Payments for the Elderly and Disabled (Ex-SPED)	

<b>3a. How efficient and effective are the point of entry and needs assessment for determining consumer eligibility and arranging for appropriate services?</b>	0
Select One <input type="checkbox"/> Very: the process is user friendly and person-centered, eligibility determinations are made timely, and a service plan is quickly established and implemented. <input type="checkbox"/> Somewhat: the process works but is somewhat complicated and cumbersome. <input type="checkbox"/> Not at all: the process is difficult and includes numerous barriers and/or obstacles.	



3b. Please explain your response.

4. What do you perceive to be the greatest strengths of North Dakota's LTC continuum and why?

5. What do you perceive to be the greatest weaknesses of North Dakota's LTC continuum and why?

6. What do you believe are the most significant barriers for consumers in accessing or receiving quality LTC services and why?

7. What do you believe are the most significant barriers for caregivers in accessing quality LTC services and why?

8. What do you believe are the most significant barriers for providers in delivering quality LTC services?

9. What changes / enhancements would be most beneficial to North Dakota's LTC continuum and how would it impact consumers, their caregivers, and/or providers?

10a. Overall, how would you rate North Dakota's LTC Services Continuum?

Select One

- Very effective: consumers who qualify generally receive quality services in their choice of programs.
- Somewhat effective: consumers who qualify sometimes receive quality services in their choice of programs.
- Not effective: consumers who qualify encounter significant problems with services and/or their choice of programs.



**10b. Please explain your response.**

Empty response box for question 10b.

**11. Other. Please tell us anything else that you feel we should know about long term care services in North Dakota.**

Empty response box for question 11.

Thank you for your participation.

## Appendix C: Analysis of Responses Received to the North Dakota Long-Term Care Stakeholder Questionnaire

Four hundred four questionnaires were sent out by email and by regular mail during the first week of November. A follow-up/reminder request was sent out two weeks later, and the due date for all responses was extended to December 20, 2013 to optimize participation. A total of 94 (23%) responses were received by the middle of February.

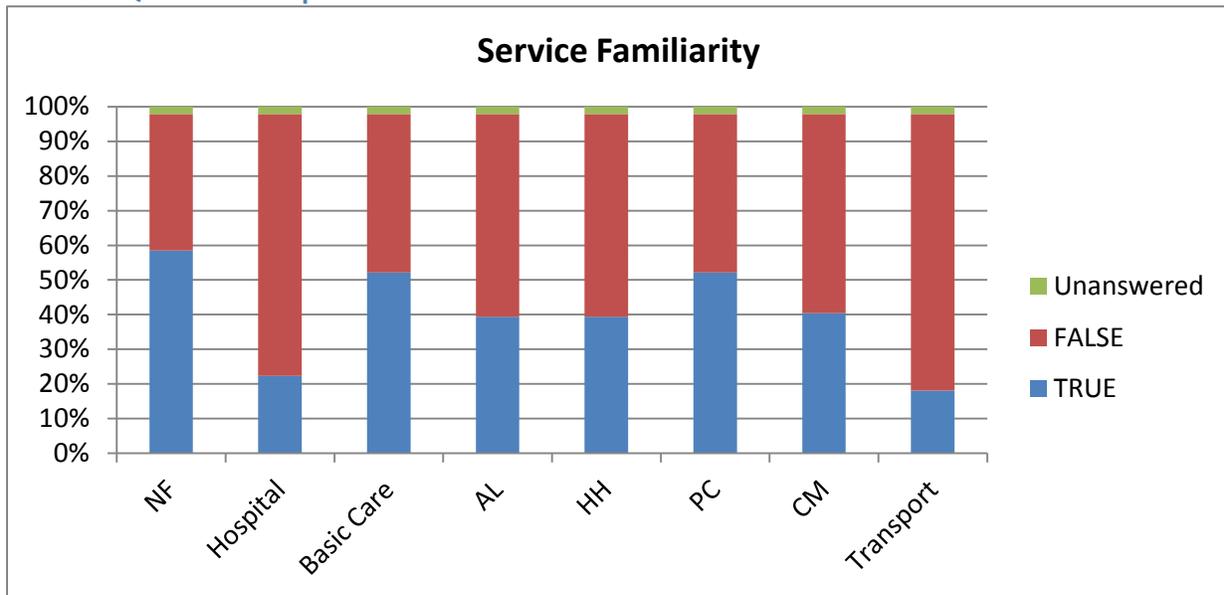
We present each of the ten questions, followed by an analysis of the responses received.

