Guidehouse

State of North Dakota –

Department of Health and Human Services

Medical Services Division

Study of Basic Care and Assisted Living Final Report

September 10, 2024

NORTH Dakota Be Legendary. | Health & Human Services

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Our Team

Guidehouse Team Introductions

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Director – SME

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Director - SME

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Project Manager

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Associate Director –
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Managing Consultant –
Policy and Programmatic Lead

Guidehouse at a Glance

* Data Source: Definitive Healthcare
** Data Source: based on 2019 data from PharmExec
*** Data Source: 2019 S&P Global Platts Top 250 Global Energy Company Rankings®

GH-022-MP GH At-A-Glance-2021_001w-WideScreen

Guidehouse Health

2,700+ **Healthcare Management, Life Sciences, and Payer Consultants**

3,500+ **Managed Services Professionals**

- Actuaries
- Change Makers
- Clinicians
- Data Analysts
- Financial Managers
- Former Government Leaders
- Former Industry Executives
- Human Capital Experts
- Operators
- Pharmacists
- Physicians
- Policy Experts
- Researchers
- Revenue Cycle Specialists
- Scientists
- Strategists
- Technologists

350+ **Certified Project Management Professionals**

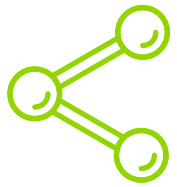
35+ **Certified Change Management Professionals**

Innovative, agile, and resilient strategies for each client's unique opportunities

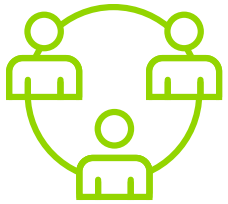
Mission-driven partner in financial, operational, and clinical transformation

Provider, public sector, payer and life sciences administrators, clinicians, and other experts with decades of frontline leadership experience

Deep Policy and Regulatory Expertise



Frontline and Administrative Leadership

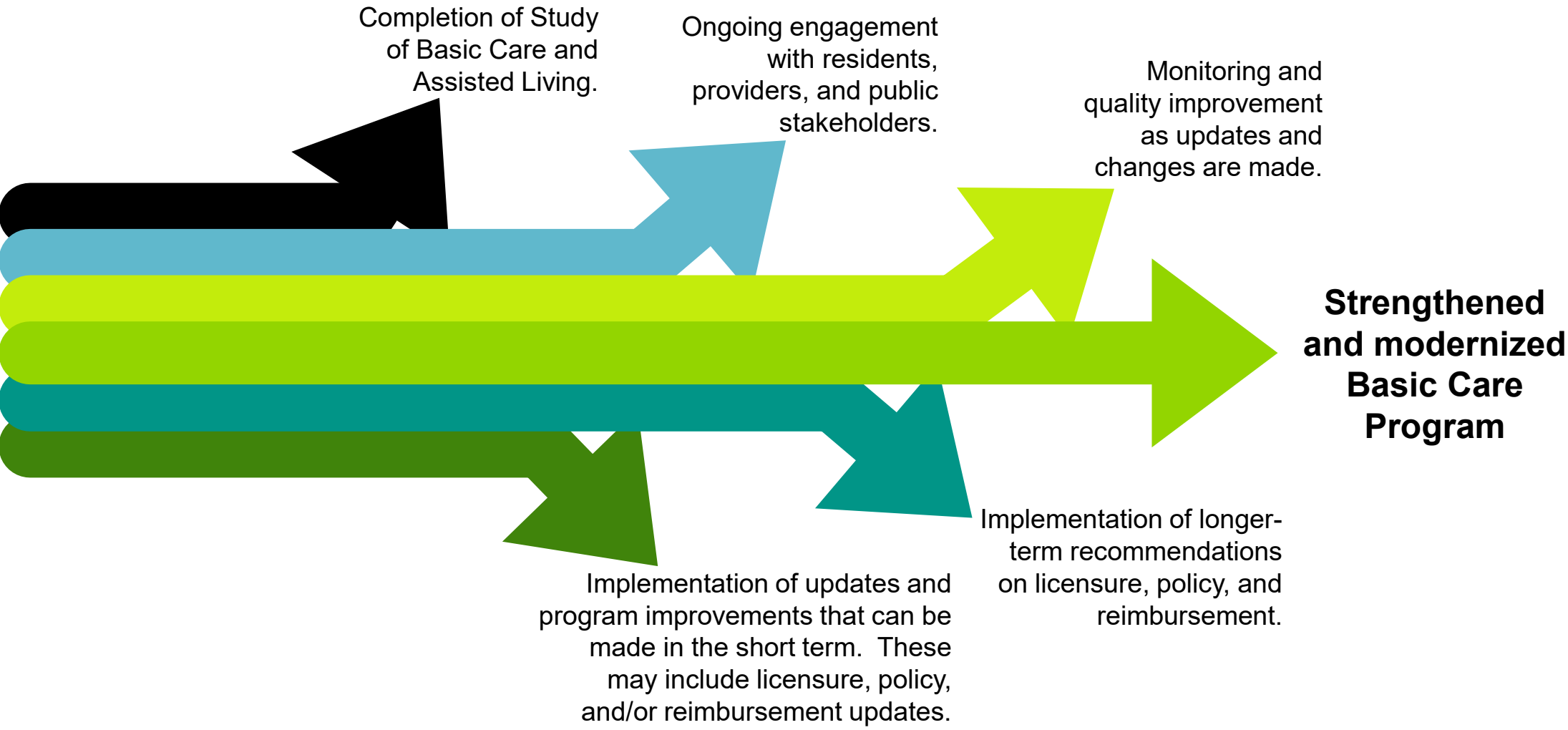


Cross-Sector and Industry Collaboration

Mission-Driven Strategy

Direction of Basic Care Program Evaluation

Direction of Basic Care Program Evaluation



Summary of Study

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 were 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 were 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.

