Study of Basic Care and Assisted Living in North Dakota

Presented to:

State of North Dakota Department of Health and Human Services, Medical Services Division

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Executive Summary

The Medical Services Division within the North Dakota Department of Health and Human Services (HHS) contracted with Guidehouse Inc. (Guidehouse) to perform a study on Basic Care and assisted living in North Dakota.

The 2023-25 North Dakota Legislative Assembly passed Senate Bill 2283, which required HHS to study "the Basic Care system and the licensure and regulation of Basic Care and assisted living facilities." Basic Care was created as a state-funded residential facility option for lower income adults who do not meet the level of care requirements for skilled nursing facilities. It is an alternative to skilled nursing facilities and assisted living settings targeted specifically for lower income adults who require assistance with activities of daily living.

As of January 2024, there are sixty-six (66) licensed Basic Care facilities in North Dakota with 2,097 beds. Basic Care facilities can be stand-alone facilities, or they can be co-located with assisted living or skilled nursing facilities. Forty-six of the facilities are enrolled with North Dakota Medicaid to provide personal care and room and board services through State Plan services. Eighteen of the enrolled 46 facilities also provide "adult residential services" or Specialized Basic Care type services through the North Dakota Medicaid Waiver for Home and Community Based Services (HCBS). These facilities must be licensed to provide these specialized services to residents.

This report summarizes the findings, analysis, and proposed recommendations regarding:

- State licensing requirements for Basic Care and assisted living.
- Present day Basic Care rate setting, including policy considerations for:
    - Changes to the property component in Basic Care rate setting.
        - An occupancy incentive in Basic Care rate setting.
        - An alternative to the current operating margin and annual inflation process in Basic Care rate setting.
        - Structuring payments to provide an incentive for providers to serve individuals with behavioral health needs.
        - Establishing rates for specialized Basic Care services for individuals with Alzheimer's disease or other related dementia diagnoses, memory impairment, or care for individuals with traumatic brain injuries.
- Opportunities for delivery of Basic Care type supports in integrated settings, including impacts associated with classifying and compensating Basic Care as permanent supported housing, rather than as a long-term-care-type facility.
- Issues of non-compliance with the HCBS Settings Rule and the potential impact to provider rates and Basic Care Assistance Program (BCAP).
- Basic Care eligibility, and the types of services that are necessary to meet the needs of individuals to be served in Basic Care facilities.
- Actions to address the gaps in residential service options for adults with serious mental illness (SMI) who have historically been served in nursing facility geropsychiatric units.

- The role of Basic Care in the North Dakota continuum of services for adults with disabilities with low income.
- The role of assisted living in the North Dakota continuum of services for older adults.

Summary of Study Findings and Recommendations

Table 1. Summary of Study Findings and Recommendations

#	Recommendation	Impact of Recommendation Implementation
1	**Streamline licensing by creating a new single licensure type to cover both assisted living and Basic Care facilities.**	The State will need to prepare and assist providers with this change. The State can provide educational materials and information sessions to providers prior to implementation of changes to properly prepare them. In addition, The State can consider a phased-in approach to this change. A clear, concise definition of the types of service packages that a facility may offer is also included as part of this recommendation. The State can also require facilities and providers to include these service package definitions in their marketing and admissions materials to educate potential residents and their families on the differences between Assisted Living and Basic Care and promote informed decision-making.
2	**Strengthen existing Assisted Living and Basic Care policy and create additional policies to reflect current requirements within the program, incorporate best practices, and align with State and federal requirements, as applicable.**	The State would benefit from clarity in policy and guidance in key areas that are presently under-defined. Policy updates should drive improved understanding of Assisted Living and Basic Care. The updates to policy clarify service definitions, delivery, and purpose to improve consistency and more effectively administer and oversee Assisted Living and the Basic Care program.
3	**Develop and implement State-led universal Basic Care and Assisted Living training and materials to educate all stakeholders.**	HHS would benefit from creating a committee to lead the development and implementation of training and materials. HHS should consider the differences in Assisted Living and Basic Care facility size and geographic location to tailor components of the universal training.
4	**Adopt strategies to improve and expand the current service and programmatic array within Basic Care to increase community integration for residents.**	Through the enhancement and expansion of the current service array, the program and the broader network of providers who deliver these services will be better able to address the holistic needs and preferences of residents. Integrating with existing programs in the community provides the opportunity for Basic Care residents to connect with an expanded network that offers additional social activities,

#	Recommendation	Impact of Recommendation Implementation
		community resources, and greater social interaction for those who seek it.
5	**Update regulatory oversight process based on implementation of recommendations.**	For each topic area that may be impacted by updates to the regulatory oversight process, the State would benefit from establish workgroups to provide feedback and assist with implementation. For example, if the State decides to create a new licensure type, a licensure workgroup that reviews current health and safety oversight processes and identifies and addresses changes that will need to be made for the implementation of a new licensure type will be beneficial for planning.
6	**Implement quality improvement initiative requirements for Basic Care facilities to improve quality of care and align facilities with federal requirements and best practices.**	The State would benefit from working closely with providers to identify policy initiatives to pursue to address current challenges in the Basic Care program that can improve the experience and care of residents. As new Rules are proposed and enacted from the Centers for Medicare and Medicaid Services (CMS), quality improvement initiatives can address requirements and recommendations. In addition, the State will need to consider ways to monitor these initiatives to assess how improvement is being made.
7	**Update regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs.**	the State would benefit from a consistent index used across the healthcare industry. HHS will need to receive legislative approval to do so.
8	**Implement a Fair Rental Value (FRV) methodology to reimburse Basic Care provider property costs.**	There is flexibility to address a variety of needs identified by providers. This would enable providers to invest capital in improvements or replacements.
9	**Implement tiered add-on payments for residents with increased Activities of Daily Living (ADLs) service need and align reimbursement methodologies.**	Providers would receive reimbursement for residents who may require extra assistance to allow for the individual to remain in the setting of their choice. To promote efficiencies and reduce administrative burden for locations that provide both Basic Care and Specialized Basic Care, the State should align reimbursement methodologies. This alignment provides the opportunity for providers of Specialized Basic Care to receive timely and appropriate changes to their reimbursement.

Guidehouse performed the work on behalf of HHS to study Basic Care and assisted living in North Dakota. The study methodology included: reviewing North Dakota and five (5) comparison state policies and regulations on assisted living and related services; conducting stakeholder engagement through interviews, focus groups, and public meetings; engaging key State staff through meetings; conducting data analytics of relevant data sources to model possible scenarios; and providing recommendations for the State. This final report provides a summary of the regulatory and policy analysis, the qualitative study and stakeholder engagement, data analytics and proposed recommendations.

The full report contains the following sections:

- ***Section I: Summary of Study*** describes the study objectives, the stakeholder engagement undertaken, and the existing Basic Care and assisted living services.
- ***Section II: Study Activities and Methodologies*** summarizes the activities completed during the study including stakeholder engagement and data analyses.
- ***Section III: Recommendations*** provides a description, rationale, impacted topic areas, and implementation considerations for the study recommendations.

Section I: Summary of Study

The 2023-25 Legislative Assembly passed Senate Bill 2283, which required the North Dakota Department of Health and Human Services (HHS) to study "the basic care system and the licensure and regulation of basic care and assisted living facilities." In 2023, the HHS, Medical Services Division contracted with Guidehouse Inc. (Guidehouse) to perform a study of the North Dakota Basic Care Program. Guidehouse conducted an assessment of North Dakota's existing programs.

Guidehouse understands the value that assisted living and Basic Care provide in the day-to-day care and living environment of older adults and persons living with disabilities in North Dakota. We completed an assessment of North Dakota's existing programs using stakeholder engagement and thorough analysis to develop pragmatic, impactful recommendations that will position the State as an effective steward of the taxpayer dollar while supporting efficient delivery of necessary services to a vulnerable population.

Section 1.1. Approach to the Study

HHS issued a competitive procurement in the Summer of 2023 to acquire a contractor to conduct a study of Basic Care and assisted living in North Dakota. Guidehouse developed a study design, including weekly meetings with HHS to advise and provide feedback on the study process. HHS identified and requested participation from key staff to advise study efforts and offer valuable subject matter expertise throughout the study.

The study consisted of three tasks: 1) develop work plan, 2) conduct stakeholder engagement, and 3) draft final report. As part of the first task, develop work plan, Guidehouse designated a Project Director and project team to lead and conduct the study. Throughout the project, we provided a weekly progress update during meetings with HHS. Activities associated with stakeholder engagement are detailed in *Section II: Study Activities and Methodologies*.

Section 1.2. Summary of Existing Basic Care and Assisted Living in North Dakota

The North Dakota Basic Care program provides room and board along with health, social, and personal care for residents of a Basic Care facility to attain or maintain the residents' highest level of functioning. The program serves both older adults and persons with disabilities. As of January 2024, there are 66 licensed Basic Care facilities with a total of 2,097 beds. Figure 1 shows the location of Basic Care beds by county. The darker shade of blue a county, the more Basic Care beds there are in the county.

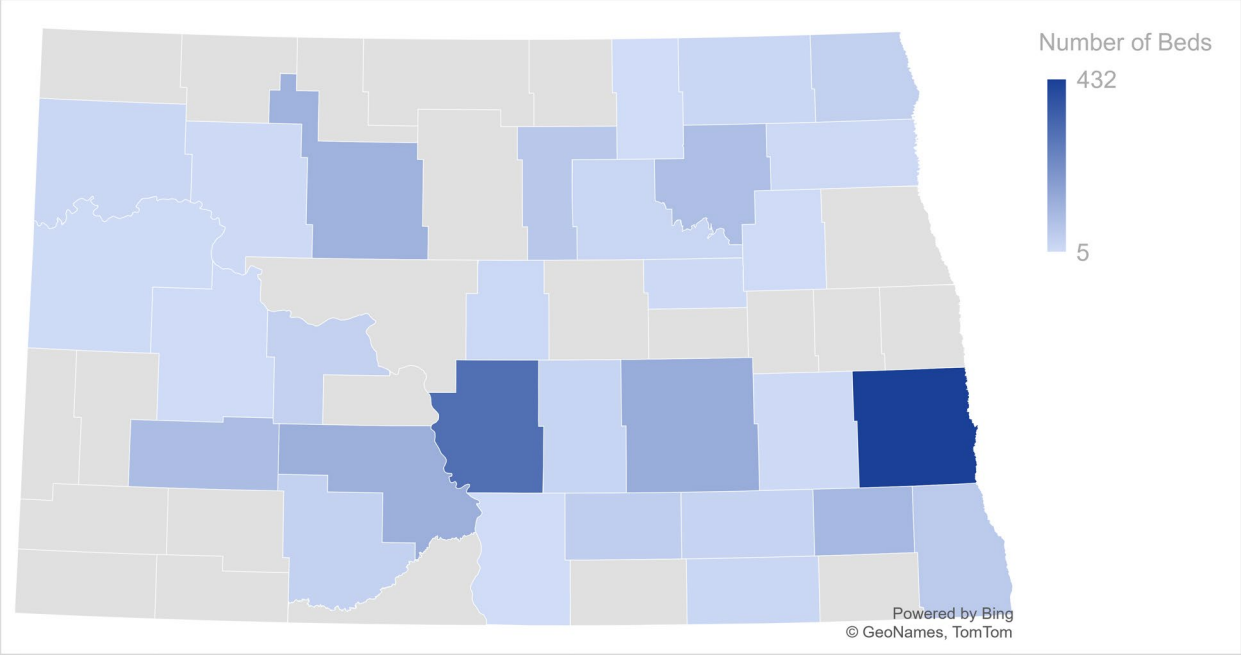


Figure 1. Total Basic Care Beds by County as of January 2024

Facilities offering Basic Care deliver core services including personal care, housekeeping, laundry, and meals. Services are designed to help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and can include provision of leisure, recreational, and therapeutic activities; supervision of nutritional needs; and medication administration.[1,2] These services are meant to support people in such a way to delay or alleviate the need for higher levels of care available in institutional settings like skilled nursing facilities, intermediate care facilities or the State Hospital. Facilities must be licensed by HHS and the license must be renewed annually. To be eligible for Basic Care, a person must be over the age of 65, or over 18 years of age and have a disability, and they must demonstrate a need for services as per a functional assessment. They may require some assistance with bathing but must be able to independently toilet, transfer, and eat in order to be considered for residence in Basic Care.

For residents who are Medicaid eligible, services are reimbursed through North Dakota Medicaid State Plan Services. This payment covers resident care services and supplies, laundry, dietary services, and housekeeping salaries. North Dakota utilizes state general funds to pay the Basic Care room and board rate for Medicaid eligible residents, as federal regulations prohibit the use of Medicaid funds for room and board. For Basic Care, this rate is the Basic Care Assistance Program (BCAP). This rate includes all other costs, such as professional services, food, property, utilities, and other building costs.

Basic Care facilities that provide care for residents with chronic moderate-to-severe memory loss or residents who have significant emotional, behavioral, or cognitive impairments must also be licensed as a Specialized Basic Care facility, in addition to the Basic Care license. The

[1] Activities of Daily Living (ADLs) means those personal, functional activities required by an individual for continued well-being, including eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.
[2] Instrumental Activities of Daily Living (IADLs) includes preparing meals, shopping, managing money, housework, laundry, transportation, use of telephone, and mobility outside the Basic Care facility.

specialized license requires employees at the facility to receive specialized training in providing services to residents with cognitive impairments. Services provided at these locations are funded through North Dakota's 1915(c) Medicaid Waiver for Home and Community Based Services (HCBS) or paid for privately by the individual.

Assisted Living

As of March 2024, there are 74 licensed assisted living facilities in North Dakota with a total of 3,020 units. Figure 2 shows a map of the number of assisted living units by county. The darker shade of blue a county, the more assisted living units within the county.

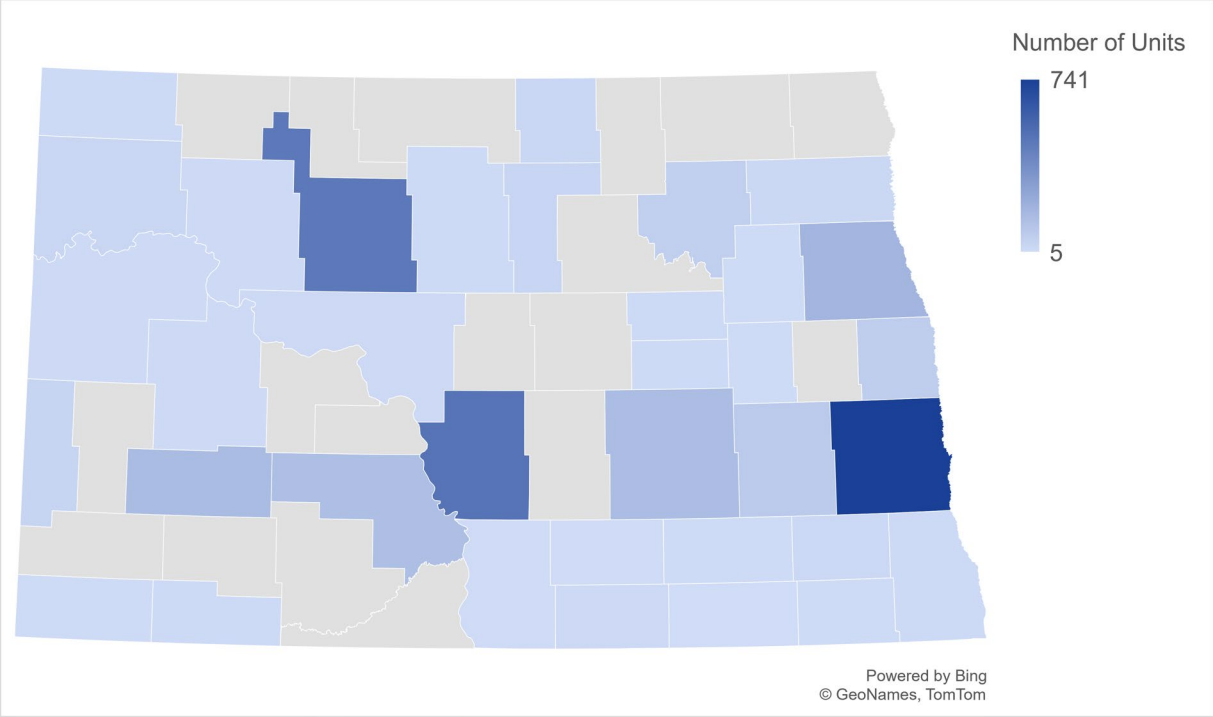


Figure 2. Total Assisted Living Units by County

An assisted living facility in North Dakota contains at least five living units operated as one entity to provide services for five or more individuals who are not related by blood, marriage, or guardianship to the owner or manager of the entity, and which is held out to the public as a place that provides or coordinates individualized support services to accommodate the individual's needs and abilities to maintain as much independence as possible.[3] Assisted living facilities must be licensed by both the Food and Lodging and Health Response and Licensure Section of HHS. The licenses must be renewed every year per North Dakota Administrative Code Chapter 33-03-24.1 and Chapter 75-03-34.

Room and board and services, such as provision of meals, housekeeping, laundry, etc., are paid for by the resident. North Dakota Medicaid may cover HCBS provided to Medicaid eligible individuals residing in assisted living facilities. At the time of this report, fewer than 10

[3] North Dakota HHS, Assisted Living, https://www.hhs.nd.gov/adults-and-aging/assisted-living

individuals residing in an assisted living facility receive State funded HCBS via Service Payments for the Elderly and Disabled (SPED).

Currently there is no authority under the assisted living license provision that allows for the State to act on any complaint received from an assisted living resident or a mandated reporter. In other words, the State does not have the authority to suspend or revoke a license, or to investigate complaints; complaints received by the State are forwarded to the appropriate agency, entity, or program for investigation. Typically, these complaints are referred to the Long-Term Care Ombudsman Program, who does not have regulatory authority or enforcement capabilities. Their role is primarily to advocate for residents of assisted living and other long-term care facilities and address concerns without the power to enforce direct changes.

HHS received 816 complaints from either residents or family members of residents in assisted living or Basic Care, or mandated reporters during Federal Fiscal Years (FFYs) 2022 and 2023. The top three categories for complaints received during this period were (1) Care, (2) Autonomy, Choice, Rights, and (3) Abuse, Gross Neglect, Exploitation.

Supported Housing

While North Dakota has various options for supported housing for residents, they are limited; State staff and stakeholders report that there are gaps for individuals who need housing that is both affordable and accessible and offers services and supports that they may require to remain independent. Basic Care functions as a facility-based form of service-enhanced, affordable housing for people with demonstrated care needs.

HCBS Settings Rule

The HCBS Settings Rule, enacted by the Centers for Medicare & Medicaid Services (CMS), ensures that individuals who receive services and supports through Medicaid HCBS have full access to the benefits of community living and are provided the opportunity to be as integrated within the community as possible. The Rule requires a person-centered planning process where the individual receives the services and supports, leads the planning for their HCBS, and their preferences and goals are directly incorporated into the plan. Under the Rule, a setting is determined to be home and community-based so long that it:

- Is integrated in, and supports access to, the broader community;
- Provides opportunities to seek employment, engage in community life, and control personal resources;
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving services;
- Is selected by the individual from among other setting options;
- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy, and independence in making choices; and
- Facilitates individual choice regarding services and supports and who provides them.[4]

[4] Administration for Community Living, HCBS Settings Rule, https://acl.gov/programs/hcbs-settings-rule

The HCBS Settings Rule applies to services funded through Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. Basic Care facilities providing specialized services, such as Adult Residential Services, funded through North Dakota's 1915(c) waiver, must comply with these regulations, ensuring greater community access. Although states have the option to extend the rule to other non-mandated HCBS services, currently Basic Care, which is funded through State Plan personal care, is not required to maintain compliance with the HCBS Settings Rule, and therefore residents living in Basic Care are not provided the same federal protections to ensure community access as those residing in Basic Care facilities providing specialized services. Basic Care providers who also offer Adult Residential Care (Memory Care) have settings that function as quasi-institutional. The populations they serve generally require more oversight, protections against wandering, and extensive medical and personal care services. Assisted living and Basic Care settings face heightened regulatory risks and compliance challenges, particularly if they are funded by 1915(c) waivers or other State Plan funding. Non-compliance can lead to scrutiny and funding issues from CMS and legal risks from the Department of Justice (DOJ). As Basic Care is considered part of the HCBS continuum of care and the Basic Care unit is an individual's home, alignment with the HCBS Settings Rule provides additional protections for these individuals.

Program Reimbursement

HHS updates Basic Care rates annually on July 1st and rates may be subject to additional changes throughout the year due to audits, or special circumstances. Rates are facility-specific and based on each facility's historical costs as reported through an annual cost report submitted to HHS. Rate setting requirements are outlined in the North Dakota Administrative Code for Basic Care Facility Rate Setting.[5] The current system has been in place since 2003. Annual and other Basic Care rate updates do not apply to Specialized Basic Care providers.

Between November 2021 and March 2022, a workgroup consisting of State staff, industry representatives, and providers met to discuss Basic Care rate setting. Topical discussion included payer mix, levels of care, rate limits, and rate analysis.[6] The workgroup came to consensus on four topics and provided recommendations for each. Table 2 identifies the topic area and the corresponding recommendation made by the workgroup. Each of the listed recommendations were accepted and implemented.

Table 2. 2021-2022 Basic Care Payment Reform Report Workgroup Recommendations[6]

Topic Area	Workgroup Recommendation
Limit Methodology	Median plus 18% for Direct and 12% for Indirect
Rebasing Frequency	Every 4 years
Rebasing Data	Use current cost reports
Uniform Cost Report Filing	June 30th, State Fiscal Year end

For the limit methodology, per day rates for Direct and Indirect rates are determined by HHS and applied to each provider. If the per day rates calculated from the cost reports are above the

[5] North Dakota Administrative Code, Rate Setting for Basic Care Facilities, Chapter 33-03-24.1
[6] *Basic Care Payment Reform Report.* https://ndlegis.gov/files/committees/67-2021/23_5212_03000presentation1115.pdf

set limit, the rates are reduced to the limit. The workgroup recommended that the Direct limit be calculated as 118 percent of the median per day and Indirect at 112 percent of the median.

Rebasing frequency indicates how often the limits described above are re-calculated. Prior to this recommendation, there was no set interval for rebasing and the applicable limits were last rebased for rates effective July 1, 2016. In years when the limit is not rebased, the limits are increased by the inflation factor approved by the Legislative Assembly.

The workgroup's recommendation is to use the most currently available cost report data as the rebasing data, which is also used to calculate provider rates each year.

The uniform cost report filing determines the fiscal year for which costs are reported. Prior to the workgroup's recommendation, each Basic Care provider submitted their annual cost report based on their own fiscal year end. Costs for providers who had different fiscal years than January to December were inflated by the consumer price index to match this time frame. The workgroup recommended a uniform cost report year of July through June.

Supports for Adults with Serious Mental Illness

During 2021, Renee Schulte Consulting, LLC completed a study to inform a report on the current challenges faced in North Dakota with delivery of behavioral health care and options. The report, *Acute Psychiatric and Residential Care Final Report*, also includes recommendations for both a short-term and long-term plan for acute psychiatric hospitalization and related step-down residential treatment and support needs in North Dakota along with the recommendations for the future use of facilities at the State Hospital.[7]

Specifically, a portion of the report reviewed and provided recommendations around licensed beds in nursing facilities designated for geropsychiatric care. North Dakota added geropsychiatric units to existing nursing homes to work within the Medicaid Institution for Mental Disease (IMD) Exclusion parameters. The IMD exclusion limits the use of Medicaid funding for inpatient behavioral healthcare. An IMD is a facility or other institution that has more than 16 beds and is primarily providing treatment or care for residents with mental disease (SSA §1905(i)). The report also recommends that geropsychiatric facilities have their own licensing standards and rules, rather than a level of care designation, to provide treatment and care for individuals with this service need.

[7] *Acute Psychiatric and Residential Care Final Report*, https://ndlegis.gov/files/committees/67-2021/23_5150_02000presentation1300report.pdf

Section II: Study Activities and Methodologies

This section includes a review of the various activities completed over the course of the study. Guidehouse completed a detailed policy analysis of current North Dakota policies along with a comparison of five states' policies, extensive stakeholder engagement across multiple groups including residents, family members, providers, and public stakeholders, and data analysis of reimbursement and cost report information.

Section 2.1. Environmental Policy Scan

Guidehouse began with an environmental scan of North Dakota's assisted living and the Basic Care program to gain a better understanding of the current policies and procedures that the State had in place and comparing North Dakota's practices against those seen nationally. This review considered how policy changes could best improve the Basic Care program by considering alternative state programs. The analysis informed the development of stakeholder interview topics and questions and policy recommendations.

The environmental scan of existing policies and regulations helped to identify ways to enhance assisted living and Basic Care. The review evaluated best practices from five other states' programs and compared North Dakota's regulatory requirements to those other states.