**Question 1: I am most familiar with the following North Dakota LTC service(s). Check all that apply.**

- Nursing facility
- Hospital
- Basic care facility
- Assisted living facility
- Home health
- Personal care
- Case management
- Transportation

Responses received indicated that respondents were most familiar with nursing facility services, basic care services, and personal care. See Chart 1 for the distribution of responses.

**Chart 27: Question 1 Responses**



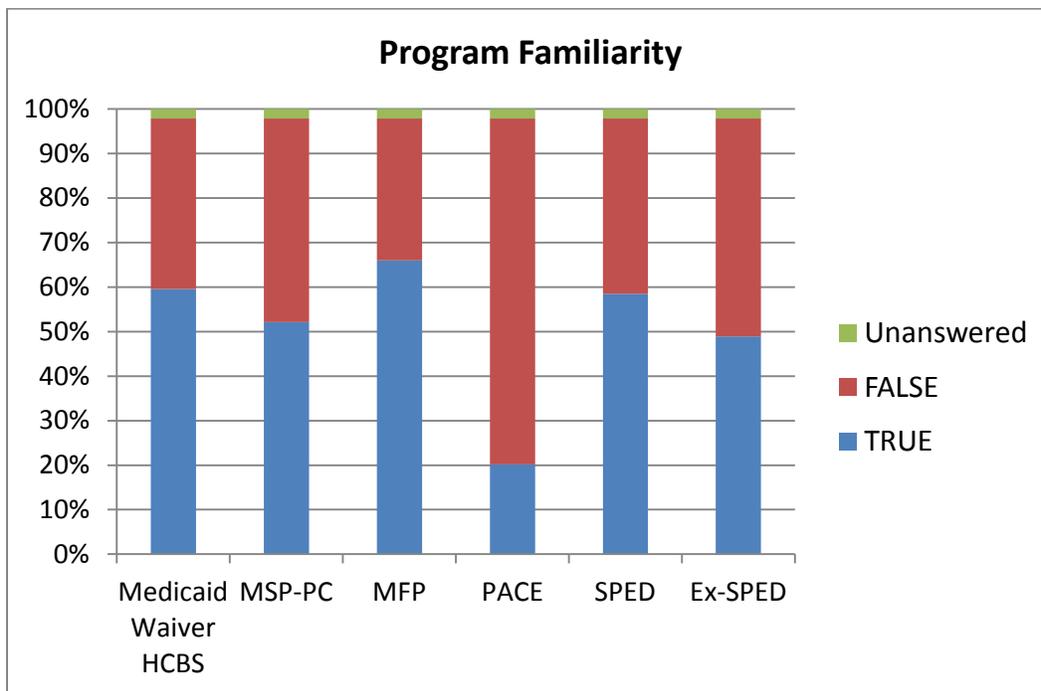
**Question 2: I am most familiar with the following North Dakota LTC programs(s). Check all that apply**



- Medicaid Waiver HCBS
- State Plan Personal Care
- Money Follows the Person
- PACE
- Service Payments for the Elderly and Disabled (SPED)
- Expanded Service Payments for the Elderly and Disabled (Ex-SPED)

Responses received indicated that respondents were most familiar with Money Follows the Person, Medicaid Waiver HCBS, and SPED services. See Chart 2 for the distribution of responses.