Basic Care and Assisted Living Study Overview

Overview of our Approach to the Study

Task 1: Develop Work Plan

- Designate a Project Director
- Create a work plan and timeline
- Monthly progress updates

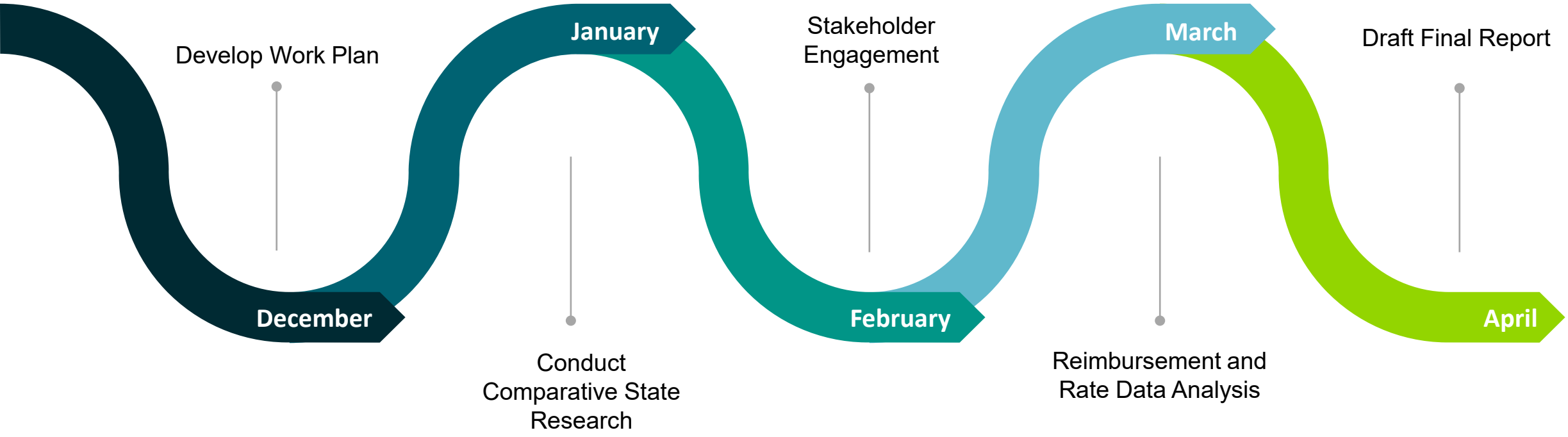
Task 2: Stakeholder Engagement

- Key State staff meetings
- In person public stakeholder meetings
- Virtual public stakeholder meetings
- Basic Care resident interviews
- Basic Care resident family member interviews

Task 3: Final Report

- State licensing requirements
- Rate setting
- Opportunities in permanent supported housing
- Issues of noncompliance with the HCBS settings rule
- Eligibility
- Gaps in options for those with serious mental illness
- Role of basic care in continuum of care

Study Timeline



Summary of Existing Basic Care and Assisted Living in North Dakota

Program History and Impetus for Study

The 1993 North Dakota Legislature created Basic Care as a state-funded residential facility option for lower income adults who do not meet level of care requirements for skilled nursing facilities. As of January 2024, there are 66 licensed Basic Care facilities with a total of 2,097 beds.

North Dakota utilizes state general funds to pay for a portion of the cost (room and board) of Basic Care for individuals who are Medicaid eligible. This rate is the Basic Care Assistance Program (PCAP). Medicaid State Plan Services covers resident care services and supplies, laundry, dietary services, and housekeeping salaries.

Basic Care is a growing setting that, on a private-pay basis, is often out of reach of moderate to low-income North Dakotans who need assistance with instrumental activities of daily living.

A workgroup met between November 2021 and March 2022 and came to consensus on how rate limits should be set and how often they should be rebased as well on uniform filing of cost reports. These items were adopted into law by the 2023 Legislative Assembly.

A study of acute psychiatric and residential care services was conducted during the 2021-22 legislative interim period that identified significant gaps in care options for adults with mental health needs and provided considerations and recommendations specific to geropsychiatry.

Senate Bill 2283 requires DHHS to study “the basic care system and the licensure and regulation of basic care and assisted living facilities.”

Study Activities and Methodologies

Study Activities and Methodologies

Mixed Methodology Approach

- Environmental Policy Scan
- Stakeholder Engagement
    - Resident Focus Groups
    - Administrator Conversations
    - Stakeholder Meeting
        - Program Administration
        - Licensure
        - Reimbursement
    - Key State Staff Meetings
        - Licensure
        - Continuum of Care
        - Reimbursement
        - Program Administration
    - Resident Telephone Interviews
    - Resident Family Member Telephone Interviews
- Critical Incident and Complaints Data Analysis
- Reimbursement and Rate Data Analysis

Environmental Policy Scan

Purpose:

- Gain a better understanding of the current policies and procedures that the State had in place for assisted living and the Basic Care program and comparing North Dakota's practices against those seen nationally.
- Consider how policy changes could best improve the Basic Care program by considering alternative state programs.
- Analysis informed the development of stakeholder interview topics and policy recommendations.

Comparison States: The analysis evaluated best practices from five other states programs and compared North Dakota's regulatory requirements to those other states.

1. Idaho
2. Minnesota
3. Montana
4. South Dakota
5. Washington

Comparison State Selection Criteria:

- *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.

Environmental Policy Scan

Policy Review Topics and Points of Comparison

1 Eligibility and Admissions

- Admissions and Discharge Criteria

2 Assessment and Care Planning

- Resident Assessment and Care Plans
- Person-Centered Planning and Documentation Requirements
- Participant Directed Services
- Allowable Services

3 Clinical Services

- Nursing Services
- Medication and Treatment Administration
- Individual Licensing, Qualification, and Certification Requirements
- Staffing Education Programs

4 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

5 Participant Rights and Protections

- Tenancy Rules
- Resident Rights
- Allowable Use of Resident Safeguards

6 Monitoring and Oversight Practices

- Response to Critical Events or Incidents
- Quality Assurance and Monitoring Activities
- Americans with Disabilities Act (ADA) Integration

7 Financial / Rate Policies

- Rate and Rate Calculation
- Financial Reporting Requirements
- Rate Rebasing

8 Issuance of Initial Licensure

- Requirements for New Construction or Initial Licensure
- Co-Located Services
- Appeals

Stakeholder Engagement

- Key State Staff Meetings
- Focus Groups – Basic Care Residents
- Telephone Interviews - Basic Care Resident
- Telephone Interviews – Family Members
- Interviews – Facility Administrators
- Stakeholder Meetings

Key State Staff Meetings

Approach

- Guidehouse hosted five (5) virtual meetings with key State staff during January 2024.
- Meetings 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.
- Additional ad hoc meetings were held, as needed, to clarify or gather additional detail.