To provide for a holistic comparative policy analysis, the following factors were considered when selecting comparison states:

- **Population and Enrollment Size**: Include states which reflect North Dakota's current program scale, as well as compared to larger states for diversity in perspective.
- **Like-Region:** Include neighbor states and/or states that have a similar make-up of rural and urban regions.
- **Policy Vehicles of Interest:** Include states which utilize policy vehicles attainable for North Dakota's current program.
- **Operating Program:** Include states with support programs similar to Medicaid funded assisted living.
- **Long-Term Services and Supports (LTSS) Leading States:** Include states known for establishing best-practice standards within LTSS.

Based on these factors HHS approved the following five comparison states: Idaho, Minnesota, Montana, South Dakota, and Washington.

For each state, Guidehouse reviewed the most recently published state policies and regulations along with 1915(c) waiver applications for waivers which included assisted living services or residences. We also reviewed North Dakota's current state policies and regulations for Basic Care and assisted living facilities including:

- North Dakota Basic Care Century Code
- North Dakota Administrative Code – Basic Care Facilities
- North Dakota Administrative Code – Assisted Living Facilities
- North Dakota Assisted Living Century Code

- North Dakota State Building Code

To promote a comprehensive and comparable review of policy language we worked with HHS to identify 25 points of comparison to be reviewed across North Dakota and the five comparison states. The points of comparison, along with the broader comparison topics, are provided in Table 3 below.

Table 3. Policy Review Topics and Points of Comparison

Comparison Topic	Point of Policy Comparison
Eligibility and Admissions	Admissions and Discharge Criteria
Assessment and Care Planning	Resident Assessment and Care Plans
	Person-Centered Planning and Documentation Requirements
	Participant Directed Services
	Allowable Services
Clinical Services	Nursing Services
	Medication and Treatment Administration
	Individual Licensing, Qualification, and Certification Requirements
	Staffing Education Programs
Additional Service Components	Dietary Services
	Alzheimer's, Specialty Memory Care, Traumatic Brain Injury, or Service Mental Illness
	Recreational Accessing and Program Requirements
	End of Life Services
Participant Rights and Protections	Tenancy Rules
	Resident Rights
	Allowable Use of Resident Safeguards
Monitoring and Oversight Practices	Response to Critical Events or Incidents
	Quality Assurance and Monitoring Activities
	Americans with Disabilities Act (ADA) Integration

Comparison Topic	Point of Policy Comparison
Financial / Rate Policies	Rate and Rate Calculation
	Financial Reporting Requirements
	Rate Rebasing
Issuance of Initial Licensure / Certification	Requirements for New Construction or Initial Licensure
	Co-Located Services
	Appeals

To provide for a consistent evaluation of policies across states, including North Dakota, we assessed comparable factors for all reviewed documents. This involved using a crosswalk containing key comparative details such as the creation or last date edited of the document, type (e.g., State Regulation, 1915(c) waiver), the specific section of the document where the language was located, and a summarized description of the content. This approach not only streamlined the review process for state staff but also created a comprehensive repository for future reference.

Section 2.1.1. Policy Analysis Findings

For each point of comparison, the team reviewed North Dakota's existing policies and comparable state policies and categorized the North Dakota policies as either sound or requiring minimal revisions, substantial revisions, or that no comparable policy was available within existing language of the comparison states. We also reviewed to identify where North Dakota's policies did not clearly align with the established comparison points and decide on the inclusion of the policy or the need for additional policies. After reviewing the policy language for each specific point, comparison states were assigned ratings of:

- Strong comparable policies
- Strong aspects of comparable policies
- Minimal strong aspects of comparable policies, or
- No comparable policies.

The evaluation of North Dakota's policies was based on an assessment of the detail and clarity of the policy, recognition as a best practice, and implementation feasibility of best practices from comparison states by HHS. The findings are as follows:

- Ten out of 25 points of comparison aligned with policies in other states.
- Ten policies require minimal revisions.
- Four required substantial revision to incorporate best practices.
- One point lacked a comparable policy in North Dakota.

For each policy component, we identified at least one comparable policy from another state, except for Tenancy Rules and Co-Located Services, which lack existing language in any

reviewed state. Where opportunities for improvement in North Dakota's policies were found, we provide actionable recommendations derived from the strengths of policies in comparison states. A summary of this policy review is provided in Table 4. The recommendations based upon the policy review can be found within *Section IV. Recommendation #2.*

Key:

Strong comparable policies

Strong aspects of comparable policies

Minimal strong aspects of comparable policies

State does not include comparable policies

Table 4. Results of Policy Comparison

Comparison Topic	Point of Comparison	ND	ID	MN	MT	SD	WA
Eligibility and Admissions	Admissions and Discharge Criteria						
Assessment and Care Planning	Resident Assessment and Care Plans						
	Person-Centered Planning and Documentation Requirements						
	Participant Directed Services						
	Allowable Services						
Clinical Services	Nursing Services						
	Medication and Treatment Administration						
	Individual Licensing, Qualification, and Certification Requirements						
	Staffing Education Programs						
Additional Service Components	Dietary Services						
	Alzheimer's, Specialty Memory Care, Traumatic Brain Injury, or Service Mental Illness						
	Recreational Accessing and Program Requirements						
	End of Life Services						

Comparison Topic	Point of Comparison	ND	ID	MN	MT	SD	WA
Participant Rights and Protections	Tenancy Rules						
	Resident Rights						
	Allowable Use of Resident Safeguards						
Monitoring and Oversight Practices	Response to Critical Events or Incidents						
	Quality Assurance and Monitoring Activities						
	Americans with Disabilities Act (ADA) Integration						
Financial / Rate Policies	Rate and Rate Calculation						
	Financial Reporting Requirements						
	Rate Rebasing						
Issuance of Initial Licensure / Certification	Requirements for New Construction or Initial Licensure						
	Co-Located Services						
	Appeals						

At a minimum, the policies identified as being strong comparable policies from this review will help to identify basic expectations and promote a standardized quality of care and resident experience. If the State seeks to make changes to the Basic Care program, the comprehensive policy recommendations included within this report will help to promote alignment to federal rules and expectations, while also drawing from practical examples from other states with similar programs.

Section 2.2. Stakeholder Engagement

To better understand the impact of Basic Care across the state, input was sought from a wide range of stakeholders who either had lived experience or administered the program. As part of the stakeholder engagement activities, the following groups provided information and feedback through interviews, focus groups, and/or in person meetings:

- Residents of Basic Care
- Facility Staff Members
- Residents' Family Members
- Facility Administrators

- Representatives from the North Dakota Long Term Care Association
- HHS Staff
- North Dakota Long Term Care Ombudsmen
- Members of the General Public

These consultations were vital to better understand the current state of service delivery, particularly those that are person-centered, and to identify how Basic Care affects the lives of those it serves. The goal was to learn about the recipients of Basic Care, the impact of the services on their lives, operational insights, reimbursement, and potential areas for program enhancement and growth.

Key State Staff Meetings

Guidehouse hosted five (5) virtual meetings with key State staff during January 2024. Each meeting lasted approximately one hour. The goal of these meetings was to understand rate setting, the licensure process, program administration, and the role of Basic Care and assisted living within the larger North Dakota continuum of care. Guidehouse and HHS worked to identify State staff subject matter experts to participate in each meeting. The list of invitees for each meeting was tailored to the meeting topic. A summary of the meeting topics and the findings are in Table 5.

Table 5. State Staff Meeting Topics and Key Findings

Meeting Topic	Key Findings
Licensure	• There is a lack of understanding by residents and their families on the differences between assisted living and Basic Care. • The State is licensing assisted living and Basic Care facilities but does not have enforcement mechanisms in place to ensure assisted living and Basic Care facilities are providing quality care and following applicable Administrative and Century Code. • While there are enforcement mechanisms and oversight in place for Basic Care facilities, there is a need for sufficient staff and resources as there are changes to licensure and as there is growth within the program. Basic Care facilities are seeing an increased acuity in residents entering the facility. • Provision of hospice requires additional licensing and monitoring.
Continuum of Care	• Basic Care facilities are seeing an increase in younger residents with behavioral health needs. • Basic Care facilities in rural / frontier settings are taking care of residents that may have greater needs due to lack of care options. • There are gaps in supported housing options for individuals transitioning out of the State Hospital or Emergency Department who have behavioral healthcare needs.

Meeting Topic	Key Findings
Reimbursement	• Individuals are entering facilities older and with higher needs, resulting in shorter stays before moving to another care level. • Providers are looking for more agility to respond to rapid changes in staffing and inflation. • Interest in changing the property component basis. • Payment levels for HCBS Adult Residential (Specialized Basic Care) are below payment levels for Basic Care.
Program Administration	• HHS case managers complete Basic Care residents' functional assessments and coordinate with Medicaid eligibility. • Adult Residential residents receive care through the State's 1915(c) waiver and are subject to the HCBS Settings Rule. • Basic Care provides increased socialization within the facility and for many residents, is a reason they moved to Basic Care. However, there is a lack of community integration for residents. • There has been a noted increased in residents with behavioral healthcare needs that current staff are not fully trained to provide. • Facilities aim to ensure availability of a Basic Care bed as individuals approach Medicaid eligibility, allowing them to transition to Basic Care at the assisted living rate before fully qualifying for Medicaid.

Residents of Basic Care

Focus Groups

Guidehouse conducted nine (9) in-person resident focus groups in February 2024, each lasting about an hour. To promote openness, neither HHS nor facility staff were present, allowing residents the opportunity to express themselves more freely in a secure setting. The focus groups were held onsite in private common areas and led by a two-person team from Guidehouse. Resident participants were randomly selected by the study team to maintain study integrity and objectivity. Guidehouse compiled a list of Basic Care locations and participants from HHS, choosing sites statewide, encompassing both rural and urban settings for the sessions. A summary of the facilities and participant numbers is provided in Table 6.

Table 6. Number of Resident Focus Group Participants by Facility

Facility Name	Location	Number of Residents Who Participated in the Focus Group
Benedictine	Bismarck	6
Bethany Towers	Fargo	11
Edgewood	Mandan	4
Edgewood	Minot	8
Odd Fellows	Devils Lake	6
Prairie Pointe	Bismarck	2

Facility Name	Location	Number of Residents Who Participated in the Focus Group
St Anne's	Grand Forks	7
Terrace	Bismarck	10
Tufte	Grand Forks	11
Total		**65**

To achieve a representative sample across all Basic Care facilities, Guidehouse selected focus group participants to reflect the proportion of residents at each location. After obtaining a resident list from HHS, Guidehouse randomly selected participants and coordinated with facility administrators to discuss the study's purpose and confirm residents' availability and capability to participate. Guidehouse communicated with facility administrators through an initial email and a follow-up call to finalize the participant list. Providers were asked to consider factors like health and cognitive abilities when reviewing the list. Administrators then distributed a letter to each selected resident, detailing the focus group's voluntary and confidential nature. The letters are documented in Appendix A and C.

Guidehouse developed discussion questions for focus groups, which included a variety of formats such as yes/no, Likert scale, and open-ended questions, with the final set refined in consultation with HHS. The focus group questions are provided in Appendix B. At each session's start, Guidehouse facilitators underscored the confidentiality and anonymity of the responses, reassuring residents that their participation would not impact their receipt of benefits. The questions covered four main areas:

- General Information and Satisfaction
- Care and Daily Routine
- Safety, Privacy, and Autonomy, and
- Transition and Choice

The approach allowed for dynamic interaction, allowing the facilitators to adapt the questions and the order to foster natural discussion while also permitting Guidehouse to ask follow-up questions for clarity. Post-discussions, Guidehouse synthesized recurring themes, noting high satisfaction with the Basic Care program, particularly with aspects like medication management and social activities. Residents emphasized a strong preference for independence, although they appreciated available assistance. Figure 3 shows the general themes that emerged from the focus groups.

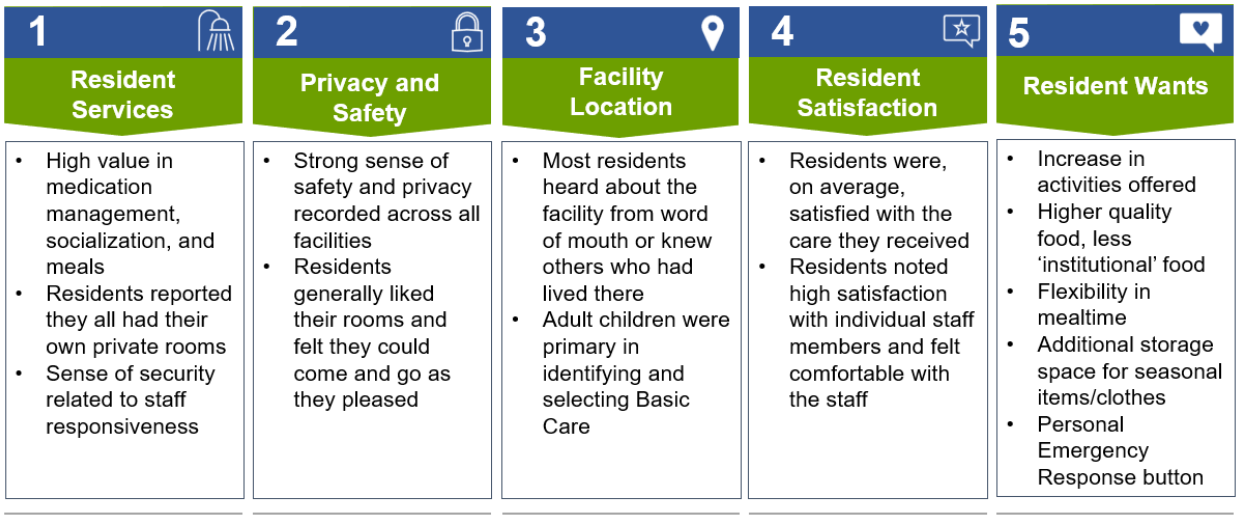


Figure 3. General Observations from Basic Care Resident Focus Groups

Focus Group Responses – General Information

Focus groups began with questions about how long a resident has lived at the Basic Care facility, the reason(s) for moving in, and why they selected the facility. Through these questions, the facilitators aimed to learn directly from residents the driving factors they considered in choosing a Basic Care facility and what need(s) individuals sought to have met.

The average time focus groups participants lived at the Basic Care facility is seven (7) years, based on self-reporting by residents. Though there was a variance, with one resident reporting having only lived at the facility for six (6) months, and another resident indicating they had been there for 30 years.

Reported reasons for moving into the Basic Care facilities included:

- Need for additional assistance with housekeeping / laundry / meals;
- The resident experienced a fall;
- The resident needed assistance with medication management;
- The resident needed affordable housing with services; or
- Their spouse had passed away.

Many residents indicated they had not visited other facilities or settings before moving into their current facility. Residents indicated this was primarily due to their own knowledge or their family's knowledge of the facility prior to moving in. Several residents also indicated that they had known someone else who had previously lived in the facility and that helped them in making their decision.

When asked about the decision-making process for the residents to move into Basic Care, a majority of residents participating in the focus groups indicated that they made the decision for themselves, their family members made the decision, or that it was a combined decision between the individual and their family.

Focus Group Responses – Care and Daily Routine

Basic Care provides assistance to residents based on the resident's care plan. Through the resident focus groups, the facilitators sought to better understand what care residents received and how often they receive care and to identify potential gaps in care.

All residents who participated in a focus group reported that they receive assistance with IADLs such as housekeeping and laundry. Residents reported that they received IADL assistance about once a week, on a day set by the facility. The majority of the residents reported their satisfaction with the day of the week they receive the assistance.

Facilitators asked residents if they receive assistance with activities of daily living (ADLs) such as grooming, bathing, and eating. Most residents responded that they did not receive assistance with ADLs. At one facility, all residents indicated receiving assistance with bathing. Residents who do not receive assistance with bathing did indicate that if they would need assistance, they felt comfortable with asking staff for help.

Each facility, per administrative code, provides a minimum of three meals each day.[8] The facilitators solicited resident feedback on the meals provided by the facility, the time of day of the meals, and the ability for them to have snacks and prepare food within their rooms. Residents confirmed that three meals a day, along with two (2) snacks, are available each day. Most residents reported their satisfaction with meals, though residents at some facilities expressed dissatisfaction with the current meals. Residents were asked to expand on their low meal satisfaction. Reasons for low satisfaction were due to personal taste, lack of options, little diversity within the menu, and lack of healthy options. Residents also expressed their desire to have more flexibility in where they can have in their meals (i.e., in their own room).

Resident Wants: Care & Daily Routine

- ✓ Flexibility in Meal Location
- ✓ Healthier Meal Options

Focus Group Responses – Safety, Privacy, and Autonomy

The facilitators sought information on the residents' views on their sense of safety, privacy, and autonomy living at their respective facilities. Residents were asked questions about their ability to do as they would like throughout the day, their ability to leave the facility to go into the community, and their privacy. Many residents expressed that they had enough privacy where they live. Facilitators heard from residents across facilities that they could keep their door open or closed as they wished and could lock their doors. Some residents indicated that while staff did knock before entering, staff did not always wait for the resident to answer before entering their room.

When asked about the ability to schedule their own day, residents responded that they were able to do what they would like throughout the day. Facilitators asked residents how they typically spent their day and if there were activities provided by the facility. Residents responded that they have activities most days and it is a personal preference on if they chose to attend.

[8] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-03-24.1

Several residents expressed their desire for more options and variety of activities offered as well as activities during the evening and weekend.

Residents also indicated they could come and go from the facility as they chose. If they were going out, the facility required them to sign out and, if they were to be gone during the time of a medication administration, that they were given their medications to take with them.

Focus Group Responses – Transition and Choice

Facilitators aimed to gain information on where residents lived prior to moving to their current facility and after they moved if they had to transition or change their rooms at any point at the facility. Residents lived in a variety of locations prior to moving into their current facility, such as:

- Own home;
- With family;
- Supported housing; or
- Skilled nursing facility.

Most residents stated they had been in the same room since they moved into the facility. Some residents shared that they were able to pick their own room, while others were not able to as there was only room available when they moved in. Those who responded that they had to move rooms were asked about why they moved rooms. Residents shared that they moved rooms due to room renovations, a room they preferred became available, or the location of the room was closer to shared spaces. A few of the residents who participated in the focus group indicated that they had to transition to a different room because they “ran out of funds” and had to move into a different room.

Focus Group Responses – Final Thoughts

The goal of the resident focus groups included gathering information on the assistance residents received, their experience with the care, and what additional services or care would they like to have available to them. Residents were asked what they liked about living at their facility, what they did not like, and what did they wanted others to know about living in their facility. At the end of each focus group, participants could provide additional feedback not captured in the focus group questions.

Overall, residents reported liking the facility in which they lived and expressed general satisfaction with the care and assistance they received. Residents indicated they enjoyed the sense of community and relationships they had with other residents and staff members at their facility. Residents reported their dissatisfaction regarding the quality of food, the lack of flexibility of mealtimes, and the lack of variety in activities offered. Residents expressed wanting access to more activities, including outings to the community, updates and variety to the meals provided, and access to additional staff. Figure 4 details the likes, dislikes, and wants expressed by residents.

Figure 4. Basic Care Resident Reported Likes, Dislikes, and Wants

Resident Interviews

In addition to resident focus groups, Guidehouse conducted 18 phone interviews with residents in March 2024, each lasting about 20 minutes. These interviews, primarily one-on-one, included one instance where a staff member assisted due to a resident's hearing impairment. Residents for these interviews were randomly selected from facilities not involved in the in-person focus groups, stratified by facility size of current residents: small (1-9 residents), medium (10-20), and large (21+). Guidehouse aimed for roughly 15 interviews per size category. Facility administrators were contacted via email, as detailed in Appendix D, to arrange interviews and confirm participation. Facilities and their size categories are listed in Figure 5.

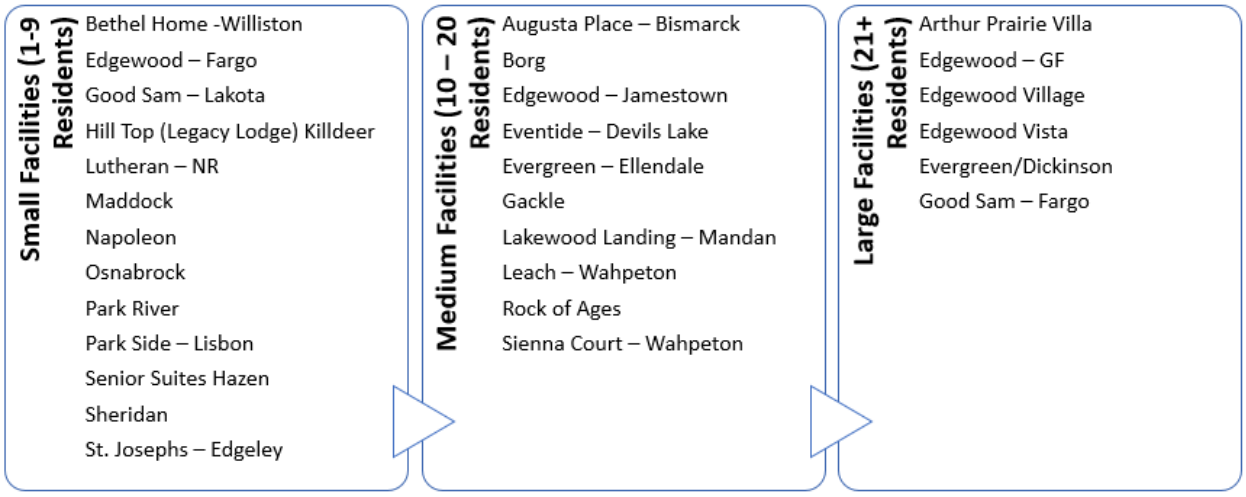


Figure 5. Facilities by Facility Size Category for Resident Telephone Interviews

Guidehouse faced several logistical challenges conducting telephone interviews, which affected the planned number of interviews. Challenges included incorrect or missing phone numbers and incomplete administrative data, hindering efficient contact with facilities and residents. These

issues led to fewer completed interviews than anticipated across the categorized facility sizes. Table 7 illustrates the actual number of interviews conducted per facility size category.

Table 7. Number of Resident Interviews Completed per Facility Size Category

Small Facility	Medium Facility	Large Facility
7 Interviews	8 Interviews	3 Interviews

Residents who participated in the telephone interviews were asked the same questions that residents who participated in the in-person focus groups were asked. Guidehouse heard similar themes during the telephone interviews as during the resident focus groups. Table 8 provides a summary of the findings of the resident telephone interviews by topic area.

Table 8. Summary of Resident Telephone Interviews by Topic Area

Topic Area	Summary of Findings of Resident Telephone Interviews
General Information and Satisfaction	• Guidehouse heard from some residents that they enjoyed where they lived, while others felt that they had no choice in where they lived. • Residents indicated that they felt comfortable with staff and that staff were willing to help if a resident needed additional assistance.
Care and Daily Routine	• Residents who reported receiving help with bathing stated they were given a set time for their shower. • When asked if there was anything else they would like or a task they would like additional assistance with, multiple residents responded that they would like to have more activities, particularly in the evenings and on weekends.
Safety, Privacy, and Autonomy	• Residents reported they had the ability to choose what they wanted to participate in and could leave the facility when they wanted. • When asked about their privacy, residents stated that they were able to keep their doors closed and staff would knock before coming in. • Overall, residents interviewed felt safe at the facility in which they resided.
Transition and Choice	• Two residents said that a fall and a corresponding hospitalization led to them having to move into a Basic Care facility. Both residents also indicated that it was not their choice to move into the facility. • Another two residents stated that they had moved to their current facility because the previous Basic Care facility they were living at had closed.

Residents' Family Members

To gain a well-rounded understanding of Basic Care, the supports it provides, and the role it plays in the continuum of care in North Dakota, Guidehouse also interviewed a small number of family members of Basic Care residents. Family members provided additional insight on the process of transitioning a family member into Basic Care. In addition, they described their experience with the Basic Care program as a whole and the facility where their family members resided. Key themes from the interviews are provided in Figure 6.

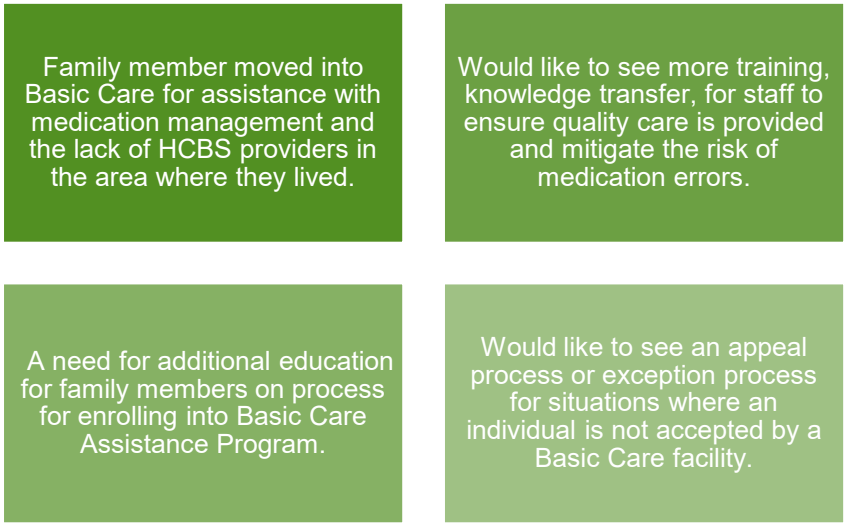


Figure 6. Family Member Interview Themes

Interviews with Facility Administrators

Alongside resident focus groups, Guidehouse conducted interviews with facility administrators and staff to gather additional feedback on their experiences with the basic care program. These discussions, totaling nine (9) interviews, took place in-person during site visits for the resident focus groups and stakeholder meetings. A two-person Guidehouse team facilitated each session. Administrators and staff shared insights into the daily operations, successes, and challenges of their facilities. Key themes emerged from these conversations and were analyzed to inform the study's recommendations, with details outlined in Figure 7.