**Chart 2: Question 2 Responses**

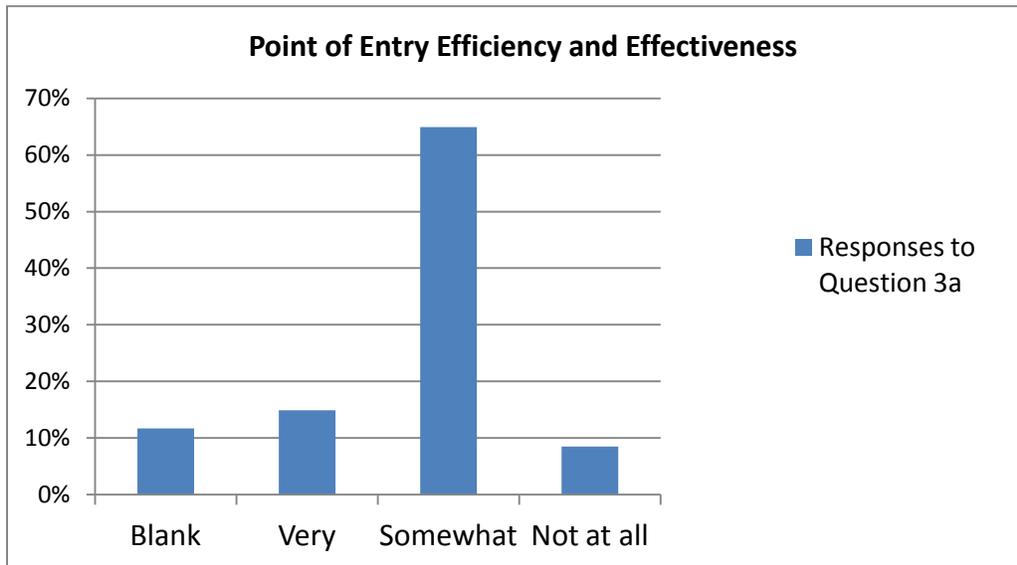


**Question 3a, b: How efficient and effective are the point of entry and needs assessment for determining consumer eligibility and arranging for appropriate services? Please explain your response.**

- Very: the process is user friendly and person-centered, eligibility determinations are made timely, and a service plan is quickly established and implemented.
- Somewhat: the process works but is somewhat complicated and cumbersome.
- Not at all: the process is difficult and includes numerous barriers and/or obstacles.

Responses received indicated that the majority of respondents (65%) find the point of entry and needs assessment for determining consumer eligibility and arranging for appropriate services to be somewhat effective. See Chart 3 to view the distribution of responses.

**Chart 3: Question 3a Responses**



Respondent explanations to Question 3 are summarized as follows:

- Need a Single Point of Entry
  - Process is burdensome and confusing
  - Paperwork is intimidating, burdensome, and time consuming
  - Regulations are burdensome
- Lack of awareness of available programs and how to navigate the process
- Lack of qualified personnel, which can delay the process
- Assessment process inefficient, cumbersome and needs to stand up to appeals
  - Screening process is subjective based on person submitting form

**Question 4: What do you perceive to be the greatest strengths of North Dakota’s LTC continuum and why?**

Stakeholder responses were as follows:

- Providing quality services
- Dedicated staff
- Variety of programs - with increased focus on community based services, includes home care, adult foster care, assisted living, basic care, and skilled nursing care
- Consistency of case management handled through licensed social workers at the county

**Question 5: What do you perceive to be the greatest weaknesses of North Dakota’s LTC continuum and why?**

Stakeholder responses were as follows:



- Bias toward institutional care
  - Lack of awareness and education of available programs among consumers and professionals
  - Need re-balancing of continuum toward HCBS
- Staff shortages especially in rural areas
- Challenges in rural areas
  - No mileage reimbursement
  - Lack of programs and education for available programs
  - Low mental health and social services support
- Process/paperwork burdensome and confusing
  - Billing process is complicated for in-home services
  - Website is confusing
- Medication management at home is a concern including the limitation of providing assistance-medication reminders for in-home services
- Medical transportation- sometimes difficult to get someone to the doctor and accurately convey situation, would help if Medicaid paid for escorted transportation
- Lack of socialization is a major concern for in home clients
- The low medically needy income level – some clients choose not to participate because of the high client contribution compared to SPED

**Question 6: What do you believe are the most significant barriers for consumers in accessing or receiving quality LTC services and why?**

Stakeholder responses were as follows:

- Lack of education and awareness of available programs and how to navigate programs among consumers and professionals, referrals often come too late
- Process is confusing, overwhelming, and burdensome
  - Paperwork is burdening
  - Website is confusing
  - Qualified Service Providers (QSP) list is confusing (providers state they do not serve county in which they are listed)
- Cost of Services, medically needy income level is too low
- Rural challenges
  - Lack of services offered
  - Lack of specialty health services (such as dialysis)
  - Travel - no mileage reimbursement

**Question 7: What do you believe are the most significant barriers for caregivers in accessing quality LTC services and why?**

Stakeholder responses were as follows:



- Lack of education and awareness of available programs and how to access such programs among consumers and professionals
- Informal family supports – often lacking but when they are available they sometimes get burned out before formal in-home services can be arranged
- Regulations are confusing and complex - cannot help remind people to take medications
- Staff shortages
  - Salary challenges
  - Housing challenges
  - Burdensome enrollment process to become a QSP
- Rural challenges
  - Lack of services offered
  - Travel - no mileage reimbursement
- Costs of services
- Cumbersome paperwork for documentation and billing

**Question 8: What do you believe are the most significant barriers for providers in delivering quality LTC services?**

Stakeholder responses were as follows:

- Regulations are confusing, complex, and burdensome
  - Paperwork/billing process cumbersome and complicated
  - Cost reporting system almost penalizes a provider unnecessarily by allocating costs to outside programs making them economically unstable
  - Filing process to check if a claim is in process - currently only can ask about 3 claims per call
  - Enrollment process for QSP is too time consuming
    - Constant changing of enrollment forms delays enrollment for potential QSP
- Staff shortages, wage competition with other industries especially in certain regions
- Travel - no mileage reimbursement
- Lack of education and awareness of available programs and how to access such programs among consumers and professionals

**Question 9: What changes/enhancements would be beneficial to North Dakota's LTC continuum and how would it impact consumers, caregivers, and/or providers?**

Stakeholder responses were as follows:

- Simplify system
  - Single Point of Entry
  - Less regulation
  - Reduce/consolidate paperwork



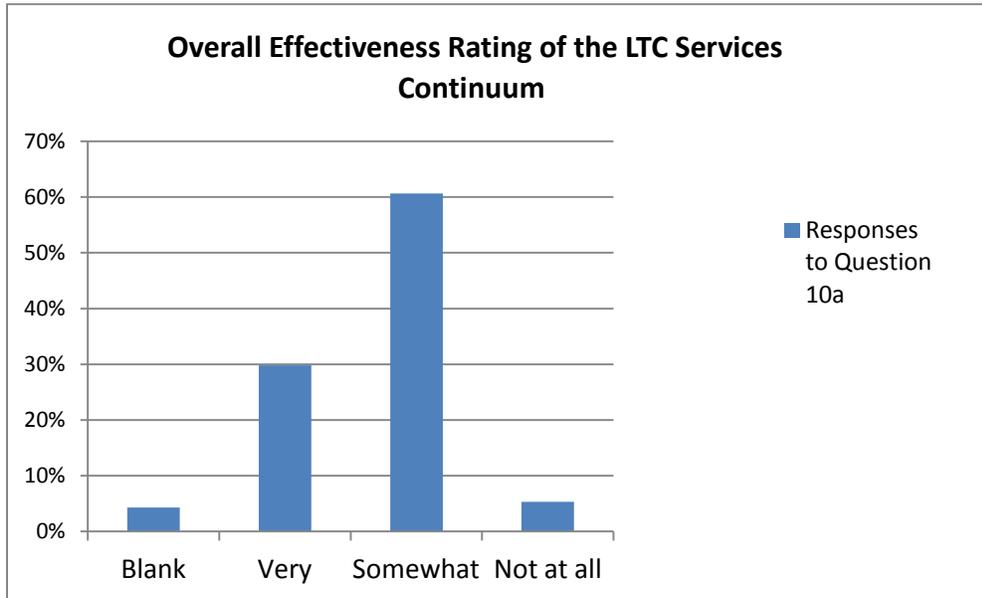
- Train providers to help set up medi-planners (remind clients to take medications)
- Better communication across continuum and coordination between LTC facilities and hospitals
- Changes must come from consumer perspective
- Simplify application and re-certification process
- Clarify financial process so families and residents better understand
- Reduce requirements for in-home services
- Allow family or friends to provide escorted medical transportation
- Update the Medicaid income guidelines
- Mileage compensation
- Increase awareness of available programs and how to access/navigate such programs
- Sustainable workforce
  - Increase compensation for qualified professionals
  - Increase tuition reimbursement for health care fields

**Question 10a: Overall, how would you rate North Dakota's LTC Services Continuum?**

- **Very effective: Consumers who qualify generally receive quality services in their choice of programs.**
- **Somewhat effective: Consumers who qualify sometimes receive quality services in their choice of programs.**
- **Not effective: Consumers who qualify encounter significant problems with services and/or their choice of programs.**

Responses received indicated that 30% of stakeholders find North Dakota's LTC Services Continuum to be very effective, 61% to be somewhat effective, and 5% to be not effective. Four percent of the stakeholder respondents did not answer this question. See Chart 4 to view the distribution of responses.

**Chart 4: Responses to Question 10a.**



Explanations to the responses to Question 10 are summarized as follows:

- Lack of education and awareness of available programs and how to access such programs among consumers and professionals
- Disparity of services between rural and urban communities
- Bias toward institutional care

**Question 11: Please tell us anything else that you feel we should know about long term care services in North Dakota.**

Stakeholder responses are summarized as follows:

- Consumers and medical professionals need to be made aware of all available programs.
- Regulatory burden and paperwork increases cost.
- Required travel times are too high (meaning that providers have to travel many miles before they receive a higher reimbursement rate.)
- There is too much focus on nursing facilities. Home care should be more of an option than it is currently.