Key State Staff Meetings

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.
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.

Basic Care Residents Focus Groups

Approach

- 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 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 questions covered four main areas:
  - General Information and Satisfaction
  - Care and Daily Routine
  - Safety, Privacy, and Autonomy, and
  - Transition and Choice

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
St Anne's	Grand Forks	7
Terrace	Bismarck	10
Tufte	Grand Forks	11
Total		65

Basic Care Residents Focus Groups

Findings

1 Resident Services

- High value in medication management, socialization, and meals
- Residents reported they all had their own private rooms
- Sense of security related to staff responsiveness

2 Privacy and Safety

- Strong sense of safety and privacy recorded across all facilities
- Residents generally liked their rooms and felt they could come and go as they pleased

3 Facility Location

- Most residents heard about the facility from word of mouth or knew others who had lived there
- Adult children were primary in identifying and selecting Basic Care

4 Resident Satisfaction

- Residents were, on average, satisfied with the care they received
- Residents noted high satisfaction with individual staff members and felt comfortable with the staff

5 Resident Wants

- Increase in activities offered
- Higher quality food, less 'institutional' food
- Flexibility in mealtime
- Additional storage space for seasonal items/clothes
- Personal Emergency Response Button

Basic Care Residents Telephone Interviews

Approach

- 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+).
- **Challenges included incorrect or missing phone numbers** and incomplete administrative data, hindering efficient contact with facilities and residents.
- Residents who participated in the telephone interviews were **asked the same questions that residents who participated in the in-person focus groups** were asked.

Number of Resident Interviews Completed per Facility Size Category

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

Basic Care Residents Telephone Interviews

Findings

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.

Basic Care Residents' Family Member Telephone Interviews

Approach

- Guidehouse 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.

Findings

Family member moved into Basic Care for assistance with medication management and the lack of HCBS providers in the area where they lived.

Would like to see more training, knowledge transfer, for staff to ensure quality care is provided and mitigate the risk of medication errors.

A need for additional education for family members on process for enrolling into Basic Care Assistance Program.

Would like to see an appeal process or exception process for situations where an individual is not accepted by a Basic Care facility.

Basic Care Facility Administrator Interviews

Approach

- 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.
- Administrators and staff shared insights into the daily operations, successes, and challenges of their facilities.

Findings

- Residents are entering facility in unmanaged conditions – takes more time and staff hours to stabilize their condition so that they can remain in Basic Care
- No community services available for mental health / behavioral need; combination of none available (rural areas) and misconception that Basic Care is providing this type of care
- Male residents have more mental health needs; female residents have more physical health needs
- The length of time for resident Medicaid approval, resident assessment, and reimbursement creates operational challenges
- Current E score requirements create challenges / barriers to end of life care; does not consider building design or structure
- Overtime there has been a shift in focus from resident care to a primary focus on staffing
- Varying interpretation of administration codes and program administration

Licensure Stakeholder Meetings

Approach

- Working with the HHS team, Guidehouse 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.
- Meeting Dates:
    - February 1, 2024
    - February 20, 2024

Key Themes: Licensure Stakeholder Meetings

Basic Care (BC) v 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 appropriate level
- Staff moving between BC and AL
- **All 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) / Mental Health (MH)

- 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

Reimbursement Stakeholder Meetings

Approach

- Working with the HHS team, Guidehouse identified a group of stakeholders to participate in a series of stakeholder meetings on Basic Care reimbursement
- Given the breadth of the topic, the stakeholders met four times over the course of the study. Meeting Dates:
  - February 1, 2024
  - February 21, 2024
  - March 25, 2024
  - April 5, 2024
- Analysis from the *Reimbursement and Rate Data Analysis* section 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.

Key Themes: Reimbursement Stakeholder Meetings

Population

- 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

Staffing

- 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 are 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 and advertising such as Indeed

Reimbursement

- 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

Program Administration and Participant Experience Stakeholder Meeting

Approach

- 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.
- 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.

Findings: Program Administration Stakeholder Meeting

What should people know about Basic Care?

- The **care provided in BC is no different from care provided by another payer** source
- 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

What challenges do you have in operating Basic Care?

- Behavioral health needs
- **Reimbursement not keeping up with the cost of providing quality of care** and needed 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**

Where do you see Basic Care in the continuum of care moving forward?

- It is the **middle ground between home- and community- based services and institutional care**
- 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

Other comments

- Providers struggle to understand the requirement of residents having to come to the dining area for meals, feels like it is institutional-like.
- Stakeholders have seen the **impact of Basic Care on quality of life** compared to those within just 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
- The cost of converting assisted living beds to Basic Care beds is prohibitive

Critical Incident and Complaints Data Analysis

Complaints

- 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.

Complaints Received by Type

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**

Critical Incident and Complaints Data Analysis

Critical Incidents 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%**

Reimbursement and Rate Data Analysis

Methodology

- This analysis focuses on examining the reimbursement rates and financial disparities among Basic Care facilities.
- Data sources include annual cost reports from 46 Basic Care providers (2020-2022), rates, and rate worksheets.
- Analyzed financial data informs recommendations to improve rate-setting methodologies.

