Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Long-Term Care Continuum budget.

Programs

The long-term care services included in this area of the budget are the Developmentally Disabled Community-Based Care grants; Nursing Facilities, Basic Care Facilities, and the Home and Community-Based Services Programs which have the following funding sources: (Service Payments for the Elderly and Disabled (SPED); Expanded SPED; the Medicaid Technology-Dependant Waiver; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; Children's Medically Fragile Waiver, Children's Hospice Waiver, and the Medicaid Home and Community-Based Services Waiver).

The Long-Term Care Continuum encompasses a wide range of medical and support services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.

I will provide an overview of the long-term care continuum budget, with the exception of the Developmental Disabilities grants, which will be provided by Tina Bay, Director of the Developmental Disabilities Division.

Program Trends

Nursing Facilities

As of September 30, 2010, the percentage of Medicaid-eligible individuals in nursing facilities was 52 percent. Attachment A shows the Licensed and Occupied Nursing Facility Beds since October 2008, and Attachment B shows the Medicaid occupied beds. Based on the September 30, 2010 occupancy reports, 24 facilities were below 90 percent occupancy. The average occupancy for these 24 facilities is 78 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. During the 2009-10 and the 2007-08 interims, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility beds that are being shifted through the state. The Department's 2011-2013 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

Basic Care

The Department continues to believe that a moratorium on the number of basic care beds should also remain. The process in place for requested exceptions to come before the Department of Health and the Department of Human Services continues to work well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the basic care beds that are being shifted and added throughout the state.

Home and Community-Based Services

Home and Community-Based Services (HCBS) continue to provide an array of services determined to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care. HCBS staff work closely with county case managers and providers to ensure clients have the services they need in a timely and efficient manner. Ongoing collaboration occurs between HCBS staff and the Centers for Medicare and Medicaid (CMS) to identify changes in federal requirements and to continually enhance quality measures to assure clients and families are receiving the appropriate services to meet their needs.

Major Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- Increased the **home delivered meals** offered in the HCBS waiver from 3 meals per week to 7 meals per week; effective January 1, 2010.

- 2009 House Bill 1433 authorized a **supplemental payment for at-risk nursing facilities.** No facility has requested reimbursement under this provision.

- 2009 House Bill 1327 authorized funding to **convert a nursing facility** into a basic care/assisted living facility. Funds to **operate**

a rent-subsidy pilot project were also included. The funding will expire June 30, 2011.

- Implemented **non-medical transportation** in SPED and ExSPED; effective January 1, 2010.

- The **SPED fee schedule** was updated, based on actual cost of living adjustments. This change was effective July 1, 2009.

- The **Adult Family Foster Care Point Split** was removed effective January 1, 2010.

- The **Hospice for Children Waiver** was implemented July 1, 2010, after receiving approval from the Centers for Medicare and Medicaid Services.

- The **third tier of Personal Care** was implemented January 1, 2010.

- The $20 **Personal Needs Allowance** for SSI only individuals was implemented January 1, 2010.

Money Follows the Person Demonstration Grant

As noted in the Traditional Medicaid testimony, the passage of the Affordable Care Act extended the Money Follows the Person (MFP) grant through 2020. The grant is now expected to transition 87 individuals with a developmental disability and 265 individuals who reside in a nursing facility to the community. To accomplish the new transition expectations,

CMS has authorized 100 percent federal administrative funding discussed previously.

The primary barriers to transition identified to date include the limited availability of affordable and accessible housing, shortage of qualified service providers in rural North Dakota, limited public awareness of the types of home and community based services offered in the home, varied availability of home health/hospice services across the state, and rural transportation capacity. Through December 2010, forty- four individuals were transitioned to the community. The transition goal for Calendar Year 2011 is thirty-nine individuals. Included with this testimony are two MFP brochures (one for each transition population) to provide additional information and detail.

Minimum Data Set (MDS) 3.0

On October 1, 2010, North Dakota, as well as other states began using Version 3.0 of the Minimum Data Set (MDS). MDS is part of the federally mandated process for clinical assessment of all residents in nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are completed for all residents in certified nursing homes, regardless of individual's source of payment. MDS assessments are required for residents on admission to the nursing facility and periodically thereafter, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the state Medicaid office, and is used as the cornerstone for establishing the resident's per day cost of care.