## Appendix D: Summary of North Dakota Stakeholder Comments

Two public meetings were held in North Dakota to obtain public comment on the State's Long-Term Care Continuum of Services. The first meeting was held in Bismarck on January 14, 2014 from 1-3 pm and was followed by a separate meeting with representatives of the North Dakota AARP office and the North Dakota Long Term Care Association. The second public meeting was held in Fargo on January 15, 2014 from 1-3 pm. Both public meetings were well-attended, with a combined 57 persons present.

Written testimony was received both at the public meetings and immediately after. Public input was carefully recorded and reviewed with the Department

For ease of reference, comments are grouped within the following nine (9) categories: Education and Outreach; Eligibility Criteria/Accessing Services; Service/Provider Issues; Staffing/Workforce Issues; Funding/Reimbursement; Housing; Nutrition; Transportation; Other.

### *Education and Outreach*

- DHS toll-free telephone number is very helpful.
- DHS program brochures are very helpful.
- DHS should develop additional informational brochures on the following:
  - Medicaid financial eligibility, especially rules regarding transfer of assets.
  - Basic care, who are the contacts and for what.
  - What services are available and what are the funding sources.
  - There needs to be more than additional brochures to better educate the stakeholders; there also needs to be an educational campaign.
  - Because of a lack of accurate information, sometimes attorneys give families bad advice regarding financial management, so the NF is left holding the bag.
  - Need more information on what eligibility workers do; they have 60 days to determine eligibility, which includes collecting information on assets, trusts, bank accounts, etc., but a NF may not get paid in the meantime. Additionally, funding that disqualifies transfers is a big problem.
- Medicaid application for services is confusing.
- Need more staff education on behavioral issues
- Alzheimer's Association provides free training.
- Hospital discharge planners need more education.
- This study needs to have consumer input to fully assess access and point-of-entry and to identify gaps and barriers; recommend that consultants go to a Senior Center to obtain that input.
- To get a fuller picture of access and service delivery gaps, need to send the questionnaire to first responders such as police, fire, and emergency service providers.



### *Eligibility Criteria / Accessing Services*

- Options counseling is a new service (2013) and is not designed right. Counselors are not permitted to assist individuals with completion of paperwork needed to access community services; cases must be closed after an action plan has been completed or within 90 days, which reduces on-going communication and contact with the individuals. Need to implement a “person-centered” approach for Options Counseling that includes assistance in completing and submitting applications for services, and on-going assistance and sustained contact for an extended period of time. Face-to-face outreach is desperately needed.
- Need to implement a “person centered” approach for Options Counseling that allows counselors more flexibility to assist seniors with completing and submitting applications for needed services and to provide on-going assistance to seniors who are navigating the application and recertification process connected with many of the programs available, and to allow sustained contact over an extended period of time. Adding this flexibility would be more seamless for seniors, reduce duplication of effort, and result in greater success in identifying and assisting seniors in accessing available programs.
- County staff members think that entry point at the county works well, although access through counties varies; counties need consistency and better communication.
- Two human services centers have higher engagement than other centers – need to replicate best practices throughout the State.
- Individuals access the LTC system through medical providers in some areas – systems don’t work well together, providers in some areas don’t talk to each other and don’t know what other providers have to offer.
- Need an option to expedite placement/paperwork for Medical Assistance, guardianship.
- Eligibility for services may not be initiated until a person is ready for discharge from the hospital, which is often too late to begin arranging for community placement.
- County staff says that a big issue is getting people when it is too late.
- Inequity in recipient liability; Medicaid recipient has to pay more to stay at home than does a non-Medicaid recipient who receives services through SPED.
- Need another level of eligibility to bring the elderly/disabled into services earlier. A level with reduced eligibility and limited services, for example limited homemaker, case management and ERS services, could provide services to clients who are at risk but not eligible because they don’t meet current eligibility requirements. Those are the clients that may end up with a fall and then be institutionalized because they did not qualify for ERS. “Limited SPED” (which has been a focus of the Adult Services Committee) would meet the needs of these clients.
- At one time if clients were negatively impacted, they did not have to apply for Medical Assistance. This option was removed when the State was short on funds and should now be re-implemented. Currently, a person who is receiving SPED may have no cost share. If the person wants personal care services, the person is frequently asked to apply for Medicaid, which then assigns a monthly recipient liability. In this case, when the client is



negatively impacted financially, the client should be able to opt out of Medicaid and instead receive personal care services through SPED.