Provider Classification
Nursing Facilities Co Located
Nursing Facilities Affiliated
Hospital Co-Located/Affiliated
Assisted Living Co-Located/Affiliated
Memory Care/TBI Co-Located/Affiliated
Standalone

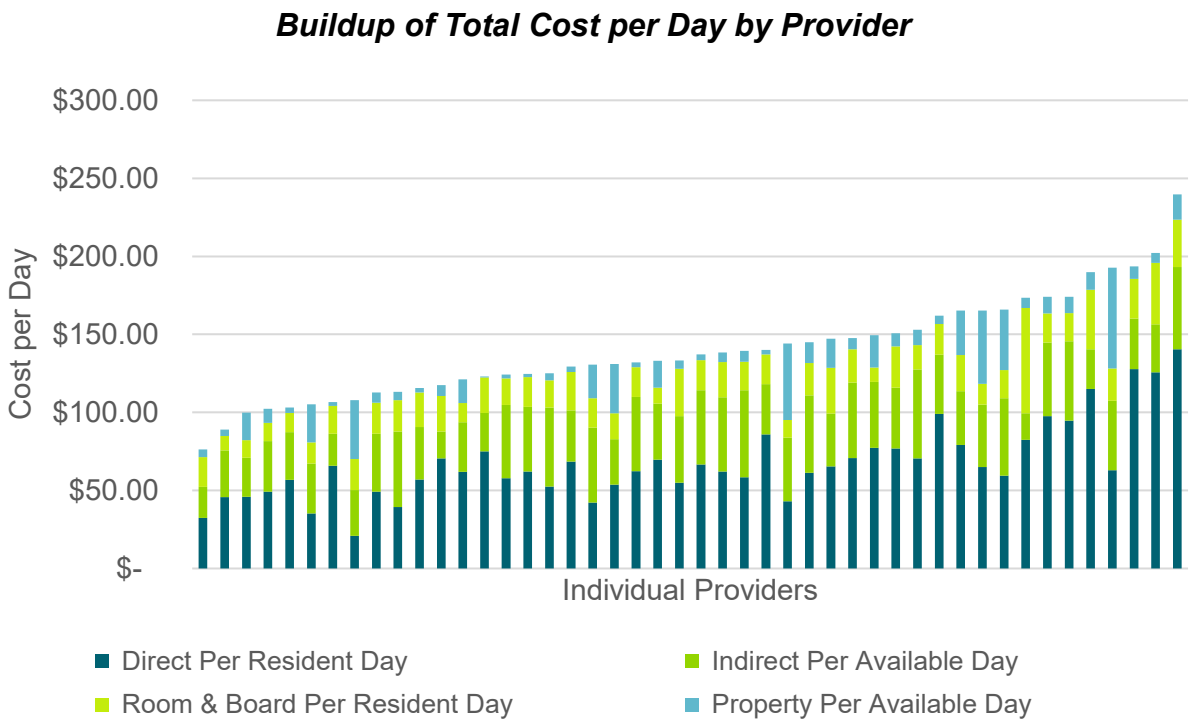
Cost Components
Direct – Personal Care
Direct – Room and Board
Indirect – Personal Care
Indirect – Room and Board
Room and Board
Property

- Costs are normalized by calculating a cost per day:
  - Resident Days for Direct and Room & Board costs (adjusts for occupancy).
  - Available Days for Indirect and Property costs (adjusts for facility size).
- Adjustments made based on occupancy to better reflect facility utilization.

Reimbursement and Rate Data Analysis

Cost

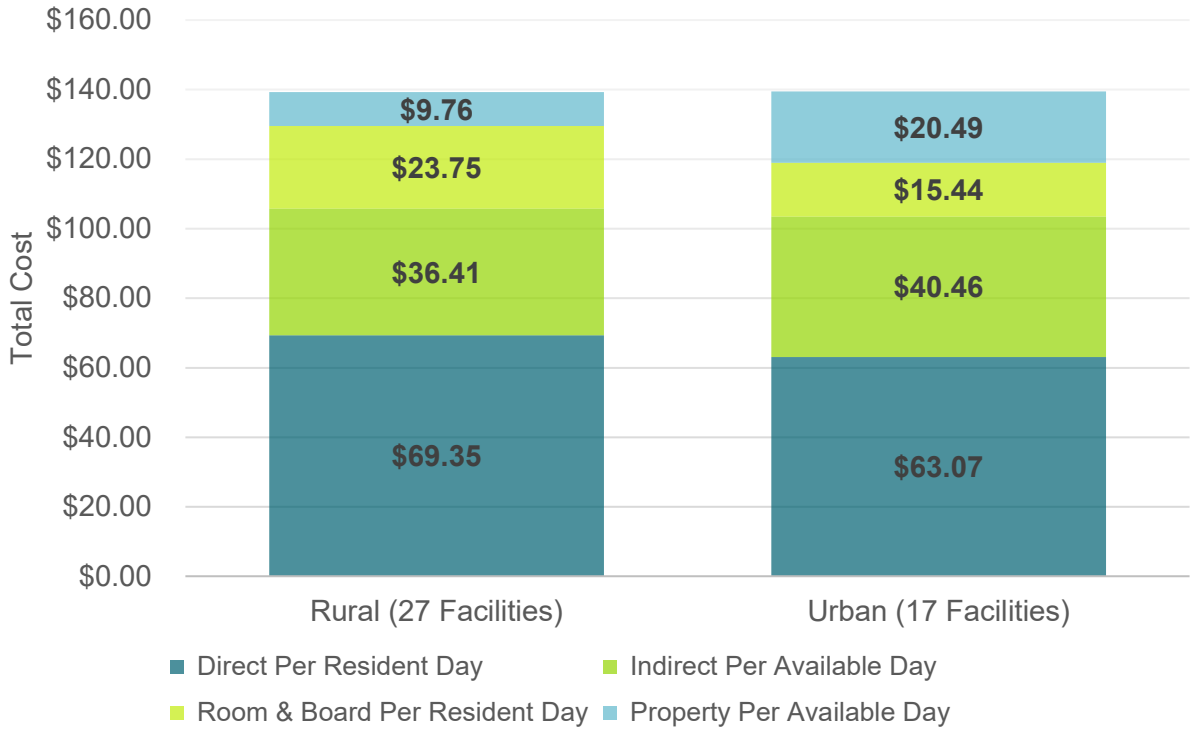
Guidehouse used cost reports provided by HHS to analyze costs based on the discrete factors mentioned earlier. This primary methodology helps identify cost drivers such as labor or property costs that disproportionately impact a subset of providers. The first step involved examining costs at the provider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



