Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, 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 Nursing Facilities, Basic Care Facilities, Developmentally Disabled Community-Based Care, and the Home and Community-Based Services Programs which have the following funding sources: Service Payments for the Elderly and Disabled (SPED); Expanded SPED; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; 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.

Program Trends

Nursing Facilities

As of September 30, 2008, the percentage of Medicaid-eligible individuals in nursing facilities was 54 percent, which has been fairly consistent for many years. **Attachment A** shows the Licensed and Occupied Nursing Facility Beds for the current biennium, and **Attachment B** shows the

Medicaid occupied beds. Based on the September 30, 2008, occupancy reports, 23 facilities were below 90 percent occupancy. The average occupancy for these 23 facilities is 83 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. Throughout the interim, the Department has been in contact 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 2009-2011 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

During the 2007 Legislative Session, approval was provided for the expansion of Geropsychiatric Services. As of December 2008, the additional 16 Geropsych beds are filled. We expect these beds to be filled throughout the 2009-2011 biennium.

The number of individuals receiving hospice service in Nursing Facilities is reported on **Attachment C** (Nursing Facility Hospice). As you can see, this number, which includes individuals receiving hospice from all funding sources, has significant fluctuation; however, it has trended higher since July 2005.

Basic Care

Overall, the Basic Care program has seen very little change over the interim. 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 appears to be working well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has been in contact with the North Dakota Long Term Care

Association for the purpose of tracking the basic care beds that are being shifted and added through the state.

Home and Community-Based Services (HCBS)

Home and Community-Based Services continue to provide options for clients who find a need for long-term care services. Staff members work closely with county case managers and providers to ensure clients have the services needed. Often times, it takes a considerable amount of collaboration between formal and informal supports, as well as programs and funding streams, to wrap the necessary services around those who need care. The HCBS staff members are committed to continuous program review to ensure clients and their families have the information needed to make the best choice for their care needs. You will hear throughout this testimony about program changes that have occurred during the interim and those that are funded in the Executive Budget.

Developmental Disabilities

As you will hear from JoAnne Hoesel when she provides the overview testimony for the Developmental Disabilities (DD) programs, there continues to be various areas for program focus. These range from the renewal of the DD waivers, consumer choice, transitions of individuals from the Developmental Center and increased oversight from the Centers for Medicare and Medicaid Services. I will cover the DD Community Grant expenditures later in this testimony.

Major Program Changes

HCBS Waiver

The 2007-2009 Appropriation for the Home and Community-Based Services Waiver included funding to add Family Personal Care, Extended

Personal Care and Home Delivered Meals. **Family Personal Care** assists individuals to remain with their family members and in their own communities, and provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services. **Extended Personal Care** includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse, licensed to practice in the state, provides training to a QSP approved by the Department to provide the required care and (the nurse) will provide at a minimum, a review of the clients' needs every six months to determine if additional training is required. Activities of daily living and instrumental activities of daily living are not a part of this service. The purpose of **home delivered meals** is to provide a well-balanced meal to an individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the individual. During the 2007-2009 interim, this service was added to the HCBS Waiver, with a limit of three hot or frozen home delivered meals per week. The Executive Budget request for 2009-2011 includes funding to increase the three meals per week to seven meals per week. This increase would require a change to the HCBS Waiver, and it is expected that the implementation date would be January 1, 2010.

Technology Dependant Waiver

Shortly after the beginning of the current biennium (August 1, 2007), the Department received Centers for Medicare and Medicaid Services (CMS)

approval to operate a Medicaid waiver for individuals who are technology dependent. This waiver has three slots available.

Children's Medically Fragile Waiver

2007 Senate Bill 2326 authorized the implementation of Medically Fragile Waiver for Children. This waiver received approval by CMS on April 1, 2008. The waiver currently serves three children and staff members are working with other families to complete the level of care and level of need documents.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions that serve individuals with a developmental disability in transitioning to home and community-based settings. The grant is expected to transition 30 individuals with a developmental disability and 80 individuals who reside in a nursing facility to the community. After receiving CMS approval of the operational protocols for the grant, transitions began in the summer of 2008. Through December 2008, five individuals were transitioned to the community. The transition goal for 2009 is 34 individuals. The grant ends September 30, 2011. We have included two MFP brochures (one for each transition population) to provide additional information and detail. (Nursing Facility Population Version; Developmental Disabilities Population Version)