- Need to reduce the impairments needed for SPED to provide ONLY homemaker tasks and ERS. People with these two services are less likely to require more intensive care since they are less likely to injure themselves doing housework or laundry. Also, the ERS gives them access to immediate attention after a fall, which may help avoid the need for long-term care outside the home.
- Need to revise financial eligibility criteria for Basic Care. Recipients are denied access to a Basic Care facility because their monthly income exceeds a facility's personal care rate; often the recipient is then admitted into an NF, maybe even in a different city.
- It is a financial hit for hospitals and NFs to discharge patients who are not eligible for services.
- The Department needs to look at the hardship provision.
- State has only two gero-psych units. Not only is it hard to get people into these facilities, but then it is also hard to get NFs to take them back.
- Spousal impoverishment protections that are included in NF regulations are NOT included in basic care.
- The Assisted Living application needs to include more questions.
- The mental health screening process needs to be streamlined.
- Problem with time period and lab work required for an admission into the State Hospital (2-3 weeks); last four gero-psych residents that needed help were transported to another provider because the State Hospital placement took too long.
- Screening to a gero-psych unit is required by statute to result in a placement only after the State Hospital has performed an evaluation of the individual; this has created decreases in admission and occupancy in the two gero-psych units despite high need for services. The statute on admissions to gero-psych beds also does not allow other professional psychiatrists and psych hospitals to utilize services without the NDSH first evaluating the individual.
- It is difficult and time-consuming to get residents of gero -psychiatric units back to the State Hospital for acute care needs; Level I and Level II screenings are not performed timely (within 24-48 hours); it takes 2-4 weeks to place a patient into the State Hospital; need to streamline services; patients in the hospital that need a Level II are penalized.
- Level II screenings are done by an out-of-state provider; service providers have to apply on-line.

### *Service / Provider Issues*

- A strong volunteer base is very helpful in keeping people in their own homes. They are however, limited in how they can help because they don't have access to info.
- ND has lost home health care agencies because there was not enough oversight and agency QSP reimbursement was too low.
- Lack of available adult foster care homes.



- Lack of available providers in some counties - one BC facility has about 40 people on a waiting list – and not enough consumers to fill a Basic Care facility in another county.
- Moratorium should be continued since the need does not exceed the supply, and buying/selling of beds allows redistribution and needed flexibility; NF bed buyout program is not needed.
- Moratorium should not be continued because no one eagerly desires to go to a nursing facility, so there is no need to limit the beds and it is not likely that a NF waiting list would develop. There is a growing need for both basic care and skilled care facilities. The current statewide occupancy rate for skilled beds is 94%, which is considered full, so why should beds be limited in the future? Extending the moratorium is also not responsive to the aging crisis of the future.
- Buying and selling beds is not working well; it has cost the State over \$3 million (286 beds), and has contributed to expensive bed buy-backs for providers and lack of rural access to services for the elderly and their families. Empty or unoccupied beds should be worthless, and occupied beds should be considered valuable, not only for the revenue that they generate but also for the people who occupy the beds. The State should be looking at unoccupied beds as an asset – not as a liability. Unoccupied beds are not funded and can be viewed as an investment for the future and much cheaper than funding new facilities at sky-rocketing costs. On the other hand, the facility is greatly affected by unoccupied beds because of lost revenue, which in turn affects viability.
- Bed licensing should be for the sole purpose of guaranteeing quality care for the elderly, not for restricting the freedom of choice of where the elderly in need of nursing care must reside. Do not implement an occupancy limitation for Basic Care facilities; doing so would add stress and anxiety to providers and possibly provoke some BC and NF providers to influence residents to enter sooner or remain in facilities longer than necessary. Providers might put beds in layaway or sell them to maintain occupancy levels, and then not have them in the future.
- Mental health services are totally lacking. The State Hospital is not a LTC option but rather a temporary option for acute care only; there are no long-term options for persons with serious mental and behavioral health issues.
- The State does not have enough professional psychiatric physicians.
- Emergency medical centers are not the solution for difficult patients. There is no safety net for difficult patients, most of whom are male and often also physically large. Desperately need quick screening and emergency placement options; providers need help ASAP before whole facility is put at risk. It would be helpful if the State Hospital accepted them temporarily in emergency cases; otherwise admission to a State Hospital is very difficult and time-consuming.
- Case management should be available for anyone who needs it and should include financial case managers to assist with correspondence and bill-paying for clients, especially those with visual/hearing impairments.