Reimbursement and Rate Data Analysis

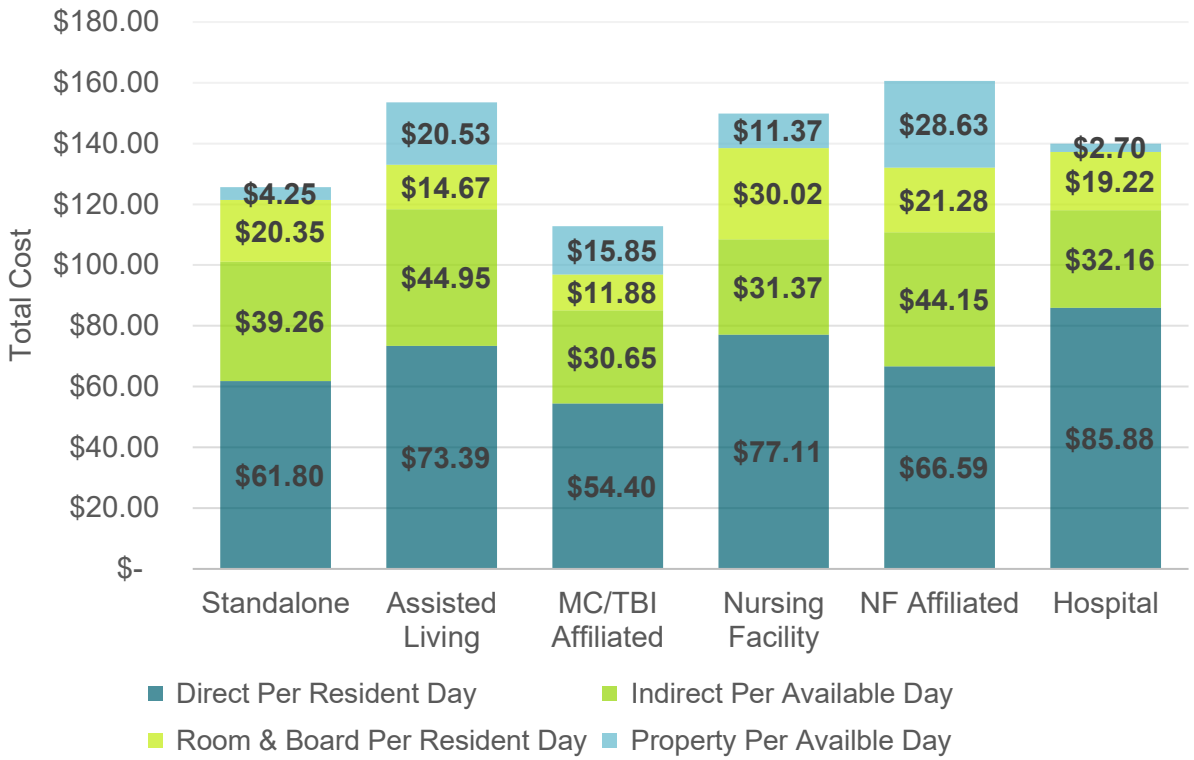
Cost – Cont'd

Buildup of Total Cost per Day by Provider



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.

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



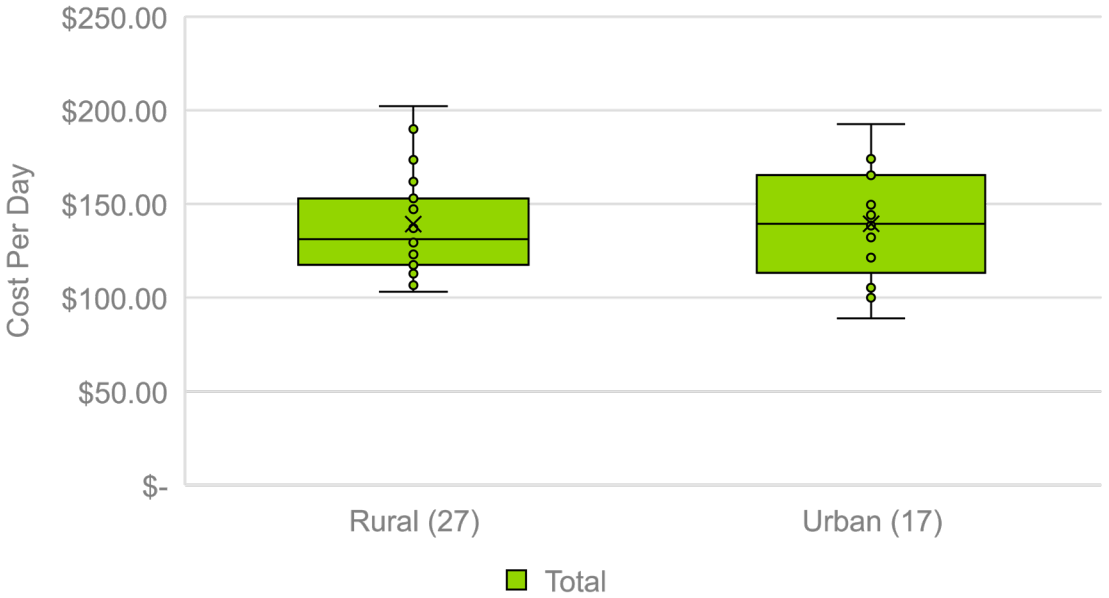
This figure shows a wide variation in both cost components and total cost. Of particular note is the low costs per day for both Standalone ($125.66) and Memory Care Affiliated / Co-Located ($112.78).