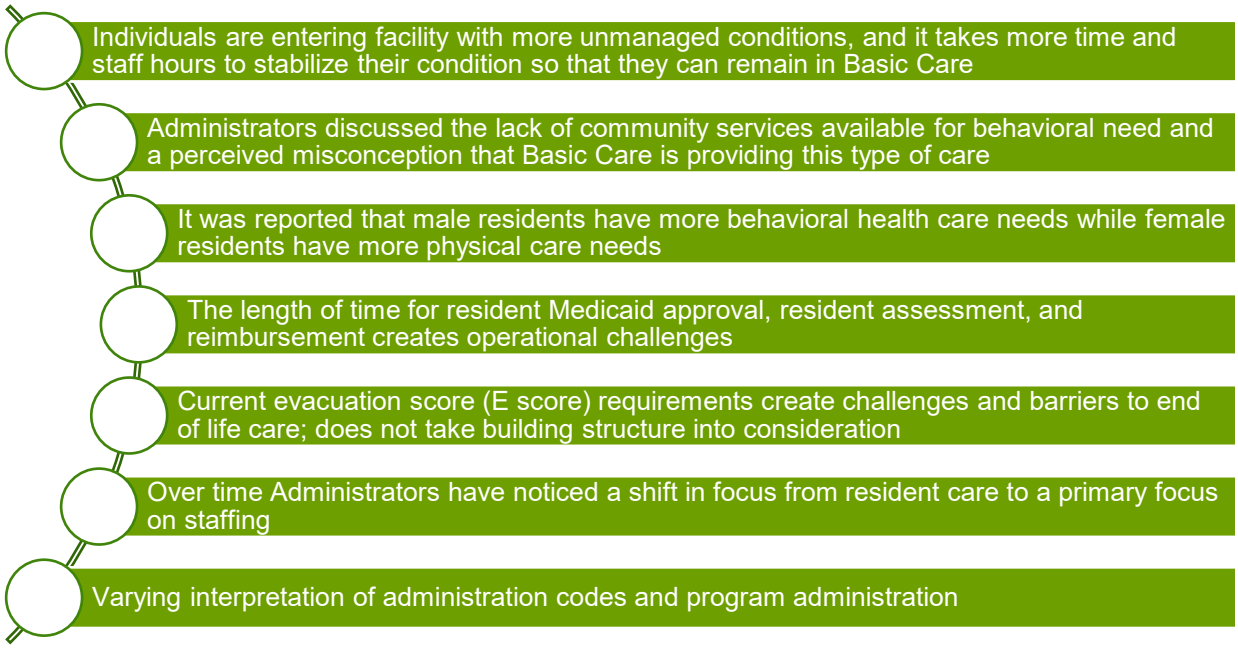


Figure 7. Administrator Conversations General Themes and Observations as Reported by Administrators

Stakeholder Meetings

As part of the study to provide information and gain further understanding from a broader range of stakeholders, Guidehouse hosted eight (8) public meetings; six (6) meetings were held virtually, and two (2) meetings offered a hybrid virtual and in-person option. The primary target audience for these meetings varied based on the topic of each meeting. Table 9 outlines the public meetings hosted and the meeting topics.

Table 9. Stakeholder Meeting Dates and Topics

Meeting Date	Meeting Topic
February 1, 2024	Licensure
February 1, 2024	Reimbursement
February 20, 2024	Program Administration
February 20, 2024	Licensure
February 21, 2024	Reimbursement
February 23, 2024	Participant Experience
March 25, 2024	Reimbursement
April 5, 2024	Reimbursement

Each meeting provided an opportunity to solicit feedback from stakeholders about the Basic Care program. Guidehouse solicited feedback in the form of open-ended questions tailored to the meeting topic.

Licensure

Working with the HHS team, we identified a group of stakeholders to engage with on Basic Care Licensure that included Basic Care facility administrators, the Long-Term Care Association, and HHS staff. Given the breadth of the topic, the stakeholders met twice to discuss the differences between assisted living and Basic Care, acuity, workforce, mixed-use facilities, life safety scores, and measurements of quality. Figure 8 provides the key themes from the licensure meetings on the differences between assisted living and Basic Care operations, oversight, facility evaluation, and behavioral health services.

Basic Care (BC) vs. Assisted Living (AL)

- Key difference between BC and AL is the funding source
- Overall, BC residents typically have more behavioral/mental health or dementia diagnoses
  - AL residents typically have more physical limitations and desire a life with fewer daily chores
- BC provides set services and AL offers packages of services
- Current structure of AL and BC licensure must be clarified through statute or administrative rule

Operations and Oversight

- State is licensing facilities but there are no accountability or enforcement mechanisms in place to ensure AL facilities are providing quality care and are following guidelines
- There are enforcement mechanisms for BC but it may not be at the approriate level
- Staff moving between BC and AL
- Staff are trained to the BC requirements, as it is a higher training requirement
- Facilities use a client and staff satisfaction survey
  - Some facilities have developed an internal quality program

Facility Evacuation (E Scores)

- Only required for BC; not required for AL
- E scores drive staffing levels
- Acute care changes impact E scores
- Providing end of life services impacts E scores
  - Many locations do not provide end of life care due to E scores
- Impact to E scores may be considered when determining admission
- Would like to see how the building is built taken into consideration
- Middle of the night fire drills have caused safety concerns for residents

Behavioral Health (BH)

- BC increasingly has more residents with BH/SUD
- Seeing an increase in mental health needs
  - Needing more 1-on-1 care
  - Those residents who take up most care time tend to have a mental health diagnosis
- No access to crisis teams
  - Perceived assumption is that BC/AL residents have built in support due to resident location
- Need for increased staffing
- Do not want a rate enhancement as belief an MDS would then need to be completed

Figure 8. Key Themes from Licensure Stakeholder Meetings, as Identified by Provider Participants

Reimbursement

In addition to the Licensure meetings, Guidehouse identified a group of stakeholders to participate in a series of stakeholder meetings on Basic Care reimbursement. This group met four times over the course of the study. Figure 9 contains the key themes from the meetings. Analysis from *Section 2.3. Basic Care Reimbursement and Rate Data Analysis* was also presented to this group for review. Topics explored during the reimbursement meetings included staffing, acuity, rate enhancements, occupancy, property, cost, operating margin, and rebasing.

Population	Staffing	Reimbursement
• Individuals are coming in with a higher level of need; stays are shorter • Assisted living residents are increasingly older • Occupancy fluctuates significantly, particularly for small facilities • Seeing more Behavioral (BH) care needs; Instrumental Activities of Daily Living (IADL) deficits are starting to use nursing or admin hours (i.e., finance, transportation) • Dementia is a concern; residents that are sent to the hospital are medicated and returned • Serving individuals with bariatric issues is currently not an issue	• Contract staffing cost and usage is coming down but to compete against contractors and Skilled Nursing Facilities, providers have had to increase wages • Geographic differences are not consistent • Staff is harder to find and recruit, some facilities compete between Nursing Facility and Basic Care • The need for social workers is growing • Major investments in staffing services such as Indeed	• Interest in changing the property component • Reasonable reimbursement to allow and incentivize facility upgrades including better rooms and infection control • Recovery period on purchased equipment is longer than the life of the equipment • Rate enhancements may provide relief particularly with behavioral and mental health • Assisted Living rates can be scaled based on need; Basic Care could use more of this flexibility • Providers are looking for more agility in the rebasing overall to respond to rapidly changing staffing/inflation • Desire for rebasing for memory care (waiver services) • Increased operating margin to allow facilities to absorb abnormal cost increases

Figure 9. Key Themes of Reimbursement Stakeholder Meetings

Program Administration and Participant Experience

Guidehouse hosted two public stakeholder meetings to engage a larger stakeholder group and provide the opportunity for Basic Care facilities, potential providers, residents, family members, ombudsman, and other stakeholders to provide information and feedback on Basic Care.

A hybrid virtual and in-person session was held to provide an overview of Basic Care and gain insight on the program administration of Basic Care. Attendees included facility administrators, care managers, finance managers, consultants, and other stakeholders. Discussion questions and comments from attendees are found in Table 10.

Table 10. Discussion Questions and Comments from Public Stakeholder Meeting Topic: Program Administration

What should people know about Basic Care?	What challenges do you have in operating Basic Care?	What challenges do you have in operating Basic Care?
• The care provided in BC is no different from care provided by another payer source	• Behavioral health needs • Reimbursement not keeping up with the cost of providing quality of care and needed	• It is the middle ground between home- and community- based services and institutional care

What should people know about Basic Care?	What challenges do you have in operating Basic Care?	What challenges do you have in operating Basic Care?
• Basic Care provides a wide range of care options at various levels; it is valuable and unique to North Dakota • Basic Care is one of North Dakota's best options and many do not know about it • It enhances residents' life and improves their quality of life • It is a public program that gives excellent care, but it will not be around long if there are not updates to the program	building expenses/improvements • Consideration of how residents are being provided with community service and integration options • Residents are coming in with higher care needs, less managed conditions • Residents are being admitted further into their decline and disease progression • Being able to stay competitive with pay for staff	• For much of the rural area, there are no home health services; Basic Care can fill that need • For residents in need of memory care that are ambulatory, Basic Care keeps them from skilled nursing, which would likely be their only other option • More cost-effective than skilled nursing care

Attendees at the meetings had several opportunities to provide further feedback through verbal comments, written submissions post-meeting, or via the chat function during the sessions. Additional comments from attendees included:

- Providers struggle to understand the requirement of residents having to come to the dining area for meals, feels like it is institutional-like institutionalization.
- Stakeholders have seen the impact of Basic Care on quality of life compared to those within supported housing, Basic Care improves quality of life by providing care, support, and socialization.
- Providers would like to see more effort on promoting Basic Care; and
- The cost of converting assisted living beds to Basic Care beds is prohibitive.

A virtual public stakeholder meeting was also held on Resident Experience in Basic Care. Attendees included care managers, ombudsmen, and public stakeholders. The attendance of this meeting was lower compared to other stakeholder meetings. As described previously, we also conducted interviews with resident family members. This meeting was shared with family members of Basic Care and Basic Care residents.

Discussion questions asked included:

- For residents of those living in Basic care, what has your experience been? Why did you choose Basic Care? Has it met your expectations?
- For family members or caregivers of those in Basic Care, what has your interaction with the Program been? Why did you choose Basic Care? Has it met your expectations?
- Are there services that you or your family members in Basic Care would benefit from?
- Thinking more generally, what services do you or your family member need to successfully and safely age in the community of choice?
- Are there any other comments or input that we should know as part of this study?

Attendees commented on:

- The variety of services that are needed to successfully and safely age in the community of choice; and
- Shortage of qualified service providers, especially in rural communities.

Critical Incident and Complaints Data Analysis

As part of the review of North Dakota assisted living and Basic Care, Guidehouse reviewed critical incident and complaint data. During conversations with HHS, it was reported that the State is seeing an increase in the number and severity of the critical incidents and complaints reported to HHS. At this time, there is limited data available for analysis due to under reporting of incidents, lack of resources to fully investigate reports, and insufficient data tracking systems.

Data from FFYs 2022 and 2023 shows an increase in the number of complaints received and documented by HHS. The most notable increase was in complaints about an outside agency, dietary, environment, and activities. The highest number of complaints for both years (46 percent of total) were around care and autonomy, choice and rights. A breakdown of the number of complaints by category is shown in Table 11.

Table 11. Complaints Received by Type for Federal Fiscal Years 2022 and 2023

Complaint Type	FFY 2022 Count (% of Total)	FFY 2023 Count (% of Total)
Care	93 (25%)	112 (25%)
Autonomy, choice, rights	79 (21%)	94 (21%)
Admission, transfer, discharge, eviction	38 (10%)	38 (9%)
Dietary	19 (5%)	35 (8%)
Abuse, gross neglect, exploitation	27 (7%)	34 (8%)
Environment	20 (5%)	34 (8%)
Financial, property	18 (5%)	28 (6%)
System and others (non-facility)	22 (6%)	26 (6%)
Activities, community integration, and social services	12 (3%)	20 (4%)
Facility policies, procedures, and practices	37 (10%)	15 (3%)
Other	6 (2%)	6 (1%)
Total	**371**	**445**

In addition to the number of complaints, Guidehouse also looked at the number of reported critical incidents during FFY 2022-2023. Table 12 provides a breakdown by the type of critical incident reported.

Table 12. Number of Reported Critical Incidents by Type for FFY 2022 – 2023

Critical Incident Type	# of Reported Incidents	Percent of Total
Hospital	200	34.5%
Injury	101	17.4%
Fall Without Injury	79	13.6%
Change in Condition	55	9.5%
Death (Natural Cause)	40	6.9%
Medication Error	33	5.7%
AWOL/Missing Person	13	2.2%
Communicable Disease	13	2.2%
Behavioral Issue	9	1.6%
Behavioral or Health Condition Jeopardizing Service	6	1.0%
Accident no apparent injury	5	0.9%
Altercation	3	0.5%
Complaint and/or Possible Litigation	3	0.5%
Confidentiality Breach	3	0.5%
Inappropriate Alcohol/Drug Use	3	0.5%
Law Enforcement Involvement	3	0.5%
Choking	2	0.3%
Exploitation	2	0.3%
Sensitive Situation	2	0.3%
Out of Home Placement	2	0.3%
Contraband	1	0.2%
Threatening Behavior	1	0.2%
Total	**579**	**100%**

As ways to address the identified limitations, the State can consider enhanced training for staff, increased staffing resources for investigation, and improved data management systems. While the State currently conducts surveys of Basic Care facilities, there is a need for increased staffing and resources to allow for all facilities to be surveyed on a consistent basis and appropriate enforcement mechanisms are in place to address potential findings from surveys. Increased resident and family education may also be beneficial, on how to report incidents and register complaints.

Section 2.3. Basic Care Reimbursement and Rate Data Analysis

Building on the stakeholder feedback gathered, the Guidehouse team evaluated the financial aspects of Basic Care. We conducted a comprehensive analysis of various data sources related to reimbursement rates, exploring financial disparities across facilities and their impact on service provision. This analysis provides valuable insights into the economic dynamics of Basic Care, important for understanding the broader implications of potential policy and reimbursement methodology changes.

Section 2.3.1. Methodology

Guidehouse analyzed cost reports, rates, and rate worksheets for individual providers and provider classifications. The following sections detail how the provider classifications were determined and how the data analysis was performed.

Basic Care Provider Classifications

Forty-six (46) Basic Care providers submitted cost reports in 2022 and Guidehouse's analysis focused on this set of cost reports for its analysis as the most recent, complete reporting year. While analyzing Basic Care costs and payments at the provider level, it was useful to classify the 46 providers using multiple criteria to help identify correlations. For this report, Guidehouse classified providers in two ways: (1) by affiliation or co-location with another facility type, and (2) by rurality. For affiliation or co-location, HHS provided the following provider classification categories:

- **Nursing Facility Co-Located** – In the same building as (co-located with) a Nursing Facility
- **Nursing Facility Affiliated (NF Affiliated)** – Owned by or affiliated with a Nursing Facility, but does not share facility space
- **Hospital Co-Located / Affiliated** – Co-located and/or affiliated with a Hospital
- **Assisted Living Co-Located / Affiliated** – Co-located and/or affiliated with an Assisted Living facility
- **Memory Care Co-Located / Affiliated (MC Affiliated)** – Co-located and/or affiliated with a Memory Care facility
- **Standalone** – Basic Care not co-located or affiliated with another type of facility

In many cases, a facility had multiple classifications assigned by HHS. For example, all the providers that are classified as Memory Care Co-Located/Affiliated were also classified as Assisted Living Co-Located/Affiliated. For facilities with multiple classifications, only one category was used for analysis and categories were applied in the following order: Memory Care, Hospital, Nursing Facility Co-Located, and then Nursing Facility Affiliated. Standalone facilities, by definition, did not have multiple classifications and Assisted Living Co-Located/Affiliated was only applied if no other classifications were part of the study.

Another provider classification considered was rurality. For this report, providers were classified as either urban or rural. Using HHS input, urban was defined by the community size and includes facilities within the city limits of Bismarck / Mandan, Fargo, Grand Forks, and Minot. All other facilities were considered rural.

Cost

Cost is a key consideration when analyzing Basic Care reimbursement, as rates are based on provider costs. These rates differentiate facilities based on operating models, resident populations, locality considerations, or unique demographics. In North Dakota, Basic Care facilities submit annual cost reports to HHS that provide a detailed breakdown of expenses. These reports contain comprehensive cost data for each facility, including costs separated by facility type when multiple types are housed in one location (e.g., Basic Care, nursing facility, assisted living, etc.). The reports also detail Basic Care Resident Days, split into In-House and Leave days. In-House days are days where the resident is present in the facility, while leave days denote days with the resident temporarily absent, but the resident's room is still considered occupied as the resident will be returning. While these cost reports are reviewed by HHS annually, they are audited every six years.

For this analysis, Guidehouse accessed the most recent three years of Basic Care facility cost reports from HHS, covering state fiscal years 2020 through 2022, along with extracts of the cost report data. This data was utilized to compare different cost factors.

In North Dakota, Basic Care costs are broken up into six main categories in the cost reports:

1. Direct – Personal Care
2. Direct – Room and Board
3. Indirect – Personal Care
4. Indirect – Room and Board
5. Room and Board
6. Property

Items 1 and 2 above fall under Direct Care. These are costs incurred for directly caring for residents and include items such as caregiver wages, drugs, supplies, and laundry. Items 3 and 4 fall under Indirect Care. These are costs that are typically considered administrative or incidental to resident care and include expenses for things like administration salaries, maintenance, housekeeping, and medical records. Room and Board consists of food, utilities, and miscellaneous room costs. Property costs are expenses like rent, mortgage payments, and depreciation.

When we compare these costs between providers, the most direct way would be to compare cost totals for each category. However, this comparison would not account for differences in provider capacity. For example, the total Direct Care costs of a ten-bed provider would not be comparable to the costs of a 90 bed provider. Similarly, we must account for differences in the number of current residents, or occupancy. For two providers that each have 90 beds, a provider with 85 residents would have much higher total Direct Care costs than a provider with 40 residents.

To account for these differences and allow for comparison between providers, we normalized the cost data by calculating a cost per day. While two providers may have large differences in total Direct Care cost, we would expect the costs per day of each resident (nursing hours, food, supplies, etc.) to be comparable. Costs per day controls for these differences and allows meaningful comparison between providers. The cost per day calculation divides the total cost for a category during the cost year by the days for that category in the cost year. For the cost

per day calculation, there are two types of days entered in the provider cost reports that can be used – resident days and available days:

- **Resident Days** are days when a resident is occupying a bed. These days control for occupancy and are best used for direct care and room and board costs that increase or decrease depending on the number of residents receiving treatment.
- **Available Days** are the total possible resident days calculated as the number of beds multiplied by the days in the year. Available days control for facility size and are more suited for indirect costs mostly independent of the number of residents.

As described above, direct care and room and board costs change with occupancy. As occupancy increases or decreases, there are corresponding increases or decreases in these costs. Accordingly, when calculating cost per day amounts, Guidehouse used resident days. Indirect and Property costs such as maintenance and rent scale closely with size (i.e., number of beds) rather than occupancy, so to calculate per day amounts for these categories, Guidehouse divided the total costs by available days.

After adjusting the direct and indirect costs to account for variances related to occupancy and facility size, we added each of these components to establish a “normalized” "total cost per day”, comprised of 1) indirect and property cost per available day and 2) direct and room and board cost per resident day. We are then able to use the normalized total cost per day to identify cost variances based on other factors, including facility location (i.e., urban vs. rural) and provider classification (i.e., standalone, nursing facility co-located/affiliated, assisted living co-located/affiliated, etc.).

Among the provider classifications, Guidehouse performed standard statistical analysis, calculating minimum, maximum, median, average, and standard deviation. The analysis in this report is primarily focused on the averages of providers within each provider classification. Two providers were excluded from the cost analysis as outliers.[9] We considered both the simple average and the weighted average per day costs. The weighted average was calculated by dividing the total cost by the total days (either Resident or Available). However, due the nature of the weighting, large facilities or facilities with large amounts of utilization could shift the overall average of the group. For this report, Guidehouse utilized a simple average as it is more suitable for comparison purposes, particularly among groups with relatively small numbers of facilities, as it better captures the central tendency in that group.

Additionally, when comparing costs across classifications, Guidehouse excluded providers that were two standard deviations or more from the mean in total cost. This approach helps to mitigate the impact of outliers, particularly in classifications with a small number of providers, ensuring a more accurate comparison.

Inflation

Another aspect of reimbursement that Guidehouse analyzed was inflation, a primary driver for annual cost increases. However, changes in utilization and resident acuity also contribute to

[9] Two providers with minimum and maximum cost that were two (2) standard deviations below or above the mean and were excluded from the cost analysis.

rising costs for providers. In North Dakota, the inflation factors used in rate setting are established and approved annually by the Legislative Assembly.

For comparative purposes, Guidehouse gathered data from public indexes commonly employed in Medicare and Medicaid rate calculations, including the Market Basket – Skilled Nursing Facilities (SNF), the Consumer Price Index – Wage Earners (CPI-W), the Consumer Price Index – All Urban Consumers (CPI-U), and the Producer Price Index (PPI). Additionally, we calculated actual year-over-year inflation based on Basic Care cost reporting.

Guidehouse calculated year over year inflation for the various indices, by dividing the index of the trend year divided by the index of the previous year and subtracting one. For the actual costs for Basic Care facilities, the calculated total costs per day were used as indices. For the other trends, either the fourth quarter or the 12th month for each year were used.

Rates and Payment

In addition to analyzing costs, Guidehouse also examined provider reimbursement rates. We obtained rates and rate workbooks for Basic Care facilities from HHS, based on FY 2020 through FY 2022 cost report data. These workbooks detail how rates for the fiscal year are calculated, including the application of limits on direct and indirect per day rates, calculation of the operating margin, and any per diem add-ons.

The limits are derived from the most recent cost reports available. HHS calculates the direct and indirect per day rates for each provider, selecting the median rate for each category identified. The direct limit is set at 118 percent of the direct median per day rate, and the indirect limit is set at 112 percent of the indirect median.

HHS currently rebases Direct and Indirect limits every four years. This was a recommendation of the Basic Care Payment Reform Report Workgroup that was approved and enacted through legislation. Rates were rebased for the July 1, 2023, rates. Prior to the 2023 rebase, rebasing was completed in 2016. In non-rebasing years, the limits are inflated using the legislatively approved inflation factor.

Guidehouse also analyzed provider payments. Payment for each facility was calculated by multiplying payment rates by the applicable days reported in the submitted cost report. The personal care rate was multiplied by resident days, or the number of days the room was considered occupied. Resident days include both “in-house” days when the resident is present in the facility and “leave days” where the resident is temporarily absent but will be returning.

The room and board rate was multiplied by in-house days. Payment rates were aligned with cost reports for the period in which the rates were effective. For rates effective from July 1, 2021, through June 30, 2022, resident and in-house days were taken from the SFY 2022 cost reports, facilitating a comparison of estimated payments to actual costs.

Section 2.3.2. Analysis

Utilizing the previously described methodology, Guidehouse analyzed various aspects of facility costs, utilization, rates, and inflation trends. An important part of this analysis was attempting to correlate differences in cost and payment with discrete factors such as rurality or association.

This correlation is often instrumental in identifying differences in operational models that can be utilized in more effective and equitable rate setting.

Cost

Guidehouse used cost reports provided by HHS to analyze costs based on the discrete factors mentioned earlier. This primary methodology helps identify cost drivers such as labor or property costs that disproportionately impact a subset of providers. The first step involved examining costs at the provider level. Figure 10 below illustrates the buildup of Direct, Indirect, Room & Board, and Property costs for each Basic Care provider (Note: Each bar is a single provider).