- Need chronic disease management programs across the state.
- Need a program like “Neighborhood Nurses” to oversee clients with multiple health issues.
- Need to expand AOA programs such as home delivered meals, congregate meals, health services, and one-on-one assessment and assistance with setting up needed services.
- Need to add socialization to the HCBS services to allow for persons to be taken out for a cup of coffee or have extended visiting time, which will reduce feelings of isolation and resulting depression that then contribute to other health issues and institutionalization.
- Need more personal, one-on-one time POA, guardianship, and/or conservatorship services for people who have no family available.
- Huge barriers to medication management. Need QSPs to be able to remind clients to take their meds or check to see if they are taking their meds; suggest some type of medication module that QSPs could take. It is cumbersome and often impossible to get a nurse to set up and monitor medications in all clients’ homes.
- North Dakota does not have enough Over 55 Retirement Communities that offer a vast array of services, and the State needs to do more to attract such private corporations.
- Need socialization for seniors who are isolated. The Senior Companion Program was meant to fill this need but doesn’t work well because the stipend is too small to interest potential providers. Need to add companion services to in-home services.
- Ombudsman can’t get data regarding how long it takes for staff to respond to patient call lights.
- Need more flexibility in delivering services in the home.
- Need stronger caregiver supports. Recommend that hospitals be required to have patients designate a primary caregiver to assist in the care planning process.
- Need to remove “Traumatic” from the Brain Injury services to expand eligibility to persons with acquired brain injuries, since their needs may be the same as TBI clients.
- Need to look at the new waiver option to expand HCBS flexibility; currently ND’s HCB programs work in silos.
- Need new program with lesser requirements and minimal services, such as homemaker, emergency response, and case management.
- Lack of specialized NFs for skilled care. Additionally, ND has no all-male facilities to accommodate patients who prey upon women and have other behavioral and mental health problems.
- Younger NF residents (those with MS, TBI for example) don’t fit in; need to have available different social activities.
- People are held in hospitals for extended time because hospitals can’t find skilled care NFs to take them.
- Lack of adequately funded Adult Protective Services.
- No good placement option for well-functioning (physical) individuals who need 24-hr supervision.



- PACE is a cost-effective alternative to LTC. Currently approximately 10% of all PACE participants are institutionalized, and PACE provides coordinating services and pays for all care delivered. It is a good care option that focuses on keeping individuals healthy and strong and provides a regular evaluation of needs. It has flexibility in the types of services provided, without a focus on the costs; rather, the focus is on providing the right care at the right time in the right place.
- Many issues affecting memory-impaired individuals: memory care lacking across the continuum; lack of adult day care; care in the home not accessible; services not within driving distance.
- Assisted Living facilities are not regulated but are not allowed to have residents with care needs; therefore some residents must be transferred right into skilled care. Basic care needs to be established as an intermediate level of care option.
- Basic care is a great option – need more paid with BCAP.
- Do not establish a minimum occupancy level for basic care facilities.
- No changes are needed for state basic care licensure requirements.
- State licensure requirements for assisted living should remain as currently designed however, the DHS should update the licensure application to reflect the additional regulations passed by the 2009 legislature. This includes revisions to the application form regarding training, background checks, and satisfaction surveys.
- The NF moratorium and buying/selling beds should not be changed.
- Three of the largest health systems use telemedicine; tele-monitoring can be very effective.
- State needs to look at placing supports around family caregivers. Paid family caregivers are a big problem; opens the system up for fraud and puts a huge burden on county staff to review. Family caregivers are not audited. Many family QSPs are poorly or not-at-all qualified to provide care, resulting in harm to individuals and overbilling of services not provided. Solutions: Limit paid family care to only patients who meet NF LOC. Hire people to make surprise home visits.
- ND ranks highly in quality of care in NFs.
- NF quality measures – encourages development of a sub-committee to further study the issue; incentives should take the form of an enhancement and not a penalty; maintain the efficiency incentive and operating margin.
- It is very important to include basic care provider representatives in the process if making changes to the program or requirements.

### *Staffing / Workforce Issues*

- It is beneficial that paraprofessionals are able to be used in both institutional and community settings.
- Difficulty in recruiting staff: social workers, CNAs, CMAs.
- Shortage and instability in staffing.



- Contract agency staffing is very expensive for providers but offers workers better pay and more flexibility.
- Staff turnover caused by staff who leave for better paying jobs with better benefits in the community. Nursing facility work is harder than working in a clinic or medical office, or staff may leave the healthcare field altogether.
- Workforce issues, especially in finding licensed social workers, which are required for most HCBS services.
- Workforce issues need to be studied at the State level and coordinated with the University of North Dakota.
- Is there a need to create standards for contract nurses?
- Each nursing facility can pay up to \$15,000 per person for nursing school.
- Recruit caregivers from American Indian population?