Reimbursement and Rate Data Analysis

Cost – Cont'd

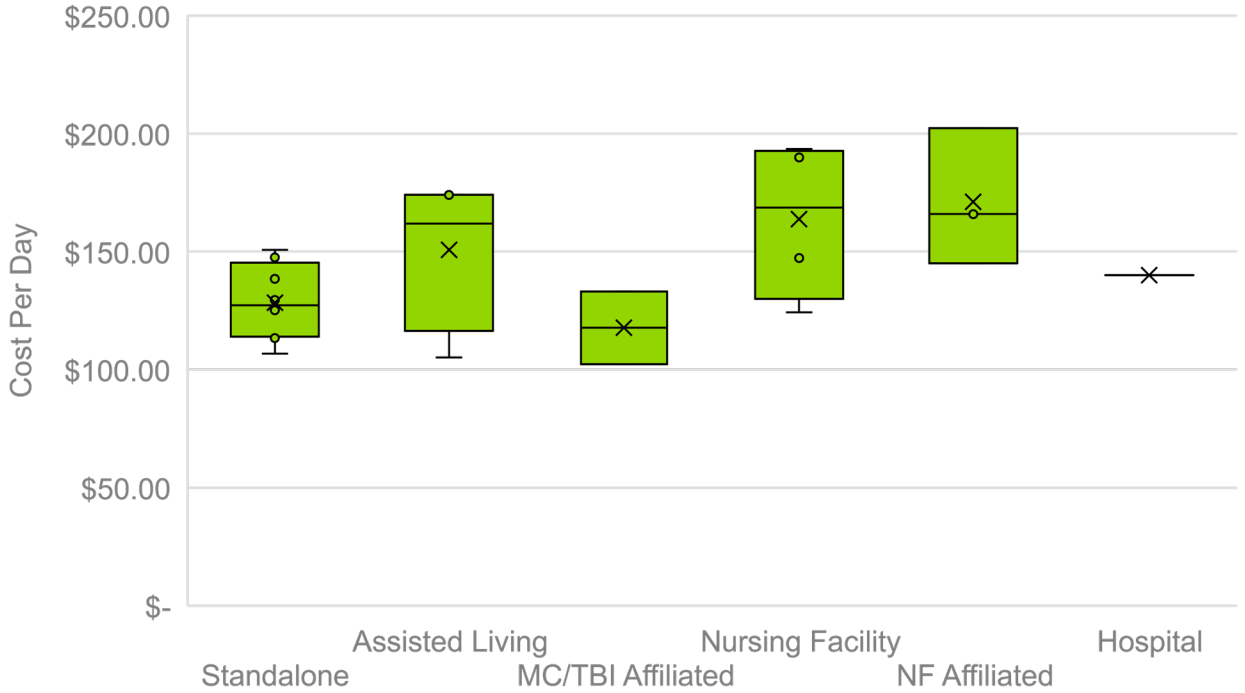
To understand cost variance, Guidehouse used Box and Whisker charts. These charts show distribution and outliers. The middle line is the median, the X is the mean, the shaded box covers the middle 50%, and the whiskers show the range from minimum to maximum. Each dot represents a facility, with outliers shown as dots outside the whiskers.

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 50 percent. As noted previously, the average total cost, X, is almost identical ($139.27 for rural facilities and $139.46 for urban facilities).

Cost per Day Distribution by Affiliation / Co-Location Classification

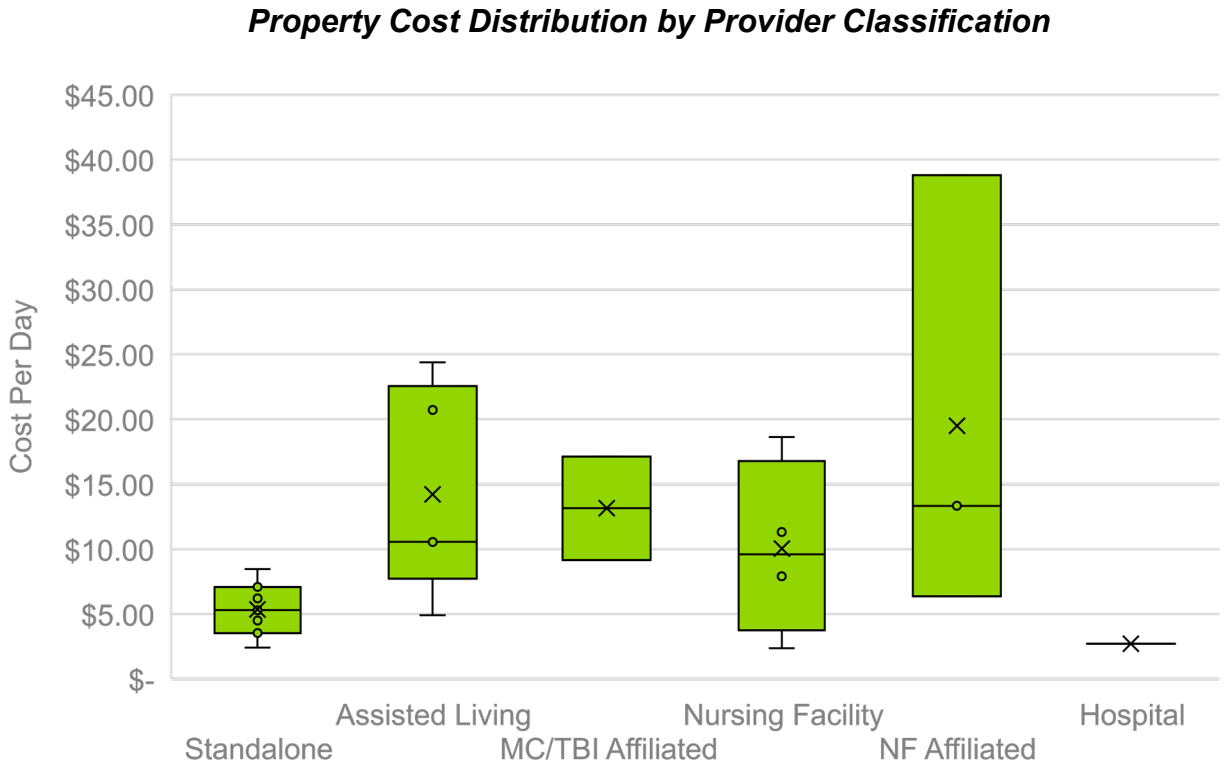


While this data shows a narrower distribution of costs in each classification, there is still considerable variation particularly with Assisted Living and Nursing Facility Affiliated.

Reimbursement and Rate Data Analysis

Cost – Cont'd

One of the main concerns expressed during stakeholder meetings was the need to modify the way rates are calculated for the property component. For this analysis, Guidehouse looked at property cost at the provider and classification levels. Property costs per day range from $2.40 to $38.80. Standalone facilities have a minimum of $2.40 and median of $5.29. As the graph illustrates, **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.