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

PACE is a program that provides complete health care coverage to persons who have long-term care needs. To be eligible for PACE, an

individual must be at least 55 years of age, live within the PACE service area, meet nursing home level of care, and be able to live safely in the community. Northland Healthcare Alliance and Medical Services staff worked together to implement this "managed care" approach to delivering services to qualifying individuals. Each month, the Medicaid program pays a capitated rate to Northland, and in turn, Northland is responsible to coordinate and pay for all Medicare and Medicaid services needed by the individual. The goal of the PACE program is to provide the necessary services to individuals to allow them to continue living at home. Each individual has a care plan that details the services needed and all services are reviewed and approved by the PACE care team. Northland Healthcare Alliance identified Bismarck and Dickinson as their PACE service areas. Enrollment in the program began in August 2008 and as of December 1, 2008 there are nine individuals enrolled in the program (seven are Medicare and Medicaid and two are Medicare only). For additional information, a PACE brochure is included with my testimony.

Minimum Data Set (MDS) 3.0

Currently, North Dakota, and other states are using Version 2.0 of the Minimum Data Set (MDS).

The following information is adapted from the CMS website:

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the Minimum Data Set (MDS) 2.0, the Centers for Medicare and Medicaid Services (CMS) is undertaking an effort to implement Version 3.0. The expected implementation date is October 1, 2009. This implementation will involve system changes and

the Department has assembled a multi-Division workgroup to ensure readiness for the October implementation.

According to CMS, the goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to shorten the tool while maintaining the ability to use MDS data for quality indicators, quality measures, and payment.

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 then periodically, 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.

Non-Medical Transportation

Funding to add Non-Medical Transportation to Service Payments for the Elderly and Disabled (SPED) and ExSPED is included in the Executive Budget. The total funds are $406,444, of which $387,660 are general funds and $18,784 are county funds. Non-Medical Transportation allows individuals to access essential community resources/services in order to maintain themselves in their home and community. Individuals receiving

non-medical transportation service: (1) are unable to provide their own transportation, (2) need a means of obtaining basic necessary community resources and/or services (i.e. grocery, pharmacy, laundromat), and (3) do not have access to transportation through an informal network.

Revising the SPED Fee Schedule

Through input of stakeholders and advocates, the Department has been urged to revise the SPED Fee Schedule. The schedule was last updated August 1, 2003. The Executive Budget includes the funding to update the fee schedule. This update was based on actual cost of living adjustments (COLA) through January 2008 and an estimated COLA for January 2009.

Removal of the Adult Family Foster Care – Point Split

The purpose of Adult Family Foster Care is to offer a choice within a continuum of care to adults, who could benefit from living in a family environment, as well as to promote independent functioning and provide for a safe and secure environment. Currently, when multiple recipients reside in a Family Foster Care setting, the reimbursement points assigned to laundry, shopping, and housekeeping are split by the number of recipients. This results in less reimbursement for the provider and a greater amount of paperwork. The Executive Budget contains funding to remove the point split. Removing the point split will compensate providers more equitably for services provided and help ensure access to Adult Family Foster Care services for clients. The point split change would be effective January 1, 2010.

Implementing Hospice for Children Waiver

Hospice options for families with terminally ill children are very limited. Today hospice is offered to terminally ill individuals who have elected

hospice, which generally requires that they are no longer looking at curative measures. A Medicaid Hospice waiver will allow a child to receive Hospice services and palliative care within the child's home. In addition, the family can continue to receive Medicaid-reimbursed services, such as curative care, as well as counseling, respite, and expressive therapies. The waiver will have 30 available slots, and is expected to be operational by July 1, 2010, contingent upon the implementation of a new Medicaid Management Information System (MMIS) and approval from the Centers for Medicare and Medicaid Services (CMS).

Personal Care – Third Tier

Personal Care Services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) so that the individual is able to live at home. Personal care services are authorized when service activities are essential either on an intermittent or ongoing basis, and the need for personal care services is expected to continue for a period of time in excess of 30 days. Currently there are two levels of Personal Care (Level A and B). The maximum number of hours available is about eight per day. In order to accommodate those unique cases where recipients are determined to require more than eight hours of personal care per day, the Executive Budget contains the funding to add a third tier of Personal Care called Expanded Medicaid State Plan –Personal Care that would allow a maximum of 10 hours of Personal Care per day. Specific criteria would need to be met and prior authorization by a HCBS Administrator would be required for approval of this service. In addition, the Centers for Medicare and Medicaid Services (CMS) will need to approve the addition of the third tier. Based on the time needed for CMS approval and computer system changes, the estimated start date for this service is January 1, 2010.