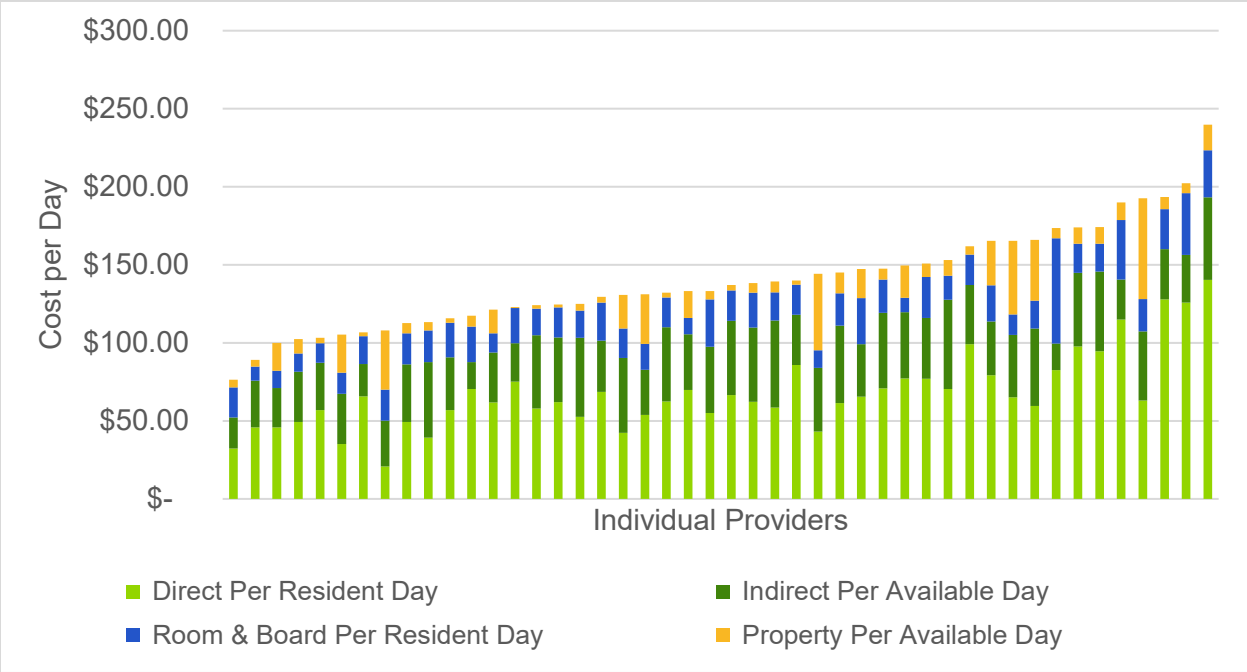


Figure 10. Buildup of Total Cost per Day by Provider

As the chart shows, there is a wide distribution of component cost per day as well as total cost per day. The average total cost per day is $140.16 with a $76.32 minimum and $239.77 maximum. The two providers with the minimum and maximum cost were two (2) standard deviations below or above the mean and were excluded from the cost analysis by provider classification. For these excluded providers, Guidehouse found no indication in the provider cost reports of significant costs or structure that explained the extremity of the costs per day. Both excluded providers were classified as rural. The two excluded providers were a Hospital Affiliated/Co-Located facility and an Assisted Living Affiliated/Co-Located facility.

The first discrete factor Guidehouse analyzed was rurality. Here, we also performed the same cost analysis of the buildup of cost using the rurality classification of facilities. Figure 11 shows the buildup of average cost classified by rural or urban.

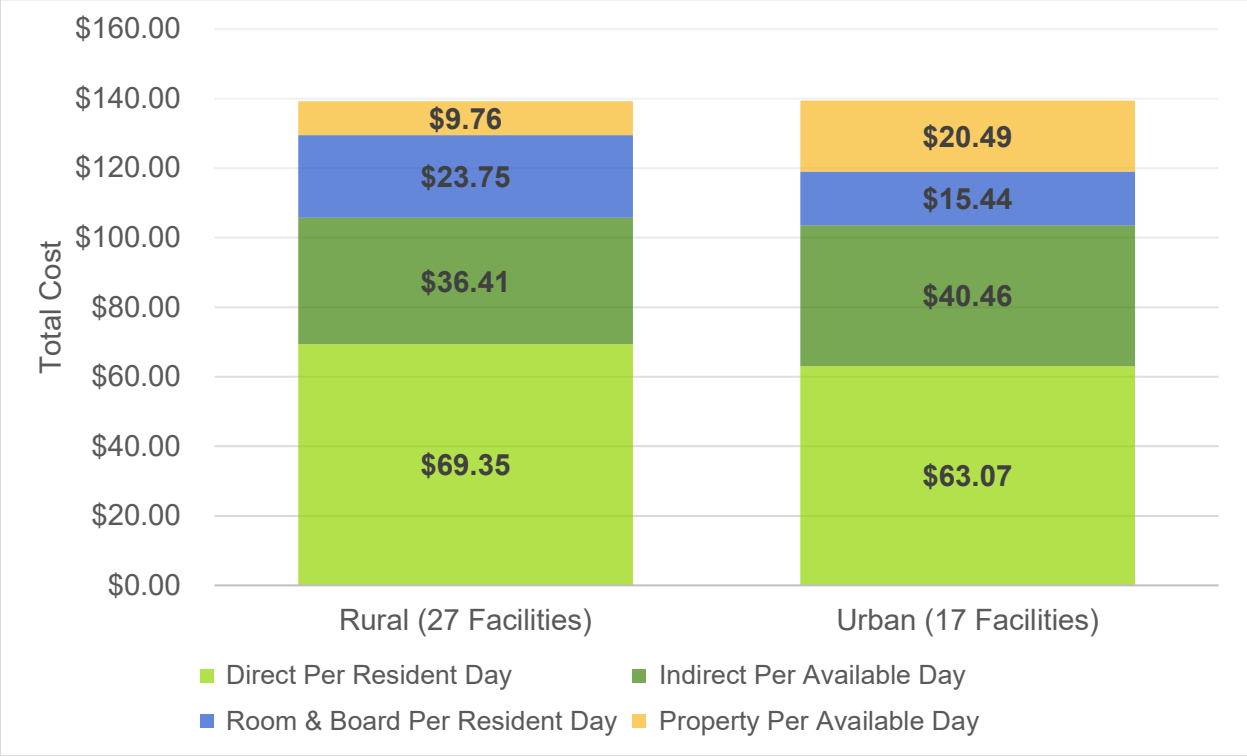


Figure 11. Buildup of Total Cost per Day by Location

As shown in the above figure, Basic Care facilities that are classified as rural have higher Direct and Room & Board costs per day, but lower Indirect and Property costs compared to facilities classified as urban. However, the total costs per day are nearly the same with rural at $139.27 and urban at $139.46.

The cost buildup was also looked at by association / co-location classification. As described in the methodology section, classifications of Basic Care facilities were assigned to one of six classification categories based on affiliation data supplied by HHS. This analysis is based on the required cost reports submitted by forty-six of the 66 licensed facilities.[10] After excluding two providers, there were 44 facilities included in this analysis. Table 13 shows the distribution of the facilities across classification.

Table 13. Number of Facilities by Provider Classification for Cost Analysis

Basic Care Provider Classification	Number of Facilities
Nursing Facility Co-Located	9
Nursing Facility Affiliated	8
Hospital Co-Located / Affiliated	1
Assisted Living Co-Located / Affiliated	6

[10] Basic Care facilities that do not participate in Medicaid or that operate as Specialized Basic Care (also known as memory care) are not required to submit cost reports as per current policy.

Basic Care Provider Classification	Number of Facilities
Memory Care Co-Located / Affiliated	6
Standalone	14
Total	**44**

Figure 12 below shows the buildup of average costs by provider association / co-location classification.

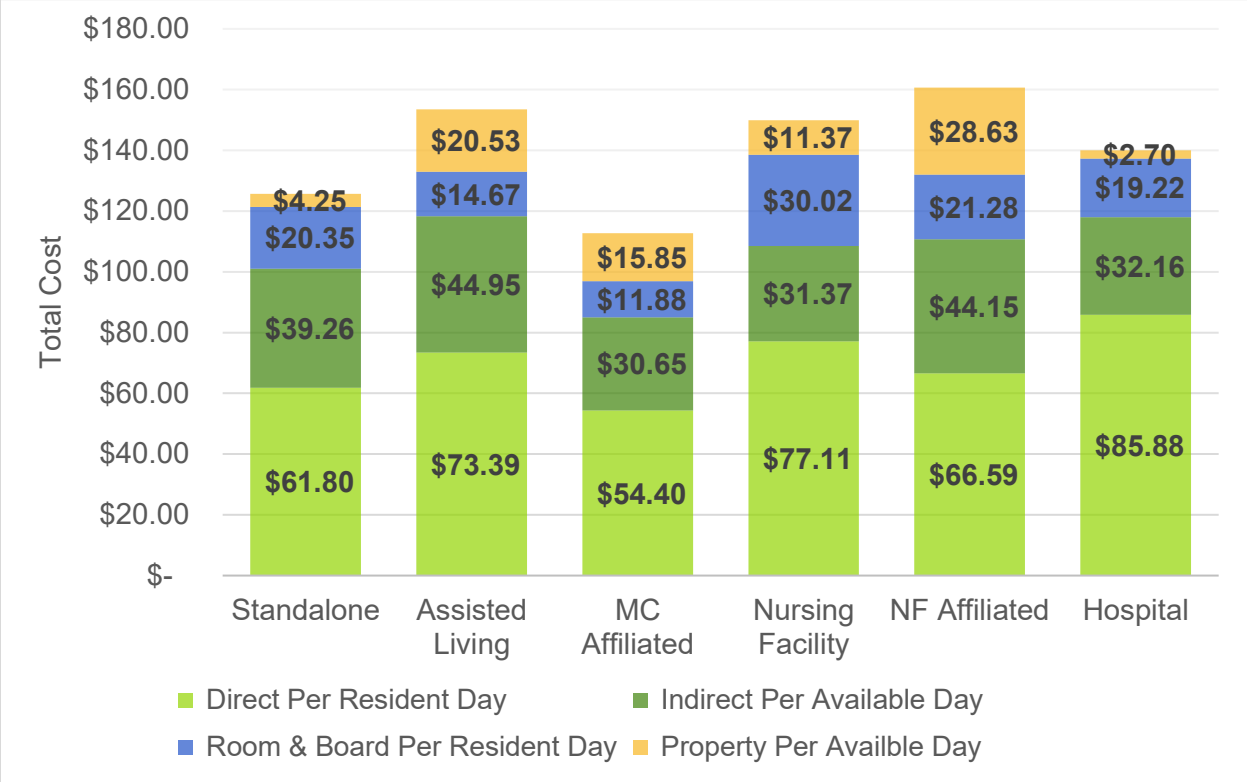


Figure 12. Buildup of Total Cost per Day by Association / Co-Location Classification

Similar to the provider level data show in Table 11, this figure shows a wide variation in both cost components and total cost. Of particular note is the low costs per day for both Standalone ($125.66) and Memory Care Affiliated / Co-Located ($112.78).

To better understand the variance of these costs, Guidehouse analyzed the cost distribution within these classifications. Figure 13 and Figure 14 below are Box and Whisker charts. This type of chart is a compact, graphical way to show distribution and outliers. The middle line is the median (middle) value with the X as the mean, or average. The shaded box encompasses the middle 50 percent consisting of the second and third quartiles. Lines (whiskers) extending outside the boxes show the span of minimum to maximum. Each dot represents one facility excluding those already represented by either lines or an X. Dots outside of the whiskers are considered outliers.

Figure 13 below shows the distribution of total costs per day for Rural and Urban providers.

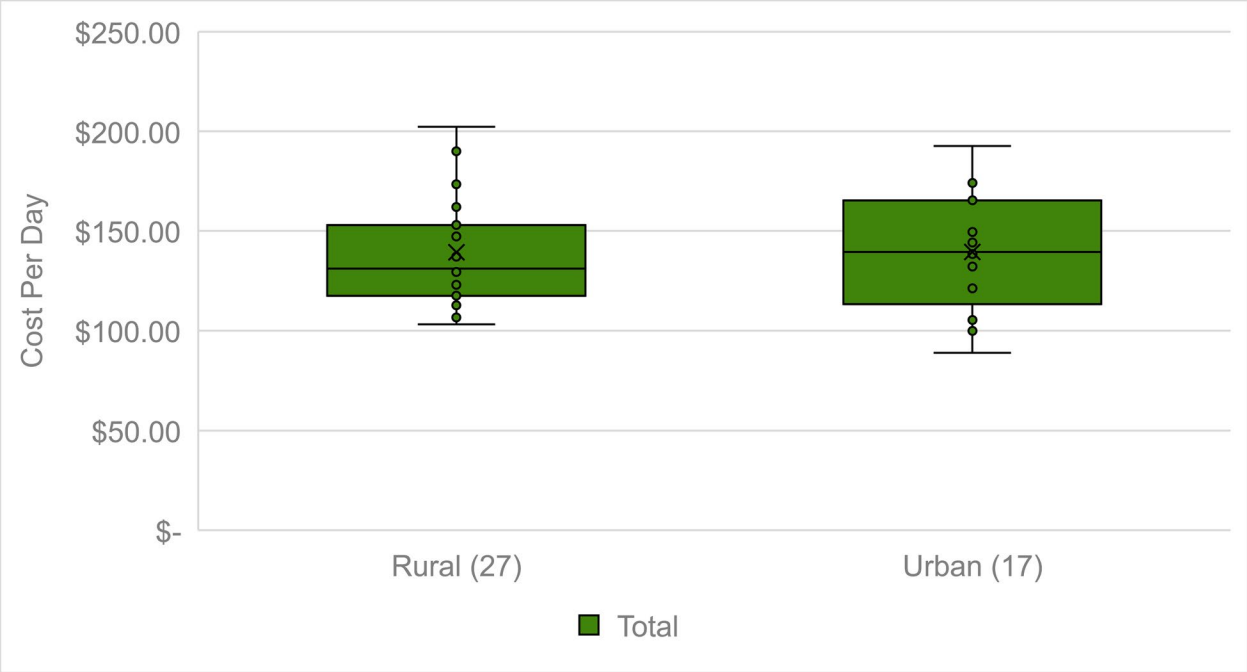


Figure 13. Total Cost per Day Distribution by Location

This chart indicates that both rural and urban facilities have a wide distribution of total costs. Rural facilities have a lower median cost ($131.09 for rural, $139.39 for urban) but wider distribution with more facilities outside of the middle 50percent. As noted previously, the average total cost, X, is almost identical ($139.27 for rural facilities and $139.46 for urban facilities).

Figure 14 below is the total cost distribution by Affiliation/Co-Location.

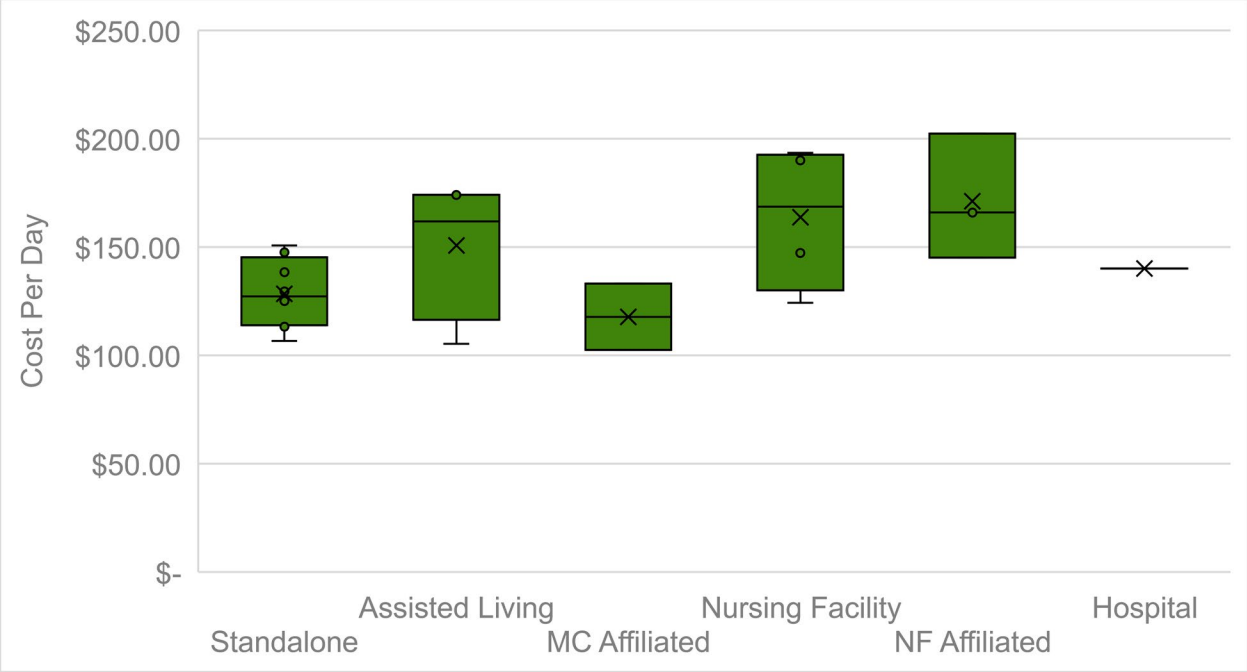


Figure 14. Cost per Day Distribution by Affiliation / Co-Location Classification

While this data shows a narrower distribution of costs in each classification, there is still considerable variation particularly with Assisted Living and Nursing Facility Affiliated.

Guidehouse also considered each component individually. One of the main concerns expressed during stakeholder meetings was the need to modify the way rates are calculated in regard to the property component. In the course of our analysis, Guidehouse looked at property cost at the provider and classification levels. Figure 15 below is the Property cost distribution by Affiliation/Co-Location.

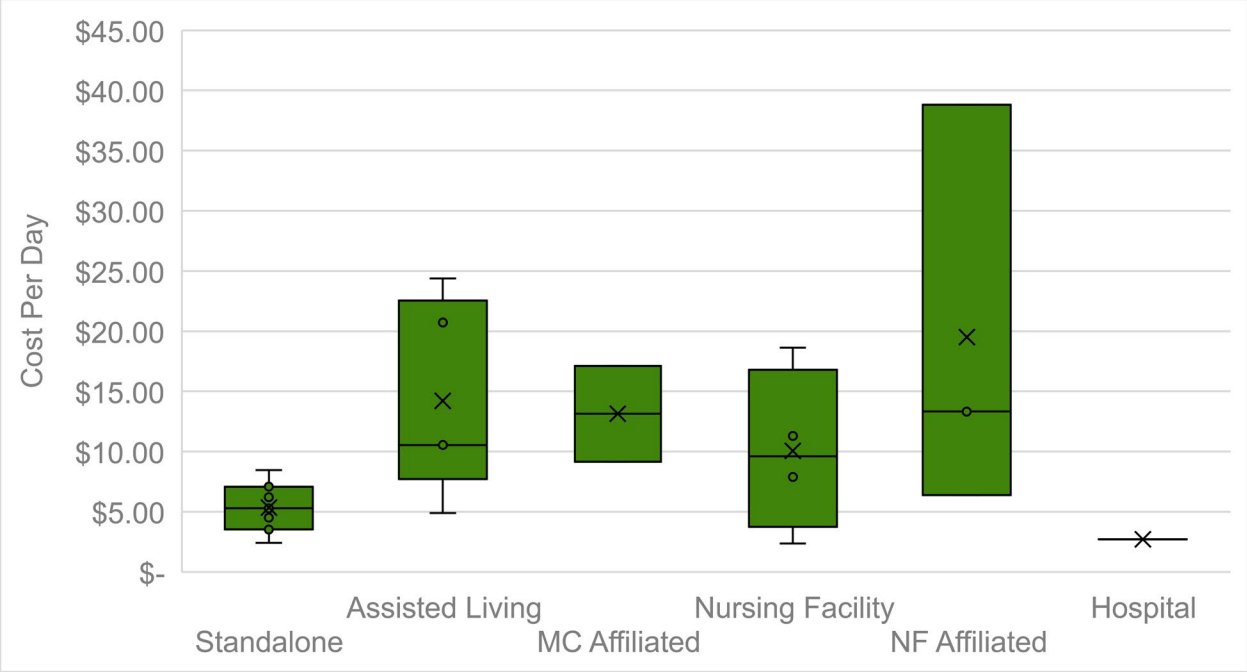


Figure 15. Property Cost Distribution by Provider Classification

As indicated above, property costs per day range from $2.40 to $38.80. Standalone facilities have a minimum of $2.40 and median of $5.29. Hospital facilities (with exclusions) have a median of $2.70. The next closest median is almost four times Hospital property cost and twice Standalone property cost.

Through this cost analysis, Guidehouse was attempting to correlate differences in cost to discrete factors such as rurality or classification. As shown above, Guidehouse did find some association. For example, facilities in rural areas had higher Direct and Room & Board costs than facilities in urban locations, and Standalone and Memory Care affiliated/co-located facilities had lower costs than other provider classifications. However, while there is relationship, the wide distribution of costs in these classifications lowers our confidence in the causality of the identified factors.

Property costs vary considerably among North Dakota Basic Care providers. Notably, standalone facilities generally have lower costs than all other classifications, with the exception of hospitals, which are represented by a single facility (n = 1). Diverse property situations – such as full ownership, mortgages, and rental or leasing agreements – create significant differences and a broad range of cost reimbursement options. Other factors such as facility age and renovations and improvements can also have significant impact on reimbursement rates and options. A detailed analysis of property situations relevant to North Dakota Basic Care was not included in the scope of this report. In general, lower property reimbursements can inhibit investment in the facility itself and lead to stagnation. Furthermore, cost-based, prospective reimbursement is characterized by a two-year lag in realizing reimbursement rates. As a result, providers may be hesitant to accept the financial risk associated with even minor renovations. Additionally, cost-based reimbursement raises concerns about related property issues, capital lease agreements, and the fair market value of leases.

Occupancy

In addition to costs, Guidehouse also analyzed occupancy at the provider and classification levels. As with cost, we attempted to identify relationships between occupancy differences and factors such as size, rurality, and co-location / affiliation. Holistically, we also were looking to inform discussions around occupancy goals. Figure 16 below shows the distribution of fiscal year 2022 occupancy among all providers by location. In general providers in rural areas maintain lower occupancy (63 percent on average) while providers in urban areas maintained higher occupancy (84 percent).

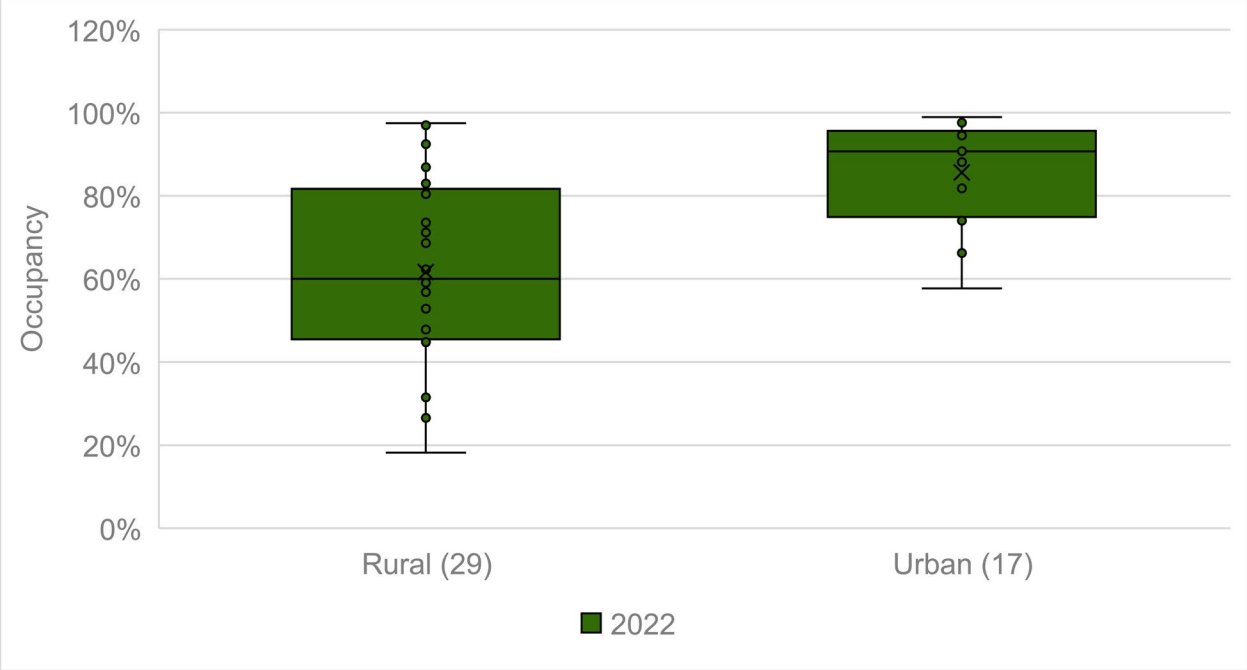


Figure 16. Fiscal Year 2022 Occupancy Distribution by Location

In 2022, Basic Care facility occupancy rates ranged from 18 to 99 percent with an average of 70 percent. Table 14 below shows the weighted average, mean, and median for each of the six provider groups. The weighted average was calculated as the total resident days divided by the total available days and gives the best read on total utilization and availability for each group. As illustrated in the table, Occupancy rates for Hospital Co-Located/Affiliated and Nursing Facility Co-Located facilities are significantly lower (57 percent weighted average for each), than other facility categories. Table 14 shows the breakdown of occupancy by facility classification.