With the implementation of MDS 3.0, one of the modifications the Department made to the classification logic was to recognize a distinct classification period for therapies when the initiation or discontinuation of therapies results in a change in a resident's classification. A resident's classification period will remain as a 3-month period; however, during that 3-month period, if a resident was classified in a rehab category and therapies are discontinued the resident's classification will be changed as of the date all therapies were discontinued to the classification that would otherwise have been in effect at the beginning of the classification period had there been no therapies. Likewise, if therapies are started during the 3-month classification period, a resident's classification may be changed as of the start date of therapies.

Overall, the implementation of MDS 3.0 went smoothly. We continue to answer questions from providers and work on individual issues as needed.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Budget	Senate Changes	To House
Nursing Homes	425,713,210	33,409,823	459,123,033	-	459,123,033
Basic Care	18,113,925	7,858,470	25,972,395	-	25,972,395
SPED	17,495,327	(3,712,339)	13,782,988	-	13,782,988
Ex-SPED	726,578	250,146	976,724	-	976,724
Personal Care Services	25,044,599	4,105,306	29,149,905	-	29,149,905
Targeted Case Management	1,957,896	(393,147)	1,564,749	-	1,564,749
HCBS Waiver	8,707,606	1,560,780	10,268,386	-	10,268,386
Children's Medically Fragile Waiver	1,147,844	(829,064)	318,780	-	318,780
Technology Dependent Waiver	532,608	(32,472)	500,136	-	500,136
PACE	7,393,711	1,977,269	9,370,980	-	9,370,980
Children's Hospice Waiver	856,410	914,020	1,770,430	-	1,770,430
Total	507,689,714	45,108,792	552,798,506	-	552,798,506
General Fund	172,803,502	75,045,834	247,849,336	-	247,849,336
Federal Funds	324,704,819	(23,030,709)	301,674,110	-	301,674,110
Other Funds	10,181,393	(6,906,333)	3,275,060	-	3,275,060
Total	507,689,714	45,108,792	552,798,506	-	552,798,506

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Budget Changes from Current Budget to the Executive Budget

Nursing Homes

The Executive Budget was based on Medicaid nursing home days paid. The monthly average days are projected to be:

97,832	–	Nursing Facility
449	–	Dakota Alpha
975	–	Geropsych Unit
1,310	–	Swing Bed
2,650	–	Hospice Room and Board
1,888	–	Out of State
105,104		Total

A "day" is the unit of service for nursing facilities. Basing the nursing facility budget on bed days more closely mirrors how claims are reimbursed by Medicaid. For example, if an individual enters the nursing home on the 20th of January. The facility may chose to bill Medicaid for January and February at the same time. This results in the “bed” only being counted once, even though the days are greater than 30.

Attachment C shows historical information on expenditures and average daily Nursing Facility Rates.

Upper Payment Limit

The Medicaid regulations contain a requirement that Medicaid payments to institutional providers, including nursing facilities, in the aggregate, cannot exceed what Medicare would pay, in the aggregate, for the same care. This is known as the Upper Payment Limit (UPL). The Upper Payment Limit must be calculated yearly for each type of facility: private; state-government owned, and non-state government owned.

Historically, the gap between the Medicaid payments and the Upper Payment Limit has been large enough, where this has not been an issue or something the Department needed to bring to your attention. However, the increases provided by the 2009 Legislature, have resulted in North Dakota approaching the Upper Payment Limit for the private facilities, and actually, for 2011, exceeding the Upper Payment Limit for the non-state government owned facilities. The Department is working with the non-state government owned facilities to ensure their rates for 2011 are in compliance with the Upper Payment Limit.

During session, when there are requests for fiscal impact related to nursing facility rates, the Department will be providing information on the estimated impact the proposed change will have on the upper payment limit and whether the proposed change will be able to be implemented by the Department under the Medicaid regulations.

Senate Changes

The Senate made no changes to this section of the Department's Budget.

Attachment D shows the changes in the Long Term Care Continuum Budget from 2009-2011 Appropriation to the 2011-2013 Executive Budget request; to the Budget to the House.

Attachment E is a cost and caseload comparison of the 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

This concludes my testimony on the 2011 – 2013 budget request for Long-Term Care Continuum. I would be happy to answer any questions.