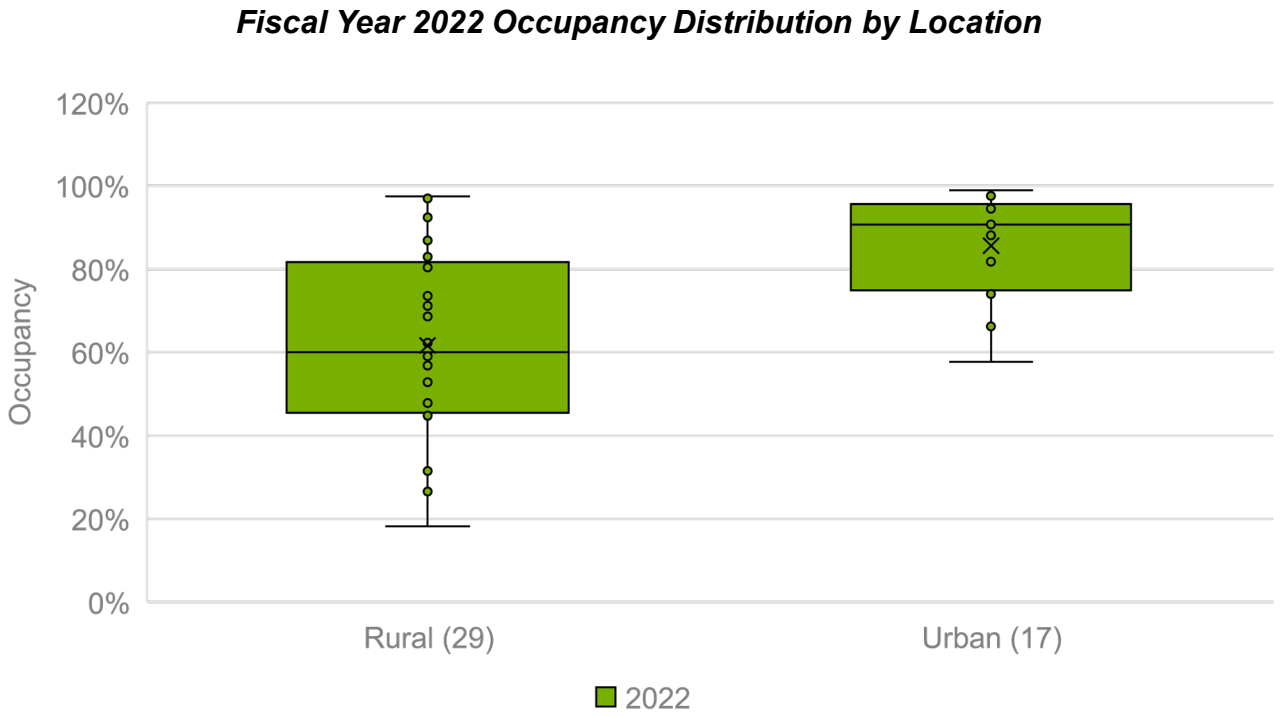


Reimbursement and Rate Data Analysis

Occupancy

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. In general providers in rural areas maintain lower occupancy (63 percent on average) while providers in urban areas maintained higher occupancy (84 percent).

Feedback from providers during stakeholder meetings inferred that occupancy was not an issue.



Reimbursement and Rate Data Analysis

Occupancy – Cont'd

In 2022, Basic Care facility occupancy rates ranged from 18 to 99 percent with an average of 70 percent. The weighted average was calculated as the total resident days divided by the total available days and gives the best indication of 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. 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.

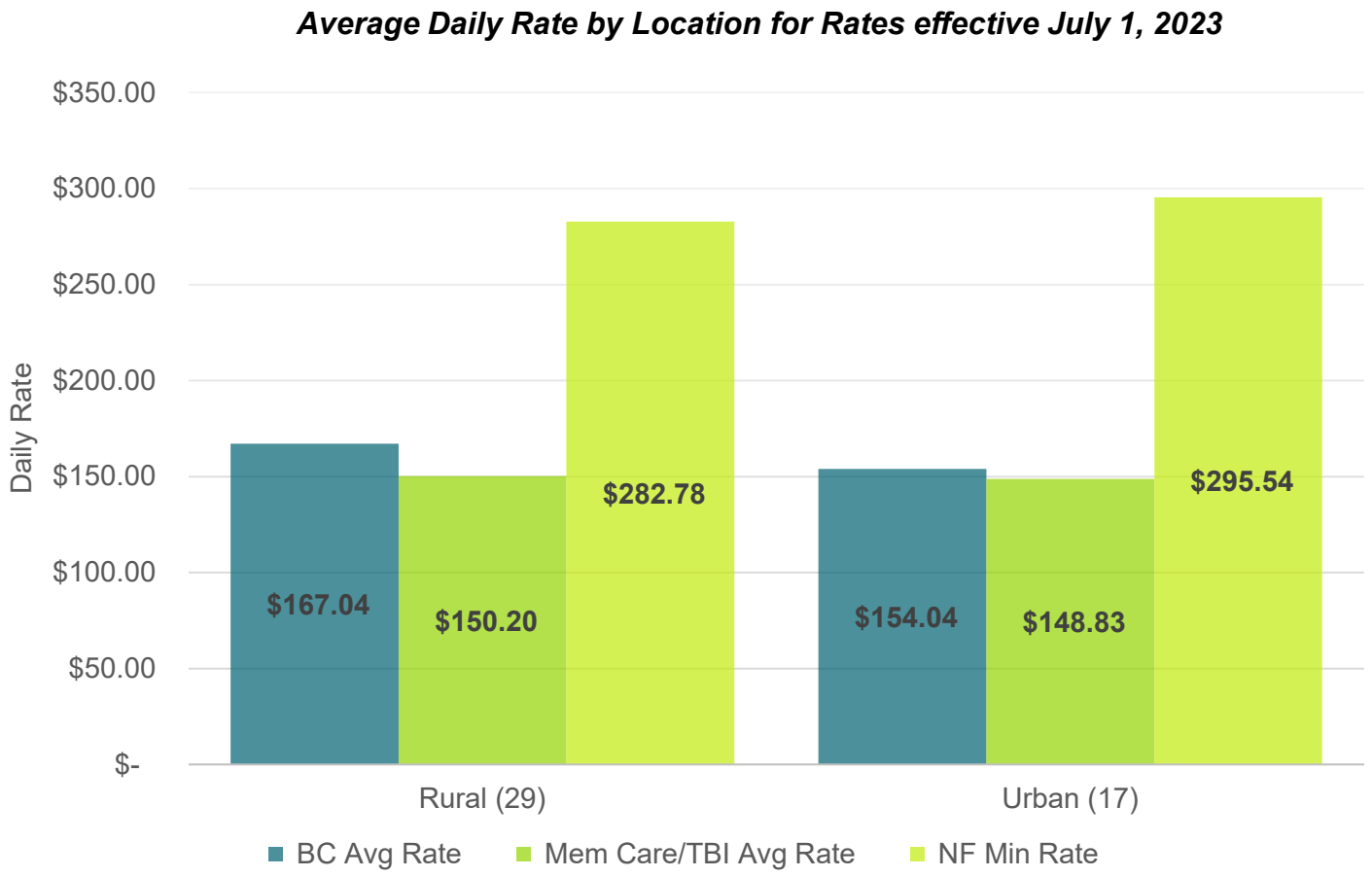
Basic Care Facility Occupancy Rates - 2022