Table 14. Basic Care Facility Occupancy Rates - 2022

Classification	Weighted Average Occupancy	Mean (Average) Occupancy	Median Occupancy
Standalone	67%	69%	70%
Memory Care Co-Located/Affiliated	82%	85%	87%

Classification	Weighted Average Occupancy	Mean (Average) Occupancy	Median Occupancy
Hospital Co-Located/Affiliated	57%	55%	55%
Nursing Facility Co-Located	57%	49%	48%
Nursing Facility Affiliated	89%	83%	94%
Assisted Living Co-Located/Affiliated	71%	75%	80%
Total	**73%**	**70%**	**73%**

Feedback from providers during stakeholder meetings inferred that occupancy was not an issue, with some reporting demand outpacing what they had space for. However, as illustrated in the tables above, occupancy rates for Basic Care facilities vary significantly based on geographic location and facility classification, with occupancy levels for many facilities, particularly those in rural areas, falling below 80 percent. Additional research should be conducted to understand specific drivers for lower occupancy, which could include quality issues, which effect demand, workforce challenges with providers not being able to staff to their full capacity or providers unwilling to accept increased financial risk that may come serving more individuals. Other issues may pertain to marketing or lack of awareness. It is also possible that some providers have Basic Care units that have been converted to other purposes but are still being reported as available.

Depending on the specific driver(s) for lower occupancy facilities, the State could take a number of approaches to address lower occupancy, including focused workforce initiatives, implementing quality improvement initiatives (see Recommendation #6), or promoting / marketing the program. There are also financial mechanisms the State could employ as part of the rate methodology for Basic Care service, to incentivize providers to maintain occupancy. The most common approach, which is one South Dakota uses for nursing facilities, would be to implement an occupancy threshold tied to indirect and property costs, where the cost-based rates for a provider are based on an assumed minimum occupancy level, typically 80 to 90 percent. In this arrangement, providers falling below the occupancy threshold would not have their total eligible indirect and property costs covered by the payment rate.

Rates and Limits

Guidehouse conducted an analysis of provider reimbursement rates and the limits used in the rate setting process. This analysis helps us understand not only how payment rates vary among Basic Care providers but also how they compare with other types of providers, such as Nursing Facilities and Memory Care units. Additionally, Guidehouse examined the application and impact of rate limits to better understand differences in reimbursement levels across providers and provider categories.

To begin, Guidehouse utilized data from FY2020 through FY2022 cost reports to compare provider rates across Basic Care, skilled nursing facilities, and memory care facilities. The objective was to evaluate how the Basic Care rate compares to rates of other facility types that may serve a similar population but have higher residents with higher needs resulting in higher

cost. Figure 17 below illustrates the average total daily rates for Basic Care facilities, skilled nursing facilities at minimum acuity, and memory care facilities, segmented by location, for rates effective July 1, 2023. While the rates for Memory Care facilities are less on average than Basic Care facilities, this is not a reflection of total cost as the rate for Memory Care does not currently include reimbursement for Room and Board costs, while Basic Care and Nursing Facility rates do.

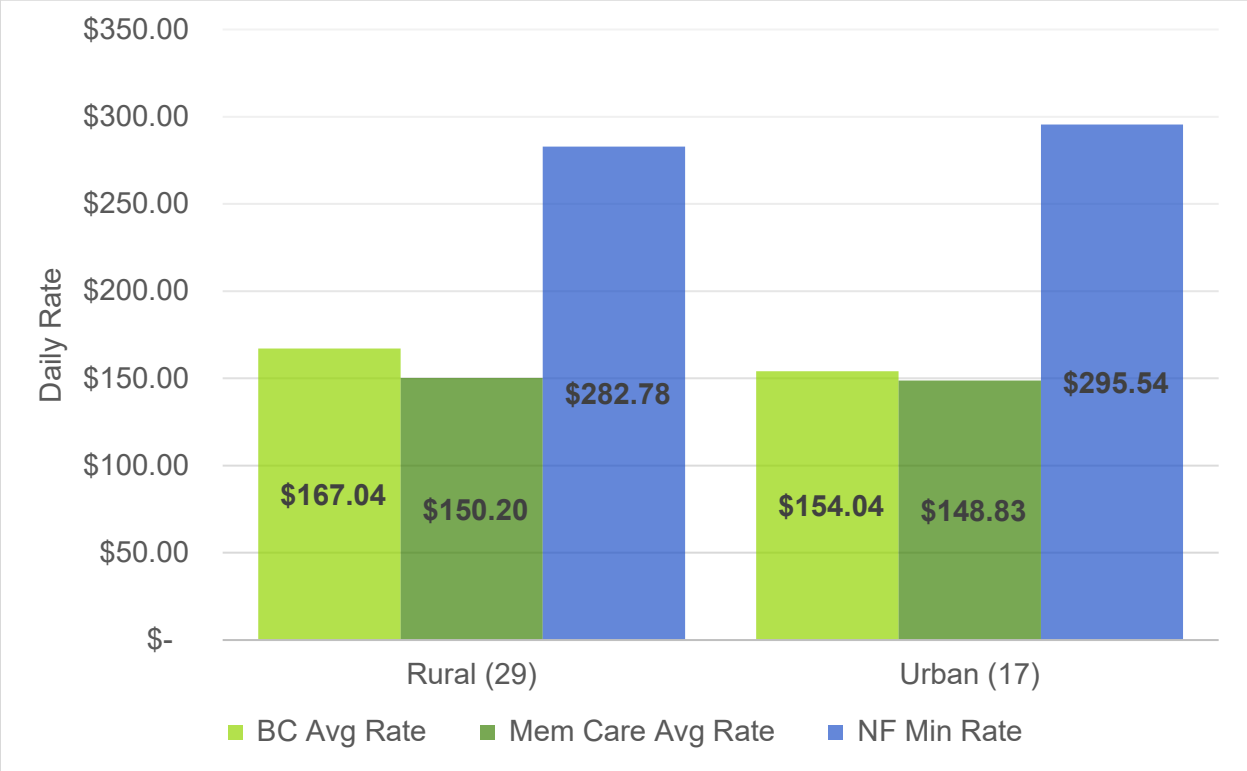


Figure 17. Average Daily Rate by Location for Rates effective July 1, 2023

Guidehouse analyzed limits on Direct and Indirect cost per day used in determining rates. Figure 18 below shows the number of facilities with Direct or Indirect costs per day above the limits in FY 2022 by provider classification. The facilities within the classification are categorized as having neither Direct or Indirect, one component above the limit, or both components above the limits.

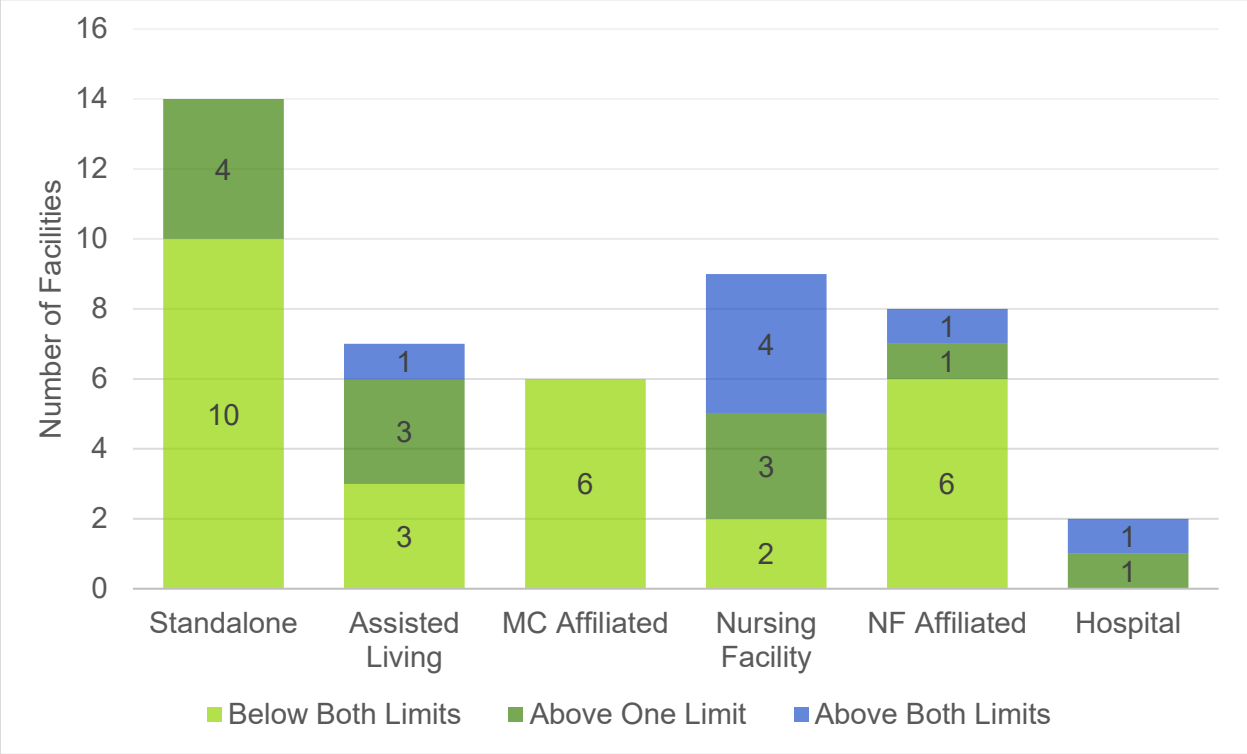


Figure 18. Count of Facilities with Costs Below or Above Rate Limits

Figure 18 above shows that classifications with the lowest average cost, such as Standalone and Memory Care Affiliated/Co-Located facilities, are least affected by cost limits. Conversely, Hospital Affiliated / Co-Located and Nursing Facility Co-Located facilities have higher than average costs and consequently often exceed one or both of these limits. This shows that the key factor on the impact of rate limits is cost, which is by design. The rate limits are intended to incentivize efficiency by not reimbursing providers for Direct and Indirect costs per resident day above a determined percentage of the median.

A separate significant factor on the impact of rate limits is inflation. In Basic Care, the rate limits are currently rebased every four years. Rebasing the limits with current cost report information ensures that the limits work as intended, only applying to rates over the designated percent of the median. As noted previously, an inflation factor is applied in non-rebasing years. This can introduce variation of the impact beyond what was intended. If the inflation factor applied to the limits is less than the actual year over year change in costs, it is likely that providers already exceeding the limits will experience a widening gap between their cost per day rates and the set limits. Moreover, a greater number of providers may exceed at least one limit because the limits are not increasing at the same rate as provider costs. Similarly, if the inflation factor is more than the year over year change, fewer providers would be impacted by the limits or have smaller reductions. With respect to the correlation of inflation to rate limit impact, Table 15 below illustrates how the number of providers affected by these limits changed over the fiscal years 2020 through 2022.

Table 15. Providers Affected by Limits for Fiscal Years 2020 through 2022

Measure	2020	2021	2022
# and Percent of Providers Either Indirect or Direct Limited	27 (59%)	29 (63%)	19 (41%)
# and Percent of Providers Both Indirect and Direct Limited	9 (20) %	14 (30%)	7 (15%)
Rate Rebased in Year?	N	N	Y
Market Basket – SNF Trend	5.56%	6.60%	N/A – Rebased
Observed Year over Year Change in Costs	N/A – No Data	9.32%	N/A – Rebased
Approved Inflation Factor	2.00%	0.25%	N/A – Rebased

Table 15 above illustrates the effect of inflation factors that do not align with actual changes in costs. Legislatively approved inflation does not align with actual changes in cost for all Medicaid providers and is not specific to Basic Care providers. With the limits rebased in 2022, we can use this year as the base to compare the effects of the inflation factors, which were previously rebased in 2016. By 2020, the first year for which we have cost reports and after multiple years of inflationary increases, 59 percent of providers were affected by at least one limit, and 20 percent were affected by both limits. In 2021, the inflation factor used was 0.25 percent and the actual change in cost was 9.32 percent. This discrepancy resulted in two more providers being affected by the limits, and the percentage of providers affected by both limits increased from 20 percent to 30 percent. In 2022, the limits were rebased. The number of providers affected by one limit dropped from 29 to 19, and the number of providers affected by both dropped from 14 to 7, 30 percent to 15 percent. This demonstrates the need for regular rebasing to reset the cumulative nature of inconsistent inflation factors.

Guidehouse analyzed rates for Basic Care facilities that are based on individual provider costs, with reductions applied for those exceeding the limits on Direct and Indirect care. Our analysis found an expected correlation between inflation below market rates and an increased number of facilities with costs surpassing these limits. As noted above, re-basing the limits effectively resets this trend back to baseline. It is important to note that these limits impact different classifications disparately, in accordance with increased costs.

Additionally, when comparing Basic Care rates to Specialized Basic Care (Memory Care) and Skilled Nursing Facilities, the average rate for Basic Care facilities is lower than the average minimum rate for Nursing Facilities. This is expected, considering the higher costs associated with the higher needs and more institutional nature of Skilled Nursing Facility (SNF) level of care. The average Basic Care rate is above the rate for Memory Care facilities, whose residents have a higher level of care, but the rates for Memory Care do not cover Room and Board costs.

Inflation

There are multiple public index options available for assessing the impact of inflation. Below are descriptions of the CMS Market Basket and the Consumer Price Index – All Urban Consumers

(CPI-U). Both indices utilize market basket price indexes, which reflect the mix of goods and services consumed by specific populations in various settings. A market basket is generally more representative of overall costs and tends to be less volatile than indexes focused solely on labor or purchased items. Both CMS Market Basket and CPI-U are widely used for tracking Medicaid costs and rate trends.

CMS Market Basket[11] is a comprehensive price index that reflects the mix of goods and services involved in providing healthcare across different settings, covering most cost components. It is produced by the Office of the Actuary within CMS and updated quarterly using national-level data. IHS Global Inc. provides a 10-year forecast of index levels, which aids in setting prospective rates, such as those for North Dakota Basic Care. The index includes specific versions for various settings, including a Skilled Nursing Facility (SNF) index, applicable to the Basic Care environment.

CPI-U[12], like CMS Market Basket, measures the average change over time in what urban consumers pay for a market basket of consumer goods and services. However, unlike CMS Market Basket, which focuses on the cost of providing goods and services, CPI-U measures what consumers are actually paying. CPI-U data is available at both regional and urban levels and is updated monthly, though it does not include forecasted index values. There is also a specific index for Nursing Facilities within CPI-U. The Consumer Price Index – Urban Wage Earners and Clerical Workers (CPI-W) is a subset of CPI-U, focusing specifically on those designated groups.

The Producer Price Index[13] (PPI) measures the average change over time in the selling prices received by domestic producers of goods and services, reflecting price changes from the seller's perspective. This is in contrast to other indices like CPI, which measure price changes from the purchaser's perspective. PPI data is available only at the national level.

Figure 19 is a visual representation of the variance in inflation based on the different inflation index options described above, from 2019 through 2023.

[11] CMS Market Basket Data, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data
[12] Consumer Price Index, https://www.bls.gov/news.release/cpi.t01.htm
[13] Producer Price Index, https://www.bls.gov/ppi/overview.htm

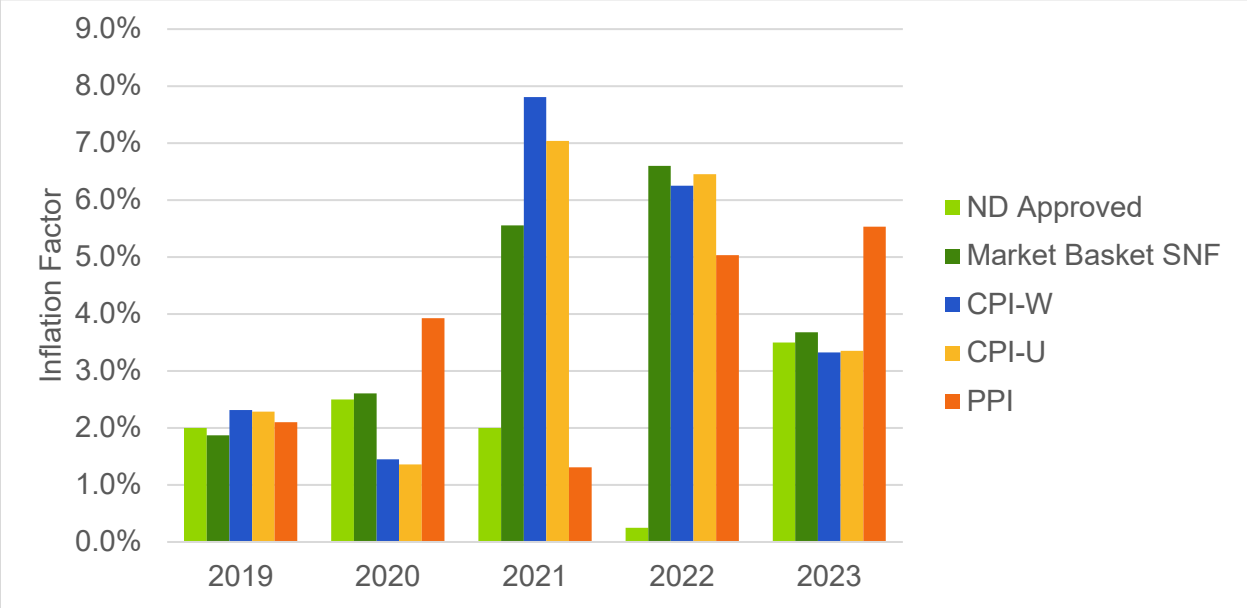


Figure 19. Yearly Inflation by Inflation Indices

The above graph shows the North Dakota approved inflation closely matches Market Basket SNF in 2019, 2020, and 2023. However, in 2021 and 2022, the North Dakota approved inflation is much lower than corresponding Market Basket trends. It should be noted that due to the pandemic, in 2021 and 2022 facilities had access to additional general funds and some received an employee tax credit. This graph also shows the volatility of the CPI and PPI trends compared to Market Basket.

Table 16 shows the breakdown and comparison of North Dakota Legislatively approved inflation and Market Basket SNF.

Table 16. Breakdown and Comparison of North Dakota Legislatively Approved Inflation and Market Basket – SNF Inflation Factors

Year	ND Legislatively Approved	Market Basket SNF	Difference
2019	2.0%	1.9%	0.1%
2020	2.5%	2.6%	-0.1%
2021	2.0%	5.6%	-3.6%
2022	0.3%	6.6%	-6.3%
2023	3.5%	3.7%	-0.2%

Figure 20 below shows how different inflation factors compare to actual year over year changes in total cost per day for 2021 and 2022.

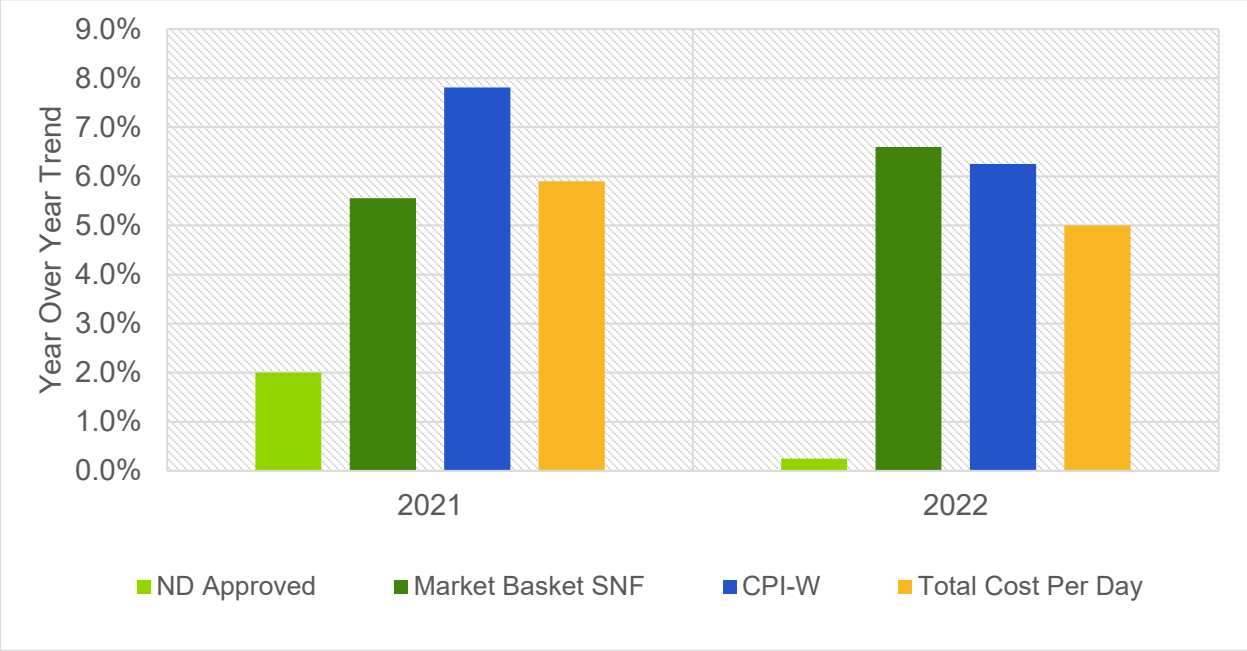


Figure 20. Year Over Year Inflation Indices and Total Cost Per Day Trends for 2021 and 2022

The change in Total Cost per day is 0.3 percent higher than Market Basket SNF in 2021 and 1.6 percent lower in 2022. In looking at individual cost components, both Direct and Indirect show significant volatility when compared to Total Cost while Property shows consistent, but slower growth.

Recent trend data shows that legislatively approved inflation often aligns with the observed change in costs. However, in 2021 and 2022, it was significantly lower (more than 20 percent) than actual changes. As noted in the previous section, this discrepancy can lead to rates being affected by the payment limits beyond the defined intention. This effect exclusively impacts rates in non-rebasing years.

Payment

Guidehouse analyzed provider payments using data from cost reports to assess the adequacy of payment rates. These rates are based on cost reports from previous years, highlighting the alignment between payments and actual incurred costs. The payment to cost ratio, displayed in Figure 21, illustrates the proportion of total estimated payments to total costs for the cost report year, with individual bars representing each provider. The average ratio for all providers was 89.9 precent. Notably, one provider with a payment to cost ratio of 164 percent saw its occupancy rise from 20 percent in fiscal year 2020 to 59 percent in 2022.

Figure 21. Provider Pay to Cost Ratio for Fiscal Year 2022

Section III: Recommendations

The recommendations presented in this report are the culmination of a comprehensive analysis that spanned from January to April 2024. This included policy reviews, discussions with key State staff and administrators, directors of assisted living and basic care facilities, finance staff, residents, and their family members. These recommendations aim to optimize the role of Basic Care and assisted living within North Dakota's care continuum.

Throughout the project, Guidehouse provided preliminary findings to HHS and met with industry stakeholders incorporating their feedback while ensuring that the recommendations were formulated from an independent analysis. Consequently, these should be viewed as independent recommendations for the State's consideration.

As specified in the RFP and aligned with the study's objectives, each recommendation was evaluated for its potential impact across the eight (8) identified topic areas, detailed in Table 17. This holistic approach ensures that the proposed changes are well-suited to enhance service delivery and meet the diverse needs of North Dakotans.

Table 17. Key Report Topics and Description

Topic Area	Description
State licensing requirements	• Facilities meeting the definition of a Basic Care facility as outlined in North Dakota Administrative Code 33-03-24.1 must obtain a license from HHS in order to operate in North Dakota. • Facilities providing assisted living services must be licensed as an assisted living facility by the Food and Lodging Unit and the Health Response and Licensure Section of HHS.
Present day Basic Care rate setting	• Current Basic Care rates are set by the State using cost reports submitted by the facilities. • Specialized Basic Care facilities rates are set upon their initial enrollment and are only updated based on legislative action. • Rates change annually on July 1 and are facility-specific based on historical costs of the facility. • Basic Care rate setting workgroup presented potential updates and/or changes to the 2023 Legislative Assembly and those updates/changes were adopted into law in Section 36 of Senate Bill 2012.
Opportunities for delivery in integrated settings	• As a state-funded residential facility option for lower income adults who do not meet the level of care requirements for SNFs, North Dakota's Basic Care system supports the health and functionality of individuals served and helps contain avoidable and potentially higher costs to other public systems, including Medicaid. • Services offered in a Basic Care setting, such as personal care services that are funded through Medicaid, can be provided in Basic Care licensed facilities or in a person's home as part of home- and community-based services.