ISLA Administrative Funding

Currently, administrative reimbursements for the Individualized Supported Living Arrangement and Family Care Option (FCO) III programs are inadequate to support programs for individuals with high levels of need. Providers of service typically lose money providing services to individuals receiving ISLA and FCO III services. These programs are essential to community placement of individuals from institutions and individuals receiving these services have very high need levels. Currently there is a disincentive in the administrative reimbursements to serve clients receiving these services. The Executive Budget contains $2.4 million (of which $.9 million are general funds for ISLA and $96,108 (of which $35,416 are general funds for FCO III) to increase the administrative reimbursement so it is based on the client level of need. This increase is intended to ensure community placements are available and to prevent additional institutional admissions.

Personal Needs Allowance – SSI Only Individuals

Personal Needs Allowance dollars are used by individuals in an institutional setting (Nursing Home, Intermediate Care Facility for the Mentally Retarded (ICF/MR) and Psychiatric Residential Treatment Facility) for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Some individuals in an institution are "SSI only" and their Personal Needs Allowance is paid to them by Social Security. This allowance is limited to $30. Funding to increase the Personal Needs Allowance for these individuals to $50 per month is included in the Executive Budget. The $20 increase per person would be funded with 100% general funds. The Executive Budget includes

$148,068 to fund this increase. Based on the effort needed to implement this change, it is expected that this increase would take effect January 1, 2010.

Intense Medical Needs – Family Homes

Currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to increase the wages of In-Home Support staff, who assist families in caring for children at home. The level of reimbursement would be at the same level as Intermediate Care Facility providers serving children with similar intense medical needs.

Intense Medical Needs – Residential Facility

As noted above, currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to compensate DD providers serving adults with intense medical needs at the same level as Intermediate Care Facilities providers serving children with similar intense medical needs.

Personal Needs Allowance – Decoupling ICF/MR

Personal Needs Allowance dollars are used for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Currently, the amount of Personal Needs Allowance individuals in a Nursing Facility and individuals in an Intermediate Care Facility are allowed to keep is currently set at $50 per person per month. During the interim, the Department has worked with the Centers for Medicare and Medicaid Services (CMS) to secure approval to “decouple” the Personal Needs Allowance for individuals in a Nursing Facility from those in an Intermediate Care Facility. The Executive Budget includes funding to

increase the Personal Needs Allowance for individuals in an Intermediate Care Facility to $60 per month. The change would be effective January 1, 2010.

Medicaid Waiver - Autism Spectrum Disorder – Under 5 Years

The Executive Budget contains the funding to implement a Home and Community-Based Services (HCBS) Waiver to provide intensive supports for young children who have a diagnosis of Autism Spectrum Disorder. The waiver needs to be written, and the Department would need to secure CMS approval; therefore, we are expecting an implementation date of July 1, 2010, which would also be contingent upon the implementation of the new Medicaid Management Information System. The waiver will have 30 slots.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Nursing Homes	370,080,827	422,244,637	52,163,810
Basic Care	14,083,121	17,070,865	2,987,744
Personal Care	19,086,421	23,919,788	4,833,367
HCBS Waiver	4,943,345	9,607,825	4,664,480
Tech Dependent Waiver	762,019	540,744	(221,275)
Children's Medically Fragile Waiver	1,343,070	1,165,293	(177,777)
SPED	11,945,116	17,340,292	5,395,176
Ex-SPED	763,149	717,401	(45,748)
PACE	1,452,310	7,393,711	5,941,401
Targeted Case Management	923,325	1,985,916	1,062,591
DD - Community Based Care	274,423,470	323,056,043	48,632,573
Total	699,806,173	825,042,515	125,236,342
General Funds	257,332,905	313,669,588	56,336,683
Federal Funds	435,566,053	505,155,627	69,589,574
Other Funds	6,907,215	6,217,300	(689,915)
Total	699,806,173	825,042,515	125,236,342

FTE	-	-	-

- Nursing Facility services account for about 51.2 percent of the 2009-2011 budget for the long-term care continuum. (Compare to 52.9 percent for 2007-2009 Budget)

- Basic Care accounts for about 2.1 percent of the 2009-2011 budget for the long-term care continuum. (Compare with 2.0 percent for 2007-2009 Budget)

- Home and Community-Based Services account for 7.6 percent of 2009-2011 Budget for the long-term care continuum. (Compare to 5.9 percent for the 2007-2009 Budget)

- DD Grants account for about 39.2 percent of the 2009-2011 Budget for the long-term care continuum. (Compare to 39.2 percent for the 2007-2009 Budget)

- This portion of the 2009-2011 Budget also contains an inflationary increase for providers at seven percent each year of the Biennium.