### *Funding / Reimbursement*

- Not enough investment in Options Counseling. Currently, this is paid only through federal funds, with no state dollars budgeted.
- Many seniors cannot afford the QSP minimum hourly rate of \$19.20 if they don't qualify for HCBS or only qualify for a 10-20% discount with HCBS.
- Need to allow payment for QSPs to provide transportation to and attend medical appointments with recipients so they can hear and provide input and know how to direct changes in meds when the recipient returns home.
- More than half of in-home services funding does not cover mental illness as the primary diagnosis.
- The SPED funding sources are based on a sliding fee scale adjusted 2-3 legislative sessions ago, which therefore have not kept up with cost of living increases. Need the SPED fee scale to be adjusted again and then annually to coincide with the cost of living increase from Social Security.
- Need more funding for Vulnerable Adults Protective Services. The area's one VAPS worker is overworked – received as many referrals as the 3 or 4 VAPS workers in the Fargo region.
- Need more/enough funding for respite care for caregivers to reduce or eliminate the waiting list.
- Assisted Living is not affordable for Medicaid.
- Basic care limits – the methodology for setting limits needs to be changed because of instability (i.e. not increased every year to coincide with increasing cost of doing business). 80% of beds pay only 2/3 providers' costs. Payment does not accommodate changes in acuity, contract issues. Need adequate annual inflationary adjustments. Limits need to be standardized.
- In NFs, dementia units pay poorly for people who have low physical needs but need constant reminders/to be directed about everything that they do, which is very labor-intensive; so NFs need to fill dementia beds with very high-need, higher paid individuals.



- Primary cost drivers of public funded LTC institutional services are labor (staff salary/benefits/over time/contract labor) and inflation on costs to operate (fuel, food, medical supplies, etc.); reliance on contract staffing; turnover; recruitment, retention of CNA's; and no housing for caregivers.
- Rate equalization is a positive feature within the NF reimbursement system as long as it is adequately funded; generally think it is good public policy, especially since NFs have the lowest paid Medicare rate in the country. This is because the State has only 6 PPS hospitals; the rest are classified as critical access hospitals.
- Recommends the development of a sub-committee to further study the issue of NF quality measures; incentives should take the form of an enhancement and not a penalty; maintain the efficiency incentive and operating margin.
- Being paid on quality measures big concern; NFs make admissions decisions, usually denials, because they want to avoid reductions in the QM points. Examples include psychotropic meds, bed sores.
- Cost allocation system is out-of-date and needs to be reevaluated.

### *Housing*

- Housing shortage and skyrocketing prices particularly in the western part of the State are unaffordable for lower-paid health care workers.
- Some rural counties with many seniors have no senior services or senior housing; nursing facilities may be the only placement option.
- Old homes may not be accessible.
- Unaffordable rent for seniors, particularly in oil boom areas
- Unfamiliarity with neighbors.
- Reasons that people don't remain in their own homes: isolation; socialization; medication management; supervision (although new legislation effective 7/1/14); nutrition.
- Technology to keep people in their own homes seems to be available.
- Need more flexibility in delivering services in the home.

### *Nutrition*

- There is not enough state and Federal funding to meet community need. The contract for nutrition services is significantly under-funded, requiring the provider to obtain gap funds within the community to help meet the expenses. Need to budget sufficient funds to reimburse providers the unit rate for every meal served and increase the unit rate for meals annually based on an inflation factor.
- The Department has indicated that additional funds from other regions that do not spend their full contract amounts may be reallocated and made available in 2014 to make up the shortfall. In addition, Federal funding was reduced by \$294,000 as a result of sequestration. Some of these sequestered funds may be restored through legislative action at the national level.

- Need to reinstate funding for congregate frozen meals (eliminated in Jan. 2012 by Aging Services). Why can't meals be funded by the State and not be part of the federal regulations?

### *Transportation*

- Limited reimbursement for mileage, which hits rural areas the hardest.
- Lack of available transportation providers.

Need to add medical transportation and medical escort to the services that QSPs can provide. Currently QSPs can be paid to transport clients for banking, shopping, hair care and other errands, but not for doctor or therapy appointments. The escort component is also important for clients with hearing problems or mild memory problems who may not understand or remember what the medical professional has told them; an escort may help back-up.

## Appendix E: References

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