Topic Area	Description
Issues of noncompliance with the HCBS Settings Rule	• The HCBS Settings Rule ensures that individuals who receive HCBS through Medicaid programs receive full access to services in the most integrated setting possible. • CMS required all States to complete transition to a fully compliant HCBS program on or before March 17, 2023 (unless granted a specific exemption from CMS due to the COVID-19 Public Health Emergency). • North Dakota received approval on their Statewide Transition Plan (STP) from CMS in February of 2019. • Currently, only Specialized Basic Care facilities are subjected to HCBS settings monitoring. • Basic Care facilities were not included in the STP and have not been assessed under heightened scrutiny; additionally, some settings are co-located in or with hospitals and skilled nursing facilities and would likely not be compliant with the HCBS Settings Rule without sufficient and intensive remediation. • Basic Care is considered part of the HCBS continuum and should move towards alignment with the HCBS Settings Rule.
Basic Care eligibility	• North Dakota currently provides Basic Care services to individuals 65 and older and adults with a disability through 66 licensed facilities with a total of 2,097 beds.[14] • Basic Care is a state-funded residential facility option for lower income adults who do not meet the level of care requirements for SNFs. • The Basic Care system provides support to individuals who need help with housework, laundry, meal preparation, and medication management, but who can toilet, transfer, and eat independently. • Eligibility requirements include demonstration of a need for services per the Basic Care functional assessment.
Actions to address gaps in residential service options for adults with serious mental illness	• The need for care options for adults with serious mental illness is growing across North Dakota. • A study of acute psychiatric and residential care services was conducted during the 2021-22 legislative interim period and noted significant gaps in care options for adults with mental health needs.
Role of Basic Care in continuum of services for lower income adults with disabilities	• Basic Care facilities can function as a type of service-enhanced affordable residential option to meet the needs of adults with disabilities and other health-related needs. • Lower income adults with disabilities may access Basic Care at various points within the continuum of services.

[14] As of January 2024.

Topic Area	Description
Role of Assisted living in continuum of services for older adults	• Assisted Living is one of the service options available to older adults and people with disabilities. The decision to use Assisted Living services is a personal choice.

Each recommendation impacts at least one of the eight topic areas described above.

Recommendation #1: Streamline licensing by creating a new single licensure type to cover both Assisted Living and Basic Care facilities.

Stakeholders, including providers and State staff, reported the challenges and complexity of the current licensing structure of individual licenses for Assisted Living, Basic Care, and Specialized Basic Care. If a facility provides both Assisted Living and Basic Care, they are required to have both license types. Specialized Basic Care provision requires an additional application for Alzheimer's Dementia or Traumatic Brain Injury Services in a Basic Care Facility. The core purpose and goal of these services is to support the well-being and safety of individuals residing and receiving care at either facility type.

Through Guidehouse's review of North Dakota Administrative and Century Codes for both Basic Care and Assisted Living, it was identified that there is overlap between areas such as administrator and staff education/training, resident rights, and medication management. Additionally, significant differences exist in the Administrative and Century Codes for each. For instance, the Administrative Code requires that Assisted Living facilities have a current, written emergency disaster plan,[15] whereas Basic Care facilities are required to adhere to specific fire safety regulations.[16] The comparative policy analysis identified best practices from other states that could serve as a basis for modifying North Dakota's Administrative and Century Codes for Basic Care and Assisted Living to enhance the quality of care and safety for residents and ease administrative burden for providers who want to offer a diverse array of services.

State staff and providers noted that the differences between Assisted Living and Basic Care have become increasingly indistinct, complicating licensure and regulatory enforcement for both service types. Facility administrators managing both types of facilities reported challenges such as staffing complexities, the necessity to relocate residents based on their service requirements, and limitations on service provision, especially when residents who might benefit from Basic Care services are housed within Assisted Living units. These issues highlight the need for clearer definitions and guidelines.

Guidehouse recommends consolidating the current separate licensures for Assisted Living, Basic Care, and Specialized Basic Care into one license type with varied service packages that can be provided in the licensed setting. For locations where the owner of the building or the person or entity leasing the building is also providing services for individuals residing at the location, a license is required regardless of the service package offered and/or provided.

[15] North Dakota Administrative Code Chapter 33-33-09.
[16] North Dakota Administrative Code Chapter 33-03-24.2

This new license would establish the services Assisted Living must provide (and therefore, that a resident should expect), and the additional services required of both Basic Care and Specialized Basic Care. Proposed clear, codified definitions of the service type are as follows:

- **Assisted living:** An Assisted Living facility is a congregate residential setting with private living areas and provides the essential services of:
    - Medication Assistance;
    - Meals;
    - Housekeeping;
    - Laundry; and
    - Recreational Activities.
    - Residents may contract additional services based on individual care needs.
- **Basic Care:** A Basic Care facility is a congregate residential setting with private and/or semi-private living areas. Basic Care facilities are required to provide the essential Assisted Living services, plus mandatory Basic Care services to participants based on need, without reaching institutional level of support. These mandatory services include:
    - Medical Transportation;
    - Personal Care Assistance (ADL assistance);
    - Supervision;
    - Needs Assessment and Care Planning;
    - Medical Scheduling; and
    - IADL Assistance.
- **Specialized Basic Care:** A Basic Care facility that provides specialized services for treatment of Alzheimer's, dementia, special memory care, or traumatic brain injury.

The policy analysis indicated a need for clearer policy language to distinguish between Assisted Living and Basic Care. Guidehouse reviewed how various states define Assisted Living in their policies, noting that clear definitions could help guide necessary updates. Idaho and Montana provide specific definitions that highlight the levels of care and supervision in Assisted Living facilities. Idaho defines Assisted Living as a "Residence, however named, operated on either a profit or non-profit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three or more adults not related to the

A recurring theme from interviews and focus groups is the confusion surrounding the definitions of Assisted Living and Basic Care. This ambiguity has led to challenges in licensure and regulation, complicating the understanding and decision-making process for residents and their family members.

owner."[17] Similarly, Montana describes it as a "Congregate residential setting that provides or coordinates personal care (ADLs), 24-hour supervision and assistance, both scheduled and unscheduled, and activities and health-related services."[18] These examples underscore the need for clear and consistent language to prevent confusion in policy application.

Services that are provided above and beyond what is included in the definition of Assisted Living and/or Basic Care must be contracted for and if required, provided by an entity licensed to provide the service. Examples of possible contracted services include physical or occupational therapy, catheter care, or wound care. These services would be monitored and regulated based on the service contract and not within the proposed facility license structure. Services provided as part of the Assisted Living, Basic Care, or Specialized Basic Care package are regulated and monitored by the State as a function of facility licensure.

Facilities under this unified licensure would follow a core set of regulations with consistent health, safety, and welfare surveys. Those offering Basic Care and Specialized Basic Care services would undergo additional monitoring to comply with the more stringent State and federal standards. This recommendation aims to streamline regulatory processes and promote consistent and quality care across facilities. As part of the streamlining of regulatory processes and to promote the provision of consistent and quality care, the Unit that oversees compliance will need to have access to adequate staff and resources. Figure 22 visualizes this proposed model.

[17] Idaho Department of Health and Welfare, Residential Assisted Living Facilities Rule, https://adminrules.idaho.gov/rules/current/16/160322.pdf
[18] Montana Code Hospitals and Related Facilities, Definitions, https://leg.mt.gov/bills/mca/title_0500/chapter_0050/part_0010/section_0010/0500-0050-0010-0010.html

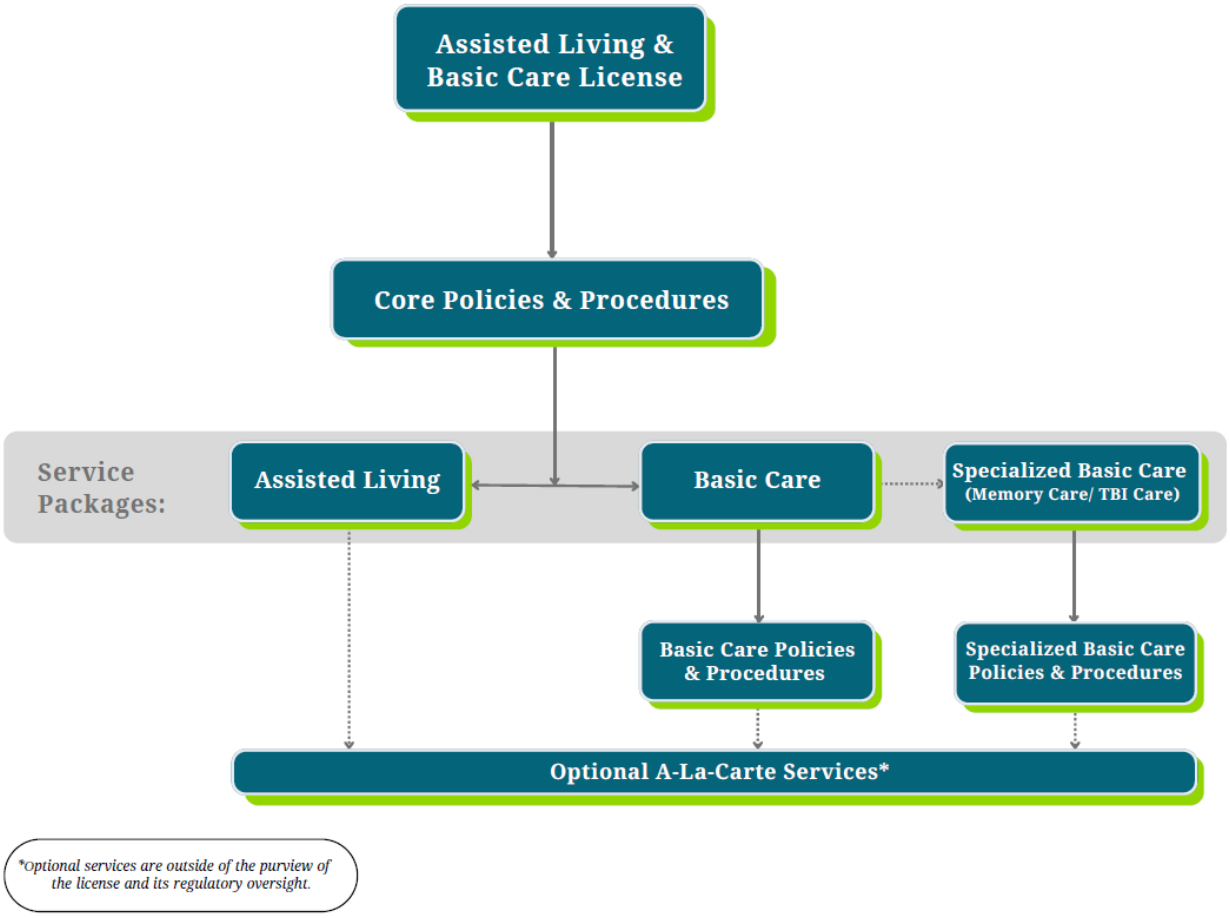


Figure 22. Proposed Assisted Living, Basic Care, and Specialized Basic Care Licensure Structure

This proposed change in licensing simplifies regulatory processes and enhances the care continuum by focusing on the individual receiving services in a location of their choosing. By adopting a single license type, facilities adhere to one set of rules, reducing confusion and easing administrative burdens. It enables continuous care for residents and for some, can eliminate the need to require individuals to move rooms or units as their care needs evolve. This unified approach not only clarifies the regulatory landscape but also improves the quality of care for individuals by maintaining consistent standards across all service packages.

Providers would indicate on their licensure application which service package(s) they will provide rather than the current process of completing applications for each type. By requiring the same core policies and procedures for all settings, monitoring also becomes streamlined reducing the burden on State staff and providers.

To promote consistent quality and safety across all care settings, Guidehouse recommends implementation of universal policies that all providers must adhere to under the single license structure. These policies cover areas of quality assurance, staff education and training, regulatory oversight, evacuation procedures, HCBS Settings Rule compliance, person-centered planning, and resident rights. It was noted during stakeholder meetings and administrator

interviews those providers offering both Assisted Living and Basic Care already adhere to the more stringent Basic Care requirements for both settings. Therefore, we recommend updating the existing administrative code for Basic Care and Assisted Living to reflect these practices more broadly. Recommended updates to the Administrative Codes include:

Evacuation Requirements (E-scores): We recommend that the evaluation of E-scores include factors such as the age of the building, construction materials, and the presence of sprinklers. Stakeholders have also supported this approach as local and county fire codes evolve to improve health and safety standards. Through research of comparison states, several other comparable states include these factors when determining evacuation ability.

Required Fire Drills: Concerns about the frequency of fire drills were raised by Basic Care residents and administrators. Examples provided by stakeholders highlighted safety issues arising from both the timing and frequency of fire drills. Unlike North Dakota, which requires monthly drills, during different shifts, other states opt for annual or semi-annual requirements. An update to reduce the frequency of required fire drills to semi-annually is recommended.

Co-Located Services: In order to uphold the principles of the HCBS Settings Rule, it is necessary to prohibit the co-location of Basic Care with skilled nursing facilities and/or hospitals. Such co-locations are fundamentally at odds with the HCBS Settings Rule, as co-locations undermine the goal of full community integration for individuals in Basic Care. The institutional environment of a nursing facility is inherently incompatible with the home-like setting that Basic Care aims to provide. By their very nature, nursing facilities and hospitals are ill-equipped to deliver the personalized, home-like care that is a hallmark of Basic Care, nor are they likely capable of offering the diverse range of activities expected for individuals living in Basic Care.

Today, the provision of Basic Care within nursing facilities appears to be an outlier service, and given federal regulations, it would be difficult to deliver services in a manner inconsistent with those already receiving services paid for by Medicaid for other long-term care residents. At present, there are only 81 licensed Basic Care beds co-located in the same facility as a skilled nursing facility, accounting for less than four (4) percent of all Basic Care beds. [19] This small number indicates that such arrangements are not the norm and highlights the limited demand for Basic Care in these settings. During 2022, these co-located beds had an occupancy rate of only 57 percent, significantly lower than other Basic Care classifications. This lower utilization rate underscores the unsuitability of nursing facilities as a setting for Basic Care, as residents and their families likely seek environments that better align with the principles of home-like, community-integrated care.

Additionally, nursing facility surveys vary significantly from Basic Care oversight activities. This variation would create an additional administrative burden on the state in conducting surveys in these settings. The need to apply distinct regulatory frameworks and survey methodologies to co-located services would likely complicate compliance efforts and further strain state resources.

Regulatory Enforcement Actions: The move to consolidate Basic Care under one license type necessitates a more nuanced approach to regulatory enforcement. Currently, the State's

[19] Number of co-located beds based on analysis of 2022 provider cost reports submitted to HHS.

regulatory enforcement actions are limited and often drastic, such as banning or limiting admissions, suspending or revoking licenses, or denying licensure.[20] These measures, while effective in addressing severe noncompliance, may not always be the most constructive approach for achieving compliance and fostering high-quality care. A tiered regulatory enforcement strategy provides a broader array of tools to engage with providers, encouraging improvement while maintaining accountability.

A tiered approach to regulatory enforcement offers a spectrum of actions that can be tailored to the severity and nature of noncompliance. This strategy provides incremental steps that can be used to guide providers towards compliance while minimizing disruption to residents. The proposed tiered approach may include the actions described in Table 18.

Table 18. Proposed Regulatory Enforcement Actions

Action Type	Description
Warning and Improvement Plans	• For minor infractions, regulatory bodies may issue verbal warnings to highlight areas needing improvement, making facilities aware of compliance issues without formal penalties. • When verbal warnings are insufficient, formal written notices may be provided. These notices specify the noncompliance issues and outline the required corrective actions that must be completed within a set timeframe. • Facilities with persistent or serious issues would be required to submit and implement detailed corrective action plans. These plans could include specific steps for achieving compliance and require periodic progress reports to the regulatory body to promote ongoing improvements.
Fines and Penalties	• Similar to existing Civil Monetary Penalties, monetary fines could be imposed proportional to the severity of the violation. These fines would serve as a deterrent and are structured to escalate with repeated offenses, incentivizing facilities to maintain compliance. • Penalties would be linked to specific performance metrics. This performance-based approach encourages continuous quality improvement by directly tying financial consequences to measurable outcomes.
Increased Monitoring and Oversight	• For facilities with identified noncompliance issues, the frequency and scope of inspections could be increased. Enhanced monitoring would allow for these facilities to be closely supervised until they meet compliance standards. • Provisional licenses could also be issued to facilities struggling with compliance. These licenses would come with stricter oversight and shorter renewal periods, providing a clear pathway for facilities to improve their practices while maintaining accountability.
Public Reporting and Transparency	• Facilities could also be required to publicly disclose their noncompliance issues and the corrective actions they are taking. This transparency would further promote accountability and allow

[20] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-09-24.1-06.

Action Type	Description
	stakeholders, including residents and their families, to make informed decisions about care providers. • In cases of serious or repeated violations, consumer alerts could also be issued or posted on websites. These alerts should inform potential residents and families of the facility's compliance status, helping them to avoid substandard care environments.
Collaborative Improvement Initiatives (See Recommendation #6)	• Participation in state-sponsored quality improvement collaboratives is encouraged. These collaboratives could offer training, resources, and peer support, helping facilities to achieve compliance and improve care quality through shared best practices. • Facilities that consistently meet or exceed compliance and quality standards could be offered incentives, such as grants or incentive/bonus payments. These incentives would recognize and reward high performance, fostering a culture of excellence within the care community. • Gradual transition to full compliance with the HCBS Settings Rule following a state mandated transition plan allowing for necessary adjustments and improvements to be made in a manageable and sustainable manner over time, ensuring the continued provision of high-quality care throughout the transition period.

A tiered regulatory enforcement approach offers a balanced and flexible framework for addressing noncompliance in Basic Care facilities. By incorporating a range of actions from warnings and improvement plans to fines, increased monitoring, and public transparency, the State may be able to more effectively work with providers to achieve and maintain compliance. This approach not only enhances regulatory oversight but also supports facilities in providing high-quality care, ultimately benefiting the residents who depend on these services.

Table 19 below discusses the implications of Recommendation #1, which proposes a new licensure structure for Assisted Living and Basic Care services.

Table 19. Recommendation #1 Topic Areas Impacted

Topic	Description
 ***Licensing Requirements***	This recommendation directly impacts the State licensing requirements for both Assisted Living and Basic Care. The proposed recommendation would change the current licensure structure to a new structure that would require updates to licensing processes for providers and the State in review and approval of license applications and regulatory oversight of the new licensure type. A clear definition of Assisted Living and Basic Care service types ensures facilities understand and comply with the relevant licensing standards. This clarity will further aid in streamline regulatory processes and enhancing facility compliance.

Topic	Description
 ***HCBS Settings Rule***	The proposed licensure aims to provide services to an individual in the setting of their choice, regardless of the funding source, while incorporating feedback from residents and stakeholders to create a community-integrated, person-centered approach to care. Necessary updates to administrative code, policies and procedures, and program administration would reflect best practices that align with the goal of community inclusion such as access to services, through the identified service packages; person-centered planning; and the right to privacy and independence through Resident Rights. Facilities may have increased costs to become community integrated.
 ***Integrated Settings***	Streamlining Assisted Living and Basic Care services under a new licensure type encourages more flexible options. With the recommended licensure type and the creation of service packages rather than separate licenses, there is an opportunity for the State to explore the provision of a type of Assisted Living and/or Basic Care service package in alternative, community-based settings. The proposed service packages, as part of this recommendation, also include the policies and procedures that would be required for the provision of Basic Care services. Over time, it is expected that Basic Care should align with the HCBS Settings Rule, reflecting its commitment to community inclusion.
 ***Continuum of Care***	A revised licensure type that focuses on service packages rather than type of licensure creates a smoother continuum of care as it allows an individual to move along the continuum of care based on the services, they may need rather than based on a physical location. The definitions of Assisted Living and Basic Care that are part of this recommendation also assist in the understanding of each and the differences for individuals and/or their family members who are identifying the next step for care along their own personal continuum of care. This allows individuals to select what they believe is the most appropriate option in their own journey across the continuum of care. This recommendation builds on legacy and investment that North Dakota has made to the Basic Care program and the importance of the program within the care continuum by creating flexibility and streamlining requirements in order to provide care for those in need when and where they need it.

Implementation Considerations

To create a new licensure that includes both Assisted Living and Basic Care, the State will need to update Administrative Code 33-03-24.1 and Century Code 23-09.3 for Basic Care and Administrative Code 33-33-09 and Century Code 50-32 for Assisted Living to codify changes and provide the structure of the new licensure. This can be done through the adaptation of current code along with creation of new code. Updates to code will require legislative approval. Additionally, educational and informational materials will require revisions. Facilities will likely also need to revise their policies and procedures or adjust the services they offer to align with the updated definitions.

HHS will also need to prepare and assist providers with the change in licensure. HHS can provide educational materials and technical assistance to providers prior to this change to properly prepare them. In addition, the State would benefit from a phased-in approach to this change. A phased-in approach may include not requiring facilities to come into compliance until they renew their license and/or grandfathering some facilities based on established, agreed

upon, and approved criteria. As part of this consideration, the State will need to determine the process for current co-located Basic Care beds to come into compliance and align with the new license structure.

Additionally, HHS will need to work closely with facilities to develop a comprehensive transition plan for alignment with the HCBS Settings Rule. The plan should be designed to gradually bring facilities into full alignment; this will require a significant investment of time and resources from both HHS and the providers. The State will need to provide educational materials, training as well as intensive and ongoing technical assistance. Additionally, the State should consider offering grants, financial support, or other value-based payment incentives to assist facilities in achieving alignment with the HCBS Settings Rule. This financial aid will be crucial in supporting the transition and ensuring the continued provision of high-quality care.

Recommendation #2: Strengthen existing Assisted Living and Basic Care policy and create additional policies to reflect current requirements within the program, incorporate best practices, and align with State and federal requirements, as applicable.

Building on Recommendation #1, the proposed updates to definitions for Assisted Living and Basic Care necessitate revisions in associated policies and procedures to clearly define Assisted Living and Basic Care. Additionally, the introduction of a new licensure type requires that core policies be refined for both service types. Based on the review of North Dakota's policy and the inter-state comparisons, we identified specific policy areas for enhancement to bolster HHS's oversight and to integrate best practices. Table 20 below illustrates several of the recommended areas for policy updates, including Admissions and Discharge, Resident Assessment and Care Plans, Patient Directed Services, Allowable Services, Dietary Services, Alzheimer's/Dementia Care Specialized Services, End of Life Services, Tenancy Rules, Response to Critical Incidents, and Quality Assurance and Monitoring.

Table 20. North Dakota Policy Updates or Creation Recommendations

Policy Component	Level of Revisions Recommended	Key Recommendations	Language Found in Existing State Policy
Admissions and Discharges	Significant revisions	Significant revisions are recommended to enhance North Dakota's admission policy only (specifically for eligibility for admissions) in the Administrative Code for Basic Care Facilities: • Include policy language for initial screening, minimum standards, collecting medical history, prior living arrangements, and/or symptoms that might require special care as part of admission process. • Add language specifying that admissions are disallowed for individuals whose care needs surpass the facility's capacity to provide safe and appropriate services within the scope of allowed services. This includes considering the facility's ability to safely evacuate these individuals in an emergency. • Include a Statewide-standard admission agreement document to be signed by the individual and provider to promote continuity in agreement language across facilities.	**Yes** Pertaining to minimum standards for admissions, discharges, and transfers.[21]
Resident Assessment and Care Plans	Minor revisions	• Revise Administrative Code for Assisted Living to provide more information to further differentiate between Assisted Living and Basic Care requirements. • Reference State Plan service assessment requirements, as appropriate.	**Yes** Pertaining to minimum standards for completion[22]
Participant Directed Services	No policy was found in existing language; Create new policy	Provide residents with the opportunity to self-direct some or all of their services, with limitations on available services and/or qualified providers based on the payer, if necessary. Updates would need to be made in an amendment through the 1915(c) Waiver application	**No** No existing language identified

[21] North Dakota Century Code, Basic Care Facilities, Chapter 23-09.3 and North Dakota Administrative Code, Basic Care Facilities, Chapter 33-09-24.1
[22] North Dakota Administrative Code, Basic Care Facilities, Resident Assessments and Care Plans, Chapter 33-03-24.1-12

Policy Component	Level of Revisions Recommended	Key Recommendations	Language Found in Existing State Policy
Allowable Services	Minor revisions	Revise Administrative Code for Basic Care Facilities to include examples for the following services to specify what the expectations are: Social Services, Nursing Services, Dietary Services, Activity Services, Pharmacy and Medication Administration services.	**Yes** Pertaining to minimum standards[23]
Dietary Services	Minor revisions	• Revise Administrative Code for Basic Care Facilities to allow residents to choose to have their meals served in their own rooms, expanding personal choice and ensuring compliance with "Resident Rights". • Revise Administrative Code for Basic Care Facilities to include the expectation of meeting the Dietary restrictions for residents (e.g., gluten-free).	**Yes** Pertaining to minimum standards and language requiring all meals be served in the dining room[24]
Alzheimer's/Dementia Care Specialized Services[25]	Minor revisions	• Bolster policy for dementia specific services and practices in the Administrative Code for Basic Care Facilities, such as wandering and engagement between residents and broader community. • Update policy in the Administrative Code for Basic Care Facilities to meet the HCBS Settings Rule such as emphasizing community integration (e.g., the residents have more options to do activities outside of the facility), inclusion of personal preferences, and facilitation of individual choice such as residents' being able to decide what they will have meals and having the option to have meals in their room.	**Yes** Primarily pertaining to minimum standards for the facility **Error! Bookmark not defined.**
End of Life Services	Minor revisions	Update Interpretive Guidelines language for Basic Care Facilities to allow for consideration of family members, hospice staff, the resident's designee, or volunteers when considering end of life needs.	**Yes** Pertaining to end of life needs, training, and care plans

[23] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-09-24.1
[24] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-09-24.1-18
[25] Services provided and reimbursed through North Dakota's 1915(c) waiver are required to adhere and be compliant with the HCBS Settings Rule.