- The impact on the 2009-2011 Budget of the decline in the Federal Medical Assistance Percentage on general funds for the Long-Term Continuum is $5.8 million.

Nursing Facilities

- The Executive Budget request for nursing facilities totaled $422.2 million, of which $153.2 million are general funds. The current budget for nursing facility services is $370.1 million of which $132.8 million are general funds. This $52.1 million increase is related to: Caseload and Utilization decreases ($9.8 million), the seven/seven percent inflationary increase ($26.9 million), and cost changes of $35 million. The cost changes include the funds necessary for rebasing the limits ($3.5 million), the funds necessary to sustain

the increase to the property limits ($7.8 million), and cost changes reported on the annual cost reports that need to be covered and sustained ($23.7 million). **Attachment D** shows historical information on expenditures and average daily Nursing Facility Rates. Earlier in my testimony, I reported that Medicaid is paying for approximately 54 percent of individuals in the nursing facilities. The remaining 46 percent are mostly private pay. The increases noted above are built into the average cost per day which affects both Medicaid and private pay residents. Private pay residents will see an increase of approximately $13 per person per day, each rate year of the 2009-2011 Biennium.

- The Executive Budget for nursing facilities was based on Medicaid occupancy of 3,388 beds per month. The occupancy includes:

  3,132 - Nursing Facility
  16 – Dakota Alpha
  30 – Geropsych Unit
  62 - Swing Bed
  86 – Hospice Room and Board
  62 – Out of State

Basic Care

- The Executive Budget for Basic Care is $17.1 million of which $7.9 million are general funds. This is a $3 million increase over the current budget. The average monthly caseload for the 2009-2011 budget request is 455, and the average utilization for the first 12 months of the biennium is 397. The increase consists of cost and utilization changes ($.8 million net increase) and $2.2 million increase for the seven percent inflation each year of the biennium.

Home and Community- Based Services

This area of the budget includes many funding sources such as the various Medicaid waivers, personal care services, SPED, and PACE. Collectively the net change is an increase of $21.5 million in total funds. The contributing factors to the increase are noted below:

- The Executive Budget includes an increase of $4.8 million for Personal Care Services. The average monthly caseload for Personal Care Services is estimated to be 671 and the caseload for the first 12 months of the biennium was 570. The estimated caseload (671) includes the expected average caseload increase of 20 for Tier III Personal Care. The budget increase in this area accounts for the utilization changes noted during the budget preparation process and also includes cost/utilization changes (net increase of $.6 million), the seven percent inflation each year of the biennium ($ 1.4 million increase) and the addition of Tier III Personal Care ($2.8 million increase). Tier III Personal Care is expected to be effective January 1, 2010, after receiving the necessary federal approval, and making the necessary computer system changes.
- The Executive Budget for the Service Payments to the Elderly and Disabled (SPED) is $17.3 million of which $16.5 million are general funds and $.8 million are county funds. This is a $5.4 million increase over the 2007-2009 Budget. The average monthly caseload is estimated to be 1,597, and the average caseload for the first 12 months of the biennium was 1,434. The estimated caseload includes the addition of 22 individuals expected as a result of revising the SPED fee schedule. The cost increase consists of the seven percent inflationary increase ($1.6 million), funding to revise the SPED fee schedule ($.6 million), the portion of the adult family

foster care point split that applies to this area ($32,141), and $3.1 million to cover the cost and utilization increases expected, based on the trends used during the budget preparation process.

- The 2009-2011 Executive Budget request for ExSPED is $717,401, as compared to the 2007-2009 Budget of $763,149. The budget request is built on an average monthly caseload of 129, and the average caseload for the first 12 months of the biennium was 109. The seven percent inflationary increase for this area is $70,441, and the portion of the adult family foster care point split that applies to this area is $2,142. In addition there were cost and utilization decreases which totaled $118,331.
- The Executive Budget request for Targeted Case Management is $2 million, of which $.7 million are general funds. This represents a $1.1 million increase over the 2007-2009 appropriation. The average monthly caseload is expected to be 458. For the first 12 months of the current biennium, the caseload was averaging 427. The increase includes $.2 million for the inflationary increase, and $.9 million increases for cost and utilization. The Medicaid Targeted Case Management regulations are on a moratorium through March 2009; therefore, we await the final implementation direction to determine if there are additional impacts in this area.
- The Executive Budget request for the HCBS Waiver is $9.6 million of which $3.6 million are general funds. The HCBS Waiver includes the waivers previously reported as the TBI (Traumatic Brain Injury) Waiver and the Aged and Disabled Waiver. The average monthly caseload included in the budget request is 349 and for the first 12 months of the biennium, the average caseload was 244. The estimated average caseload includes expected increases for the Adult Family Foster Care Point Split (eight) and for the Hospice

Waiver (15). The increase in the projected utilization is a result of the new services added to the waiver over the interim, which were discussed earlier in my testimony. The overall increase, as compared to the 2007-2009 appropriation, is $4.7 million. This increase consists of $.8 million for the seven percent inflationary increase, $81,156 for the portion of the adult family foster care point split change that affects clients within the waiver, $.9 million to fund the new Hospice Waiver for Children, and an increase of $2.9 million for cost and utilization changes accounted for when preparing the budget. The implementation date for the additional home delivered meals is expected to be January 1, 2010 and the implementation date for the Hospice Waiver for Children is expected to be July 1, 2010.

- The Executive Budget request for the Children's Medically Fragile Waiver is $1.2 million of which $.4 million are general funds. The current appropriation for this waiver is $1.4 million. The 2009-2011 budget request estimates an average monthly case load of 11 for this waiver. Currently there are three children receiving waiver services, and the budget is built with estimates of increasing the caseload gradually over 2009-2011. The wavier has a maximum of 15 slots. This area includes a $.1 million for the seven percent inflationary increase, and a net decrease of $.3 million, related to cost and utilization changes.
- The Executive Budget request for the Technology Dependant Waiver is $.5 million of which $.2 million are general funds. The 2007-2009 budget is $.8 million. This waiver is now serving one individual, and the budget request is based on the expectation that we will provide services to two individuals in SFY 2010 and three for SFY 2011. The waiver has a maximum of three slots. The budget request

includes $55,740 for the seven percent inflationary increase and a net decrease of $277,015 for cost and utilization changes.

- The Executive Budget request for the Program for All-Inclusive Care of the Elderly (PACE) is $7.4 million, of which $2.7 million are general funds. While this presents a $5.9 million increase in the budget, it is actually a "shifting" of dollars from other services. The utilization in the other Medicaid services was reduced for the budgeted PACE utilization. As noted earlier in my testimony, PACE is a capitated long-term care program; therefore, PACE is responsible for all Medicaid services needed by enrolled participants. As a result, it is expected that Medicaid would have fewer direct expenditures for services, such as nursing facility care, personal care and hospital services, as these "bills" would be paid directly by the PACE program. The monthly average enrollment for PACE was budgeted at 76, which includes the additional enrollments Northland Healthcare Alliance is expecting in the Bismarck and Dickinson areas. The PACE budget does not contain funding for the inflationary increase, as the rates are established by an actuary and not subject to inflationary increases.

Developmental Disabilities

The increases of approximately $48.6 million in the DD Grants are from following eight areas:

- $190,195 net decrease in caseload. The decrease consists of $151,145 in general funds and $39,050 in federal funds.

- $17.6 million is due to cost changes that occurred during the 2007-2009 Biennium, which must be sustained during the 2009-2011

Biennium. The cost change increase consists of $6.5 million in general funds and $11.1 million in federal funds.

- $28.5 million is due to a seven percent inflationary increase each year of the 2009-2011 Biennium. The increase consists of $10.5 million in general funds and $18 million in federal funds.

- $103,680, of which $38,341 are general funds, to increase the Personal Needs Allowance for individuals residing in an ICF/MR from $50 per month to $60 per month.

- $805,412, of which $297,842 are general funds, to cover the cost of services provided to adults with intense medical needs who live in a residential facility.

- $644,330, of which $238,274 are general funds, to cover the cost of services provided to children with intense medical needs who are cared for in their family homes.

- $57,854 of which $21,394 are general funds, for the portion of the adult family foster care point split change that applies to this area of the budget.

- $1 million, of which $.4 million are general funds, to operate a Medicaid Autism Waiver for one year. The funding is only for one year; it is expected to take one year after legislative approval to write the waiver, secure public input and receive CMS approval.

I would be happy to answer any questions you may have.