Policy Component	Level of Revisions Recommended	Key Recommendations	Language Found in Existing State Policy
Resident Rights	Minor revisions	Update the policy language in the Administrative Code for Basic Care Facilities to align the Resident Rights listed under Alzheimer's/Dementia Care Specialized Services with all Basic Care residents.	**Yes** **Pertaining only to** Alzheimer's/Dementia Care Specialized Services[26]
Tenancy Rules	No policy was found in existing language; Create new policy	Guidehouse recommends that the State develop a policy for rent subsidization for individuals eligible for Basic Care services to standardized tenancy / leasing rules.	**No** No existing language identified
Response to Critical Incidents	Significant revisions	Include the following in the Administrative Code for Basic Care Facilities. Where applicable, language should be consistent with other guidelines provided by the State: • Define "critical incident" and outlining minimum standards and protocols for critical incident reporting to the State, with defined methods for publicizing any core critical incident / health and safety findings around the facility and made available to residents prior to and upon admission. • Enhance language that defines how providers and personnel shall report instances of suspected abuse, neglect, or exploitation of a resident. Consider referencing mandatory reporting laws to adequately incorporate how these laws apply to professionals within the setting. • Define timelines surrounding when critical events must be responded to by specific departments or administrators to increase accountability. When defining these timelines, it is important to consider that adequate staffing will be imperative to the specified departments and administrators being able to meet these timelines.	**No** No existing language identified

[26] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-03-24.1-24

Policy Component	Level of Revisions Recommended	Key Recommendations	Language Found in Existing State Policy
Quality Assurance and Monitoring	Significant revisions	• Add language in the Administrative Code for Basic Care Facilities to require facilities to establish a quality assurance component; with definitions and required topics outlined in policy. • Include language in the Administrative Code for Basic Care Facilities that considers and seeks input on individual's satisfaction.	**Yes** Pertaining to minimum standards[23]
Rates and Rate Calculation	Minor revisions	Update language to reflect rate recommendations including: • Using publicly available indexes for trending to increase relevance of cost-based rates; • The use of Fair Rental Value (FRV) based reimbursement; and • Rate enhancement for increased ADL care needs. • Include language to allow for facilities licensed and providing Specialized Basic Care to seek reimbursement for services not covered by waiver services (e.g., Room and Board). • Require reporting to align with current Basic Care financial reporting requirements.	**Yes** Pertaining to rate calculation, costs, and adjustments
Co-Located Services	No policy was found in existing language; Create new policy	In alignment with Recommendation #1 of this report, add language to Basic Care Chapter 33-03-24.1 to disallow the provision of Basic Care services at any facility co-located under the same roof of an institutional setting.	**No** No existing language identified

The points of comparison included only reflect the areas in which North Dakota's existing policy was found to need revisions and / or where policy points were not included in North Dakota's current language. North Dakota's existing policies that were identified as being strong and not requiring revisions are not included.

Recommendation #2 is designed to enhance and clarify the policies governing North Dakota's Assisted Living and Basic Care programs. It involves aligning existing regulations with the latest program requirements, best practices, and both state and federal standards. This recommendation supports the introduction of a new licensure type and necessitates the revision of existing policies. Table 21 below highlights the various areas impacted by this recommendation, including admissions and discharges, assessment and care plans, and more, outlining the need for updated policies across these domains.

Table 21. Recommendation #2 Topic Areas Impacted

Topic	Description
 **Licensing Requirements**	Updates and additions to policies and procedures, directly align with licensing requirements as policies provide the guidelines for the operationalization of licensing requirements, including requirements for specific service provisions provided in the service packages as described in Recommendation #1.
 **Eligibility**	This recommendation specifically includes an update to policies on eligibility to provide clarity for both providers and residents and/or their family member(s).
 **Rate Setting**	Any updated or added policies may impact factors that are used to determine rates including how factors may be defined. The recommendation to include policy on the allowing of reimbursement for room and board for Specialized Basic care facilities will need to be considered for rate setting in the future.
 **HCBS Settings Rule**	Several of the recommended policy changes / additions provide clarity that align with the HCBS Settings Rule and other related best practices for person-centered care and resident rights and privacy. Specifically, the recommendation for Dietary Services and the ability for the individual to decide where they would like to have their meal and Participant-Directed Services and the ability for individuals to direct their own care to support a fully person-centered approach to care. The current state of Basic Care may face additional scrutiny and be at risk regarding the goal of community integrated services.
 **Integrated Settings**	Through updated and clarified policies, the parameters of where and how Assisted Living and Basic Care can be provided allow for the opportunity for exploration of providing a Basic Care type service package in alternative settings while ensuring the health and safety of individuals receiving care.

Topic	Description
 **Continuum of Care**	The proposed policy changes and additions detailed in Recommendation #1 are designed to solidify and expand the roles of Assisted Living and Basic Care within North Dakota's continuum of care. These recommendations provide clear guidelines and requirements for service provision. Coupled with the new licensure structure proposed in Recommendation #1, these revisions aim to meet individuals' needs more effectively at various stages of their care journey, enhancing the overall continuum of care in the State.

Implementation Considerations

Should the State elect to implement some, or all proposed policy modifications as recommended, the State may require legislative action to update policy. In addition, the State would also need to provide updated information and training for providers and stakeholders on any modifications enacted. Policy updates drive improved understanding of Assisted Living and Basic Care and how they differ (e.g., eligibility), improved individual experience and quality of life, improved services and consistency in services across all sites, and position the State to incorporate better oversight components into the Basic Care program.

Recommendation #3: Develop and implement State-led universal Assisted Living and Basic Care training and materials to educate all stakeholders.

To provide for consistent and up-to-date information on Assisted Living and Basic Care, HHS needs to create an Assisted Living and Basic Care training program that can be provided to all State staff, facility staff, residents, and their families or caregivers. Guidehouse has identified opportunities to strengthen common functional and cultural needs within Assisted Living and Basic Care facilities through targeted technical assistance and training. It is recommended that the HHS address additional aspects of care that are common across Assisted Living and Basic Care, as well as the differences between the two, to provide technical assistance and support for Assisted Living and Basic Care that is currently not explicitly addressed.

HHS can facilitate training for all relevant populations, including facilities, residents, family members, and the general public, to promote consistency in the information provided. The State needs to also develop guidance and outreach materials to be shared to individuals looking at long-term care options, families and caregivers looking for care for a loved one, providers and potential providers, and other interested stakeholders. Training sessions can be conducted in various formats and tailored to each audience. Providing training that addresses the nuances of the program and how providers can effectively meet program requirements while meeting the specific needs of residents would be a cost-effective and impactful recommendation.

Based on observations and findings through the study, suggested training topics include, but are not limited to:

- **Differences between Assisted Living and Basic Care**
    - With the recommendation of a new licensure type there is an opportunity to educate providers, residents, family members, State staff, and public stakeholders on the licensure changes, specifically the differences between the service packages: Assisted Living, Basic Care, and Specialized Basic Care. A core training program

that explains the services included in each service package, provides examples, and demonstrates the differences between service packages would allow for universal education and the creation of materials that can be used for new staff orientation, facilities, and the general public.

- **Role of Assisted Living and Basic Care in the continuum of care**
    - North Dakota offers a unique option within the continuum of care through Basic Care. Training on what Assisted Living and Basic Care is, the eligibility requirements, and how to access it would increase awareness of the program. This could potentially allow more individuals to make an informed choice to access Basic Care, which may delay or prevent the need for nursing facility-level care.
- **Gathering and responding to individual input and grievances**
    - Some residents have expressed dissatisfaction regarding the quality of the services they are receiving. While some residents have filed grievances or spoken with facility staff, others have not. Residents would benefit from education on how to file a grievance or complaint and the process that facilities follow to handle and resolve grievances. Staff will need to also receive training on how to receive grievances from residents, the process residents follow to file a grievance, and the facility's policy on handling and resolving grievances, including any necessary reporting to the state.
- **Developing and expanding community integration**
    - A consistent theme during the resident focus groups was a desire for more activities at the facilities and within their communities, this was especially noted as an issue when the day shift leaves and on weekends. By researching best practices used by other older adult programs that focus on community integration and participation, staff and residents can work together to develop activity plans that address the expressed needs of residents. Training may include information and presentations from other adult programming, such as senior centers, community centers, and public libraries.
- **Mental Health First Aid, Serious Mental Illness, and strategies for mental health support**
    - Facility staff and stakeholders have reported an increasing number of Basic Care residents with behavioral health care needs. Training staff in Mental Health First Aid or similar mental health support models and providing care for people with a serious mental illness would teach them how to identify, understand, and respond to signs of mental health needs. This training should also include information on other available community and state resources, such as the Human Resources Centers, to support behavioral health service needs.

The review of state policies revealed that North Dakota requires facilities to design, implement, and document educational programs to orient new employees and improve their skills to fulfill their job responsibilities. This includes trainings on End-of-Life Services, as well as an annual requirement for continuing education hours.[27] However, North Dakota does not have a required training on the fundamentals of the Basic Care program, and as mentioned in Recommendation

[27] North Dakota Administrative Code, Basic Care Facilities, Chapter 33-09-24.1-11

#1, there is no policy that clearly distinguishes Basic Care from Assisted Living, which could serve as an educational resource for stakeholders.

Additionally, Guidehouse examined training programs required by other states. For example, Minnesota requires all staff providing and supervising direct services to complete an orientation to Assisted Living facility licensing requirements and regulations.[28] The orientation materials cover facility policies and procedures, staff and resident rights, a review of services, and a discussion of critical events and consumer advocacy services**Error! Bookmark not defined.** Similarly, Montana requires staff to complete a minimum of eight hours of training hours annually.**Error! Bookmark not defined.**

Discussions with State staff and providers indicated that there were different interpretations of the difference between the Basic Care program and Assisted Living. Stakeholders expressed a desire for more training and education on the program to better understand what the Basic Care program is intended to provide. Facility staff indicated that additional support and training could be beneficial in providing more targeted care for residents with behavioral health conditions. Furthermore, resident focus groups and interviews revealed that one of the most requested services or changes was an increase in social activities. Additional training and education on community integration, along with a community-centric activity planning process and awareness of other local older adult programming, would help meet the expressed needs of residents.

Table 22. Recommendation #3 Topic Areas Impacted

Topic	Description
 **Licensing Requirements**	Education on the definition of Assisted Living and Basic Care along with their similarities and differences provides education to both providers and residents on which setting may best meet an individual's needs. Understanding the difference and requirements for each other is necessary for providers as they establish or renew their license for either or both Assisted Living and Basic Care. Training and education also allow the State to share any changes made to the licensing requirements in a uniform way to reach providers, staff, and other stakeholders.
 **Eligibility**	As individuals and/or their families are exploring options for care, training and other educational materials can be beneficial in describing the differences between Assisted Living and Basic Care, including the eligibility for each. If there are other updates or changes to eligibility, including updates to policies that impact eligibility, this provides an opportunity to provide education in a streamlined manner to those who may be impacted and/or interested.
 **Rate Setting**	Based on the recommendations adopted and implemented from this report by the State, training, and education materials on changes to the program, including any changes to policy and procedure for rate setting, or changes to the rate setting/ reimbursement methodology is important to disseminate to providers.

[28] Minnesota Statue, Chapter 144G.63 Assisted Living – Staffing Requirements, Orientation and Annual Training Requirements, https://www.revisor.mn.gov/statutes/cite/144G/pdf

Topic	Description
 **HCBS Settings Rule**	With CMS's finalization of the HCBS Settings Rule and the focus on community integration, along with updates to policies and procedures, there is an opportunity to provide training and materials to providers and stakeholders to align with the HCBS Settings Rule in addition to the promotion of increased quality of life and experiences for individuals residing in Basic Care or Assisted Living. This training would cover the requirements of the rule, the work that HHS has already done to meet these requirements, and best practices from providers within the State and across the country.
 **Integrated Settings**	The Basic Care study and the corresponding recommendations provide an opportunity to enhance integration of the program within the community. Education and training allow for the awareness of importance of community integration and how it can meet the requested needs of residents, as discovered during resident focus groups and the opportunity to highlight best practices of integration both across the state and the country.
 **Continuum of Care**	Assisted Living and Basic Care are both important options within the continuum of care for older North Dakotans and North Dakotans with disabilities. North Dakota's Basic Care program provides an opportunity to provide affordable housing and services as an option for lower income adults who do not meet the level of care requirements for nursing facilities but require some assistance.
 **Behavioral Health**	Stakeholders, including providers and residents, have expressed concerns about the growing number of individuals with behavioral health care needs residing in Basic Care. Training, such as Mental Health First Aid, equips staff with the skills to recognize and respond to signs of mental health and substance use disorders. It also provides strategies to help individuals experiencing a behavioral health crisis and prevent such crises from occurring. Additional training and materials specific to North Dakota can be developed, incorporating the state's efforts to increase awareness and expand options for services and supports for those with behavioral health conditions. Resources like the Human Service Centers and the 988 Suicide and Crisis Lifeline must also be included.

Implementation Considerations

The State would benefit from creating a work group to lead the development and implementation of the training and materials specific to Basic Care and Assisted Living. HHS should assure that any Assisted Living and Basic Care trainings align to the broader training and professional development resources available for HCBS and long-term services and supports in North Dakota. The State should consider the differences in size and geographic location of the Assisted Living and Basic Care facilities to tailor components of the universal training as not all community services and resources may not be consistently available across the state.

Recommendation #4: Adopt strategies to improve and expand the current service and programmatic array within Assisted Living and Basic Care to integrate residents more comprehensively into the community.

Throughout the study, residents and stakeholders provided insights on how the Basic Care program meets residents' needs, as well as areas where there are opportunities to expand the service offering to promote and increase community integration. Discussions with State staff and providers highlighted the need for partnerships and assistance from community-based behavioral health services. Currently, Basic Care facilities serve as a form of service-enhanced affordable housing for many residents. Stakeholders also expressed interest in providing a Basic Care type service package in other settings to meet individuals where they are and enhance community integration.

Guidehouse recommends that HHS update the current services offered within Assisted Living and Basic Care to adopt a holistic approach that addresses individual's needs, increases community integration, and pilots alternative ways and settings to deliver Assisted Living and Basic Care services. These updates can include adding additional services to the program, integrating an Assisted Living and/or Basic Care service package with existing community programs, piloting a Basic Care service package in supported housing settings, and expansion of the Basic Care Assistance Program (BCAP) to pay for supported housing outside of room and board at a Basic Care facility.

Based on the review of the existing program and input received from residents, providers, and stakeholders, the following strategies are recommended for expansion:

- **Partnership and cross-training with community behavioral health providers:** The most commonly reported challenge identified during provider conversations and stakeholder meetings was providing care and support for residents with a behavioral health diagnosis. HHS and the facilities can consider developing partnerships with community behavioral health partners and the statewide network of Human Service Centers (to be known as community behavioral health clinics). This would involve connecting facilities with their community providers to provide information and training on Assisted Living and Basic Care and the services available to residents. It would also create an opportunity for facilities to discuss their specific challenges in providing care for individuals with behavioral health care needs and find ways to person and community specific ways to address the needs of residents.
- **Prioritize community integration through developing partnerships and linking with community-based networks**: To enhance community integration and address the desires of individuals residing in Basic Care, facilities should establish connections with local aging and disability service networks. Some facilities already have partnerships with local senior centers, and some residents participate in these programs. Guidehouse recommends identifying and promoting these partnerships as best practices.
- **Pilot a Housing with Supports program with a provider of rent-subsidized housing:** Guidehouse suggests that HHS pilot a Housing with Supports program in collaboration with a local provider of rent-subsidized housing. This approach could address the lack of housing for individuals with intermediate to severe behavioral healthcare needs by offering an Assisted Living or Basic Care type service package in affordable housing settings across the state. Stakeholders have reported that Basic Care facilities are increasingly becoming the

housing solution for low-income individuals with behavioral health conditions in certain areas. Several resident focus groups have highlighted the negative impact on quality of life when Basic Care recipients have these behavioral health conditions, such as violent outbursts, bullying, and manipulative behaviors. Currently, Basic Care is not designed to provide behavioral healthcare, and staff are not adequately trained for this population's needs.

One model to consider is the Affordable Assisted Living Program in Maine, where the State partners with Public Housing Authorities (PHAs) to provide housing and a package of services for low-income adults in need of supports. Residents pay for housing through various means, such as savings, Supplemental Security Income (SSI), or rental assistance. For North Dakota, the BCAP could be utilized for housing assistance. Services are subsidized through state-funded contracts. These services include personal care, medication administration, homemaker services, meals, and emergency response systems. Affordable Assisted Living Facilities (AALFs) also provide service coordination, housekeeping services, assistance with daily living activities, one nutritious meal a day, and chore services. Approximately half of the AALF residents receive rental assistance through the Department of Housing and Urban Development (HUD), while others have their rent determined based on their monthly income. It is important to note that room and board costs are not covered by Medicaid but in North Dakota, could be covered by the state funded BCAP.

Table 23. Recommendations #4 Topic Areas Impacted

Topic	Description
 **HCBS Settings Rule**	The HCBS Settings Rule ensures that people who receive services and supports through Medicaid's HCBS programs have full access to the benefits of living in the community and receive services in the most integrated setting possible.[29] Although Basic Care is not required to comply with the HCBS Settings Rule due to its payment source, it is considered by many as an alternative to institutionalization. The State is committed to promoting access to community living and services in integrated settings. This recommendation builds on the existing efforts of HHS and the State to ensure that Basic Care residents have access to the broader community. Additionally, the partnership and cross-training with Human Service Centers can enhance provider knowledge and support for residents with behavioral health conditions. This collaboration enables staff to improve their ability to interact with and assist residents, ultimately enhancing person-centered planning.
 **Integrated Settings**	Through the pilot project with a provider of subsidized housing, HHS can explore providing an Assisted Living or Basic Care type service package in additional integrated settings. This ensures that those who need services can receive them in a location where they are fully integrated within their community. In addition, building relationships with current community programs fosters integration while meeting the wants of increased community engagement and a variety in activities expressed by current residents during focus groups and telephone interviews.

[29] Home & Community Based Services Final Regulation, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

Topic	Description
 **Continuum of Care**	The activities suggested as part of this recommendation reinforce the importance of Assisted Living and Basic Care in the continuum of care for older adults and adults with a disability while providing the opportunity to remain fully integrated in the community of their choice. The role of Assisted Living and Basic Care may also be expanded in the continuum of care through a provider of subsidized housing partnership to allow for North Dakotans to access Assisted Living and/or Basic Care service packages at various settings within the continuum of care and at the time that they need to.
 **Behavioral Health**	Developing a strong relationship with the Human Service Center provides the opportunity for the care needs of residents with a behavioral health condition to be addressed sooner in a streamlined manner. Stakeholders expressed that the Human Service Centers have the training and services that individuals residing in Assisted Living or Basic Care need and are part of the community, making it an ideal location for individuals residing in Assisted Living or Basic Care to receive services and supports. In conjunction with the behavioral health training for facility staff as described in Recommendation #3, the partnership with Human Service Centers would create a strong wraparound of support for individual residing in Assisted Living or Basic Care with behavioral health conditions.

Implementation Considerations

Should HHS enhance and expand the current service array as recommended, the program and the broader network of providers who deliver these services will be better able to address the holistic needs of residents. Integrating with existing programs in the community provides the opportunity for individuals residing in assisted living or Basic Care to connect with an expanded network to offer residents additional social activities, community resources, and greater social interaction, for those who seek it. This integration may also create more capacity to support individuals with behavioral health needs.

Recommendation #5: Update regulatory oversight process based on implementation of recommendations.

Meetings with State staff and focus groups have highlighted how important it is for the State to provide routine regulatory oversight of licensed facilities as a core responsibility and expectation associated with licensure, including both Assisted Living and Basic Care facilities. These discussions have emphasized the need for more effective and proactive (i.e., not solely complaint driven) monitoring that is focused on the key elements of facility licensure, as well as the importance of investing in the staff resources that are required for such oversight.

In light of the recommendations outlined in this report, the State should conduct a comprehensive review of its regulatory oversight practices. Currently, oversight is conducted by several different entities, leading to potential redundancy and inefficiencies. This review should focus on identifying and eliminating redundant activities and streamlining oversight processes to promote a more cohesive and efficient regulatory framework.

By conducting this comprehensive review, the State has an opportunity to update and refine its oversight processes to effectively encompass and support the necessary changes in the Basic

Care and Assisted Living programs. This presents an opportunity to incorporate new procedures or steps that are essential for effective oversight of the implemented changes. Re-evaluating oversight practices in conjunction with these recommendations will enable HHS to establish a regulatory framework that is robust, adequately staffed, and responsive to the evolving needs of the Basic Care and Assisted Living programs and working towards compliance with the HCBS Settings Rule. This streamlined approach will provide for regulatory efforts that are both effective and efficient, ultimately enhancing the quality of care provided to residents.

Following the review, the State should update the regulatory oversight process to address the outcomes and gaps identified through the review. As well as adding in processes to promote the movement towards alignment with the HCBS Settings Rule. Necessary staff and resources will be required in order to meet the need of regulatory oversight changes as well as to allow for the implementation and continued monitoring of the Basic Care and Assisted Living program.

The review of North Dakota's policies revealed that the current policy lacks specific language explaining the regulatory oversight process for the Basic Care program. In our analysis, we examined how other states oversee their Assisted Living programs as a comparison. Examples include the following:

- **South Dakota (Medication Management and Follow-up: Methods of State Oversight and Follow-up):**[30] The Department of Health in South Dakota has a survey team that conducts facility tours and interacts with residents to gain an overall understanding of the environment and identify areas of focus. The team collects observations, conducts interviews, and reviews residents' care records to assess compliance. They also hold Exit Conferences with the facilities to discuss any non-compliance findings and provide necessary technical assistance.
    - As part of the pre-survey tasks, the survey team leader reviews previous deficiencies and the facility's plan of correction, any complaints received since the last survey, and information about relevant operational changes.
    - Facilities may be surveyed more frequently if there are complaints related to potentially harmful medication administration practices.
    - Survey team leader reviews copy of deficiencies and plan of correction from prior survey for each facility, any complaints since the last survey and information about relevant operational changes as pre-survey tasks.
- **Idaho (Facility Inspections):**[31] The Licensing Agency in Idaho conducts inspections and investigations at specified intervals to assess compliance with the rules.
    - Facilities without any major deficiencies in two consecutive surveys are inspected at least every thirty-six months.
    - Facilities with major deficiencies are inspected at least every twelve months.

[30] SD Home and Community-Based Options and Person Centered Excellence (HOPE) Waiver (0189.R07.00) | Medicaid
[31] IDAPA 16 - Department of Health and Welfare.book (idaho.gov)

These examples illustrate two approaches used by states to provide for regulatory oversight and compliance in Assisted Living programs. Table 24 provides a summary of the topic areas impacted by Recommendation #5.

Table 24. Recommendation #5 Topic Areas Impacted

Topic	Description
 **Licensing Requirements**	Updates to the ongoing monitoring efforts that are part of the state's regulatory oversight process for basic care and Assisted Living will require correlated adjustments in facility licensing requirements. This includes reviewing and potentially revising the policies and procedures that facilities must adhere to as part of their licensure.
 **HCBS Settings Rule**	Updating the regulatory oversight process enhances the State's ability to monitor and track compliance with the HCBS Settings Rule and offer guidance and support to those that are not in compliance. To do so, the State will need adequate staffing to carry out this process (e.g., conduct surveys, quality assurance reviews, etc.). While the HCBS Settings Rule is mandatory for services provided under the 1915(c) and 1915(i) Waivers, states have the option to extend its application to Medicaid State Plan HCBS, either fully or partially. Through an updated monitoring process, the State can gain a better understanding of each facility's adherence to, and transition towards, compliance with the HCBS Settings Rule. This will further enhance people's ability to live in the most integrated and least restrictive settings possible, tailored to their needs.

Implementation Considerations

Should HHS decide to implement any of the proposed recommendations and review the oversight processes, it would be beneficial for the HHS to establish committees to review the changes, oversee the process, and implement necessary modifications. For instance, if the State decides to create a new licensure type that covers both Assisted Living and Basic Care facilities (Recommendation #1), a licensure committee would be beneficial to review and update the range of oversight processes that will need to align with this change. These committees can include but are not limited to HHS staff, providers, and facility administrators.

Recommendation #6: Implement quality improvement initiative requirements for Basic Care and assisted living facilities to improve quality of care and align facilities with best practices.

Stakeholders have emphasized the need for a process to promote and enhance the provision of quality care in the Basic Care program, meet State requirements, and protect residents. Although Quality Assurance and Performance Improvement (QAPI) processes are not currently required for Basic Care or Assisted Living providers as they are for Nursing Facilities[32] and Managed Care Organizations[33], implementing a QAPI program is beneficial for ensuring quality and resident protections. Guidehouse recommends that HHS consider requiring Assisted Living and Basic Care facilities to adopt formal Quality Assurance and Performance Improvement

[32] Code of Federal Regulations, Quality Assurance and Performance Improvement, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.75
[33] Social Security, Provisions Relating to Managed Care, https://www.ssa.gov/OP_Home/ssact/title19/1932.htm

(QAPI) initiatives. These initiatives, which have already proven successful in other providers' experiences, can also be instrumental in facilitating the transition to full compliance with the HCBS Settings Rule. This can be achieved through updates to policies and procedures, with ongoing monitoring through programmatic oversight as described in Recommendation #5. The adoption of QAPI initiatives will promote continuous improvement and adherence to the HCBS Settings Rule.

The recently finalized rule by the Centers for Medicare & Medicaid Services (CMS), "Ensuring Access to Medicaid Services,"[34] aims to improve access to care, quality, health outcomes, and health equity for Medicaid beneficiaries. The rule includes provisions for strengthening person-centered service planning, incident management, establishing grievance systems, and implementing a new strategy for oversight, monitoring, quality assurance, and quality improvement in HCBS programs, among other topics. Individuals residing in Basic Care or Assisted Living are afforded a set of Rights and should have care provided in a person-centered manner (See Recommendation #2, Table 21 for proposed revisions to Resident Rights policy). By implementing the recommendation for quality improvement initiatives, the State will position itself to align with the rule once it is fully enacted by CMS.

Integrating best practices and federal guidelines into daily operations will enable Assisted Living and Basic Care facilities to enhance care quality, effectively meet individuals' needs, and foster an environment dedicated to continuous improvement and excellence in care provision. One option to expand quality improvement initiatives across Assisted Living and Basic Care is to extend the use of the National Core Indicator – Aging and Disability (NCI-AD) survey to Assisted Living and Basic Care facilities. The NCI-AD surveys older adults and people with disabilities on how publicly funded services and supports impact their quality of life through indicates such as community engagement, independence, decision-making, self-direction, and other person-centered components.[35]

Through the comparison state policy review and analysis, we identified several states that have established quality assurance processes and procedures. Although these states do not have Basic Care programs, valuable lessons can be drawn from their practices and adapted to suit North Dakota's Basic Care program.

- **Minnesota:** Requires facilities to incorporate quality management appropriate to the size of the facility and relevant to the type of services provided. Quality management activities include evaluating the quality of care by reviewing individual services, complaints made, and other issues that have occurred. The State also requires facilities to conduct satisfaction surveys with residents. These surveys must be conducted at least once every two years.
- **South Dakota:** Requires facilities to conduct quality assessment evaluations. Each facility shall conduct on-going evaluation of the quality of services provided to residents. Components of the quality assessment evaluation shall include establishment of facility standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body.

[34] Medicaid, Access to Care, https://www.medicaid.gov/medicaid/access-care/index.html
[35] National Core Indicators, https://nci-ad.org/about/the-surveys/

- **Washington:** Requires each facility to have its own Quality Assurance Committee, which meets quarterly to address quality-related initiatives or challenges. The committee must include a licensed registered nurse, the administrator, and three staff members.

By implementing quality improvement initiatives and learning from these comparison states, North Dakota's Basic Care program can enhance its commitment to quality care and align with best practices. Table 25 below provides a summary of the topic areas impacted by Recommendation #6.

Table 25. Recommendation #6 Topic Areas Impacted

Topic	Description
Licensing Requirements	Implementing quality improvement initiatives can enhance compliance with licensure requirements and promote continuous improvement in Assisted Living and Basic Care facilities. This recommendation provides an avenue for facilities to voluntarily implement person-centered approaches and community integration, further enhancing the quality of care provided.
HCBS Settings Rule	Quality Assurance and Performance Improvement (QAPI) initiatives serve as a powerful tool for facilities to not only meet and exceed the requirements of the HCBS Settings Rule on community integration, but also to facilitate their transition to full compliance. These initiatives can be leveraged to enhance specific areas within each facility, address systemic issues, and promote a smooth transition to full compliance with the HCBS Settings Rule.
Integrated Settings	Possible QAPI initiatives may include piloting Assisted Living and/or Basic Care type service packages in non-traditional settings through approval from HHS and potential partnerships with local public housing authorities and/or other housing providers. Additionally, traditional providers can focus on initiatives enhancing engagement with the greater community and expanding community integration for individuals residing in Assisted Living or Basic Care.
Continuum of Care	QAPI initiatives further solidify the role Assisted Living and Basic Care plays within the continuum of care in North Dakota. Initiatives could also expand the role Assisted Living and Basic Care plays within the community by exploring ways to provide services and supports for the greater community.
Behavioral Health	Facilities can implement quality improvement initiatives that address the growing behavioral and mental health needs of residents in innovative ways. This recommendation allows facilities to tailor QAPI programs around behavioral/mental health based on the specific population they serve in different areas of the state.

Implementation Considerations

Should HHS decide to implement quality improvement initiatives, the State would benefit from working closely with providers to identify policy initiatives that focus on current challenges in Assisted Living and Basic Care that can improve the experience and care of individuals. In addition, HHS will need to consider ways to monitor these initiatives to assess how

improvement is being made. Depending on the methodology HHS chooses to implement quality improvement initiatives, updates to Administrative Code for Basic Care and/or Assisted Living may be necessary.

Recommendation #7: Update regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs.

Currently, inflation factor is directed by the Legislative Assembly and as noted in the analysis in Section 2.3, has typically been comparable to public indexes. Fluctuations associated with biennial budget decisions can have long term impacts on service providers. Tying inflation to a publicly available index will help prevent these impacts, allow for easier financial forecasting for facilities, and reduce some of the volatility seen in the analysis of historical data.

As shown in the earlier analysis, recent trend data indicates that legislatively approved inflationary adjustments are usually commensurate with the SNF Market Basket index. However, when inflationary adjustments in state appropriations are not in alignment with overall market indicators, underpayment can occur in two ways. First, since prospective rates are based on historical costs and are intended to reflect costs for the period the rates are in effect, the calculated rates are trended appropriately (usually upward) to reflect anticipated change. If the trending factor is not in alignment with the observed trend, it may not keep pace with actual changes in costs from year to year, and payments may fall below what service providers consider to be financially sustainable. Second, the limits applied during rate setting are also trended in the same way. If the trend is not in alignment, the limits may be lower than the designated percentage of the median. This misalignment would be compounded with future trending until the limits are rebased.

In Section 2.3, Guidehouse identified several publicly available indexes that are potentially applicable to the Basic Care setting. Of these options, we note that two may be particularly appropriate: CMS Market Basket – SNF or CPI-U for Nursing Facilities. While there are significant differences in the cost structures of SNF and Basic Care, when considering the specific types of costs that drive the costs of service delivery, our view is that the similarities in expense between the two settings are more important than the differences. Below we discuss some of relative merits of each index.

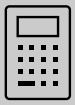
CMS Market Basket – SNF is more applicable to Basic Care in some respects since it is based on actual changes in cost rather than payments for particular items. As illustrated in the earlier analysis, this characteristic results in less volatility than CPI-U. Additionally, CMS forecasts this index out for ten years, allowing for easier implementation in prospective payment systems such as North Dakota Basic Care. However, the CMS Market Basket is only calculated at the national level and is designed to meet the policy needs of Medicare. Regional cost disparities or programmatic differences between Medicare and the North Dakota system may be sufficient to warrant an alternative.

CPI-U for Nursing Facilities has the advantage of incorporating regional level data, increasing applicability to the unique cost circumstances encountered by North Dakota providers. Furthermore, CPI-U is generally more widely used in healthcare and other settings familiar to stakeholders and decision-makers. While CPI-U data does not include forecasted indices, there are multiple accepted methods of forecasting, and this flexibility can be a virtue for

implementation. Because CPI-U is driven by payments, however, it is more susceptible to volatility and can present issues in provider budgeting.

Table 26, below, describes the topic area impacted by this recommendation.

Table 26. Recommendation #7 Topic Areas Impacted

Topic	Description
 **Rate Setting**	Tying inflation to a publicly available index may help prevent adverse fiscal impacts on financial sustainability of service providers and allow for easier financial forecasting for facilities. It would also be expected to improve the effectiveness of rate limits.

Implementation Considerations

Although Guidehouse recommends inclusion of a regular cost trend into state rate updates based on a transparent, publicly available index, we also understand that ultimate authority for rate changes for the program resides with the Legislative Assembly, and inflationary increases are subject to legislative determination.

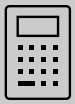
Recommendation #8: Implement a Fair Rental Value (FRV) methodology to reimburse Basic Care provider property costs.

North Dakota Basic Care providers are currently reimbursed for their property costs according to a traditional cost accounting and depreciation method. As indicated in the analysis in Section 2.3, property costs vary considerably among providers, and disparate ownership and property conditions result in a wide range of reimbursement, and the mechanics of the current methodology may disincentivize providers from taking on the financial risk of renovations, due to lags between incurring expenses and receiving payments.

Guidehouse recommends that North Dakota adopt an alternative Fair Rental Value (FRV) methodology over the current approach. FRV has several merits for both payers and providers and is especially valuable for its flexibility to address a variety of system needs. It differentiates reimbursement based on age and condition as well as provide incentives to invest capital in improvements or replacements. It would also provide a more equitable and consistent method to compensate facilities for the value of an individual's tenure. Specifically, Guidehouse recommends that the State consider using an FRV approach to incentivize financing modern housing environments while controlling costs to target essential capital priorities. The mechanics of the FRV methodology support distinct levers to implement separate payment levels for different types of living units and/or property amenities, and can include or exclude other cost factors, such as rurality, depending on whether they prove to be substantial or trivial under different circumstances. Lastly, feedback received in stakeholder meetings points to a strong desire by the providers to move to an FRV payment method similar to what was implemented for nursing facilities.

The topic area impacted by this recommendation is described in Table 27.

Table 27. Recommendation #8 Topic Areas Impacted

Topic	Description
 **Rate Setting**	An FRV methodology would provide a more equitable and consistent method to compensate facilities for the property value of an individual's housing environment. It would also incentivize financing modern facilities while controlling costs to target essential capital priorities.

Implementation Considerations

Implementation of FRV represents a significant overhaul of the State's property component methodology, so there are many options to consider. The simplest approach would establish a single rate assumption for all Basic Care units. Alternatively, it could be advantageous to establish different rates based on type of living unit and/or property amenities, as well as distinctions in geographic location or ownership affiliation. Individual providers may present special circumstances for square footage, land value, equipment value, or other intangible costs.

Once in place, an FRV approach is appreciated for its transparency. However, implementation of FRV reimbursement can be complicated and time-consuming in the initial policy and rate development it requires, both for state agencies and providers. Once needed baseline data is gathered and rates are set, though, year-over-year update typically involves less administrative burden, data gathering requirements, and calculation processes than traditional cost-based rates.

The first step of an FRV methodology is to collect baseline provider data on beds or "rooms" (a.k.a. living units) in the system, which typically consists of surveys and informational provider meetings to support data collection and identify potential differences in the various types of living units that may need to be acknowledged in the reimbursement framework. Once types are established, the number and characteristics of the various types of living units/arrangements are surveyed for each provider and are then categorized into levels and validated as accurate and active. Validation of information can be folded into licensure or handled separately through other means such as inspections or blueprint submission.

For subsequent years, the State would need to develop a process and establish requirements by which providers would qualify for modifications to their FRV rates based on renovations, room repurposing or other updates/changes a provider may make to the facility which could impact the FRV. An incentive for certain types of living units or amenities could be incorporated into the methodology. For example, rooms with private bathrooms may be incentivized over shared bathroom spaces.

Rental values for each type of living unit are then determined based on initial policies. This is an in-depth process that combines multiple components. A base value for the living units in a particular property (housing environment) must be established. This valuation may be done through an appraisal, whether commercial, individual property appraisals or proxy appraisals using standardized values. The appraisal calculates market values for construction,

maintenance, and land values. Additional information can be obtained from cost surveys of newly constructed or renovated properties either in-state or in neighboring/peer states.

Per-living-unit rental values are affected by the age of the property. A living unit built 25 years ago will likely have a lower rental value than a newly built living unit, and a depreciation schedule must be adopted to gauge the rate of value decrease acceptable to stakeholders. An example schedule may decrease the rental value of a living unit by 1.5 percent per year. Depending on policy priorities, aging can be valued on a graduated schedule, with the year-over-year percentages varying across the lifespan of the building. A depreciation rate too low does not promote renovation, but a high rate can reduce the economic value and effectiveness of the rates.

Rental percentages are calculated once the per-living-unit values and depreciation have been determined, and this value consists of the percentage of the rental value used to calculate annual reimbursement rates. The value is derived from a combination of market research, provider surveys, and budget considerations.

In addition to the base value and rental rate, adjustments can be made for individual provider considerations including interest, interest rates, mortgage balances, risk factors, and return on equity to get the final annual amount eligible for reimbursement. This final amount is then used to determine the per day amount for this rate component.

Lastly, when first implementing an FRV reimbursement method, payers may choose to implement risk corridors that limit the change in reimbursement on an individual provider basis. In this scenario, the payment rate may only change a given percentage from the previous rate or the current cost per day amount. This prevents large shifts in payment for both the providers and HHS.

Recommendation #9: Implement tiered add-on payments for residents with increased ADLs service need and align reimbursement methodologies.

Based on feedback in the stakeholder meetings, providers are seeing higher ADL needs for incoming residents. One of the identified factors driving these trends is the fact that individuals are staying home longer before becoming a resident. An individual's desire to defer a move often results in what providers experience as increased levels of acuity at the point an individual does choose to move into a basic care living arrangement. The potential increased types of services needed can present operational and financial challenges for providers, especially when current payment assumptions may not be aligned to individual needs.

To help address the costs of providing the types of services needed, Guidehouse recommends add-on payments under a three-tier structure for the Basic Care service package bundled payment rate. These tiers would utilize an assessment score to tier mapping. Scores that include particular combinations of different categories would be included in higher tiers such as combinations of ADLs and IADLs. Further analysis of the possible assessment mappings should be performed to enable a reasonable population distribution in higher tiers to allow for rates that address resident's service needs.

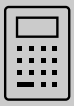
An example of what an implementation may look like can be found below:

- **Base Tier** – Residents that either do not qualify for a higher tier or have not been assessed
- **Tier 1** – 25 percent to 40 percent of residents, $(X) per day increase
    - Residents with clinically complex ADL scores of 4 or 5 and an IADL score of at least 1.
- **Tier 2** – 5 percent to 10 percent of residents, $(Y) per day increase
    - Residents with Cognitive Performance Scale scores of 3 or more and the above ADL and IADL scores
    - Residents that receive at least 120 minutes of rehabilitative therapy weekly, have an ADL score between 4 and 10, and have an IADL score of at least 1.

As part of this recommendation and in alignment with Recommendation #1, which advocates for moving to one licensure type to encompass services packages covering Assisted Living, Basic Care, and Specialized Basic Care, we recommend aligning the reimbursement methodology of Specialized Basic Care with the current and proposed methodologies of Basic Care reimbursement. This alignment will increase transparency and reduce the administrative burden for providers and the State in determining and setting rates. We suggest that Specialized Basic Care adhere to North Dakota Administrative Code Chapter 75-02-07.1, which pertains to rate setting for Basic Care facilities. This alignment will also simplify the process for facilities by requiring only one annual cost report.

Table 28, below, describes the topic area impacted by this recommendation.

Table 28. Recommendation #9 Topic Areas Impacted

Topic	Description
 **Rate Setting**	Add-on payments would offset potential financial risk for providers who accept new residents that may have higher levels of care. Additionally, it would reduce barriers people may face today as they consider a move to a property that offers Basic Care services.
 **HCBS Settings Rule**	The shift of Specialized Basic Care to State Plan services aligns all of Basic Care under one funding source thus aligning the federal requirements to which facilities may be required to be in compliance with.
 **Continuum of Care**	For providers offering both Basic Care and Specialized Basic Care, the alignment of reimbursement methodology can reduce the administrative burden for providers allowing for an increase focus on care. By also using the same reimbursement methodology, the focus remains on the individual receiving care and meeting their need where they are at within their continuum of care.

Implementation Considerations

Assessments are currently only completed for Basic Care residents who are receiving services through Medicaid. The State will need to consider how and by who individual assessments will be completed prior to implementing this recommendation. Assessments would need to be completed on all individuals residing at the location, or at least individuals that qualify for an elevated tier, regardless of the payment source for the services they receive. Time to allow for the mapping of the current assessment would also need to be considered. Initial tier mapping can be based on implementations in other states and modified as more data becomes available. The State can choose to continue the current practice of assessments being completed by the State for all individuals or explore the option of the facility or another third party completing the assessment.

Finally, the funding source of the rate increases will need to be determined. Typically, the funds come from some combination of newly appropriated funds (new money) and withholds from the current provider rates. As an example, for a projected overall increase of three percent of total projected payments, 1.5 percent can be new money, and the other 1.5 percent can come from an equal reduction (withhold) of all provider rates by the same margin.

If the State aligns reimbursement methodologies for Specialized Basic Care with Basic Care reimbursement methodologies, HHS will need to provide education and training for current Specialized Basic Care facilities on cost reporting currently done under Basic Care. Updates to Administrative and Century Code will also need to be updated to reflect the alignment.

Recommendation and Key Topic Areas

Through the policy review and comparison state research, data analysis on current and options for rate methodology, and stakeholder engagement, Guidehouse developed the eight recommendations presented in this report. All recommendations considered the key topics areas HHS identified at the start of the study. Table 29, below, shows each recommendation and the key topic area that may be impacted by the implementation of the recommendation.

Table 29. Basic Care Study Recommendations and Key Topic Areas

Recommendation	Licensing Requirements	Eligibility	Rate Setting	HCBS Settings Rule	Integrated Settings	Continuum of Care	Behavioral Health
1. Streamline licensing by creating a new single licensure type to cover both assisted living and Basic Care facilities.	X			X	X	X	

Recommendation	Licensing Requirements	Eligibility	Rate Setting	HCBS Settings Rule	Integrated Settings	Continuum of Care	Behavioral Health
2. Strengthen existing assisted living and Basic Care policy and create additional policies to reflect current requirements within the program, incorporate best practices, and align with State and federal requirements, as applicable.	X	X	X	X	X	X	X
3. Develop and implement State-led universal assisted living and Basic Care training and materials to educate all stakeholders.	X	X	X	X	X	X	X
4. Adopt strategies to improve and expand the current service and programmatic array within Basic Care to integrate residents more comprehensively into the community.				X	X	X	X
5. Update regulatory oversight process based on implementation of recommendations.	X			X			
6. Implement quality improvement initiative requirements for Basic Care facilities to improve quality of care and align facilities with best practices.	X			X	X	X	X
7. Update regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs.	X		X				
8. Implement a Fair Rental Value (FRV) methodology to reimburse Basic Care provider property costs.			X				
9. Implement tiered add-on payments for residents with increased ADLs care need and align reimbursement methodologies.			X	X		X	

Appendix A: Letter to Facility Administrator about Resident Focus Group

Dear [Residential Coordinator / Administrator]

The North Dakota Department of Health and Human Services (HHS) has contracted with Guidehouse to study the Basic Care Program. The 2023 Legislative Assembly authorized HHS to conduct a study of "the Basic Care system and the licensure and regulation of Basic Care and assisted living facilities." In this part of the study, we are conducting a series of resident engagement focus groups and interviews with a randomly selected group of Basic Care Program residents. The purpose of the focus groups is to gather resident input on their experience with the Basic Care Program. This is an opportunity for the study to hear directly from the residents on their thoughts on the program model.

We will be asking approximately 10 of your residents, all who are randomly selected, to participate. All participation is voluntary.

We are seeking your assistance in notifying the randomly selected residents. Please help them understand the purpose of the study and encourage their participation. Key points to convey include:

- The study aims to identify strengths and areas for improvement in the program, offering residents a chance to provide valuable insights for the benefit of future older adults in North Dakota.
- Rest assured that neither State nor provider staff will attend; all input is confidential and anonymous.
- The team comprises professionals experienced in services for older adults, ensuring the discussion will be conversational and informal.
- Your input as a resident is important, and providers and program staff statewide are wanting to hear your feedback.

We are proposing hosting the focus group on [DATE] at [TIME]. We will also request assistance in identifying and securing an appropriate meeting space.

We will provide a follow up secure email with the list of randomly selected residents to participate and the resident notification letter. We will also be following up with a phone call to answer any questions.

In addition, we would like to also schedule time to speak with you or an identified staff member to hear your feedback on the Basic Care Program.

Thank you for your assistance with this important initiative. Please let us know if you have any questions.

Thanks,

Appendix B: Resident Focus Group and Telephone Interview Questions

General Information and Satisfaction

- How long have you lived here?
- Why did you move to this Basic Care Facility?
- Why did you choose Basic Care over other options like assisted living or in-home services?
- What do you like about living here?
- What do you not like about living here?
- If you could 'wave a magic wand' and change anything about living here, what would it be?

Care and Daily Routine

- What services / care do you receive here? Which ones are most important to you?
- Are you able to choose your own daily schedule?
- Are there services you feel are missing or that you would like more of?
- Do you feel there is enough staff at the facility to provide care?

Safety, Privacy, and Autonomy

- Do you have enough privacy where you live? Can you describe what privacy looks like for you?
- Do you feel your personal opinions and preferences are considered in your care?
- Do you feel that staff members respect and listen to you?
- Do you feel like you're a part of the community, both here and outside?
- Do you feel comfortable talking with the staff if you have questions or concerns?

Transition and Choice

- Where did you live before moving here?
- Have you had to move into a different room since being here, what caused you to have to move?
- Could you share any challenges or positive experiences you had during your transition to this facility?
- If you wanted to or needed to, do you feel like you could change where you live?

Appendix C: Letter to Randomly Selected Resident Focus Group Member

Dear Resident

The North Dakota Department of Health and Human Services (HHS), in partnership with Guidehouse, is studying the Basic Care Program. As part of the study, we will be talking to residents like you to learn about your experience living here and your ideas and thoughts on the Basic Care Program.

We would like to invite you to take part in a focus group on [DATE] at [TIME] to talk about the services you receive and your experience as part of the Basic Care Program. The conversation will talk place in a group with other residents in [INSERT ROOM/LOCATION] and last about an hour. Two staff members from Guidehouse will be part of the conversation. No staff from the North Dakota Department of Health and Human Services nor the Basic Care Facility will be in attendance. You may opt to have a representative attend if you wish.

Participation is voluntary.

We are interested in hearing what you like or dislike about the Program. Your feedback is valuable and will be used to help inform the future of the Program. All responses will be kept anonymous and will have no impact on the services you receive.

The two staff members from Guidehouse that will be at your facility are:

- [Name 1]
- [Name 2]

Thank you for your participation.

Appendix D: Letter to Facility Administrator on Resident Telephone Interviews

Dear [Residential Coordinator / Administrator]

The North Dakota Department of Health and Human Services (HHS) has contracted with Guidehouse to study the Basic Care Program. HHS is conducting the study in response to Senate Bill 2283 passed by the 2023-25 Legislative Assembly, which required HHS to study "the basic care system and the licensure and regulation of basic care and assisted living facilities." In this part of the study, we are conducting a series of resident engagement telephonic interviews with a randomly selected group of Basic Care Program residents across the State. The purpose of the interviews is to gather resident input on their experience with the Basic Care Program. This is an opportunity for the study to hear directly from the residents on their thoughts on the program model.

We will be asking approximately **2** of your residents, all who are randomly selected, to participate. All participation is voluntary.

We are seeking your assistance in notifying the randomly selected residents. Please help them understand the purpose of the study and encourage their participation. Key points to convey include:

- The study aims to identify strengths and areas for improvement in the program, offering residents a chance to provide valuable insights for the benefit of future older adults in North Dakota.
- Rest assured that neither State nor provider staff will attend; all input is confidential and anonymous.
- The team comprises professionals experienced in services for older adults, ensuring the discussion will be conversational and informal.
- Your input as a resident is important, and providers statewide are wanting to hear your feedback.

We will be conducting these interviews between February 27th and March 8th. For your facility we will initially contact them on **Wednesday, February 27th in the morning**. If we are unable to reach them, we will try again on **Thursday, March 7th**.

We will also request assistance in identifying the most appropriate contact information for the randomly selected residents.

We will provide a follow up secure email with the list of randomly selected residents to participate and a copy of notification letter to distribute to each selected resident. We are also available via phone or email to answer any questions you may have.

Thank you for your assistance with this important initiative. Please let us know if you have any questions.