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

Reimbursement and Rate Data Analysis

Rates and Limits

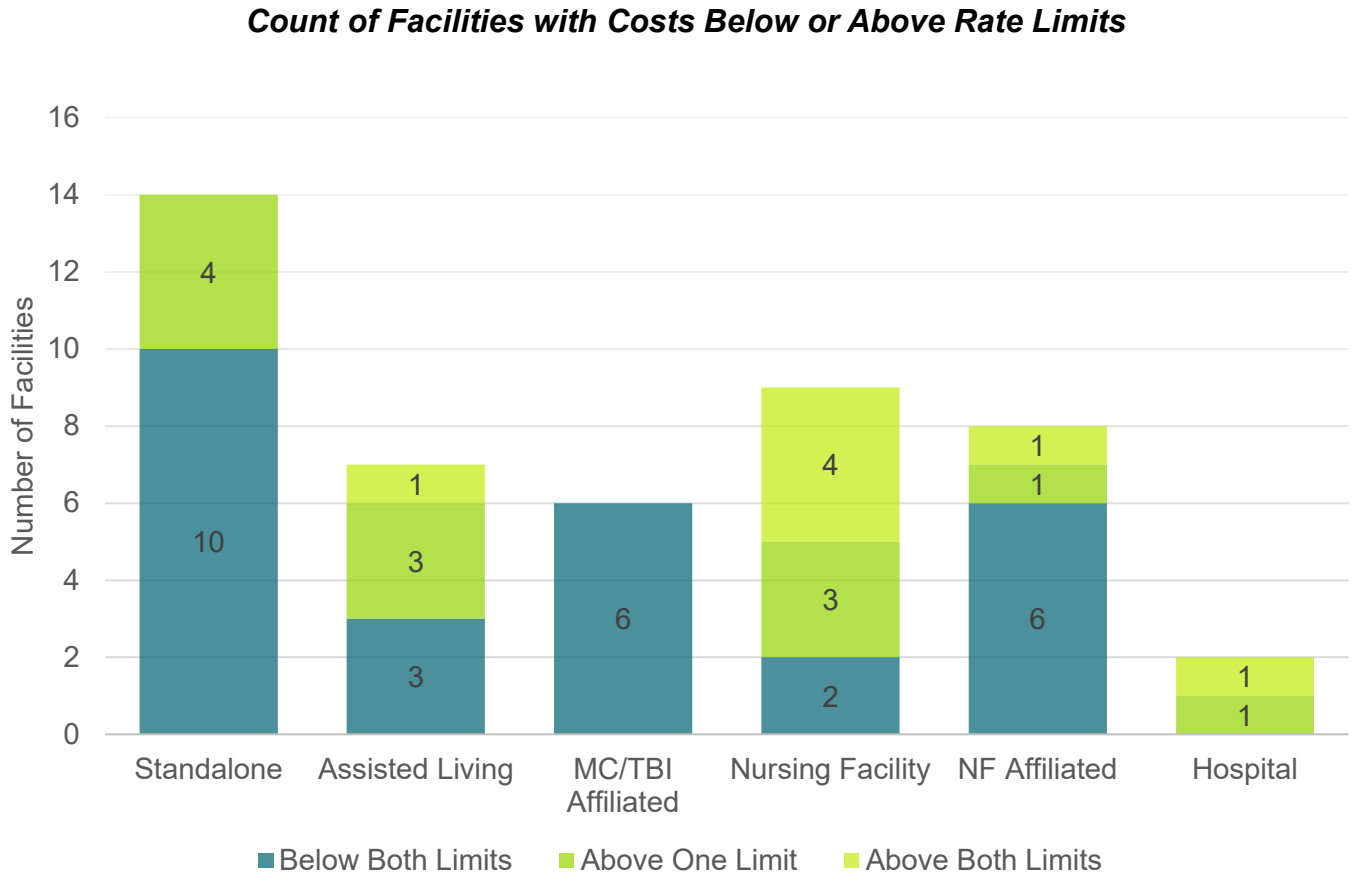
Guidehouse conducted an analysis of provider reimbursement rates and the limits used in the rate setting process. Guidehouse utilized data from FY2020 through FY2022 cost reports to compare provider rates across Basic Care, skilled nursing facilities, and memory care facilities. The objective was to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



Reimbursement and Rate Data Analysis

Rates and Limits – Cont'd

Guidehouse analyzed limits on Direct and Indirect cost per day used in determining rates. The facilities within the classification are categorized as having neither Direct or Indirect, one component above the limit, or both components above the limits. 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.



Reimbursement and Rate Data Analysis

Rates and Limits – Cont'd

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, 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. This demonstrates the need for regular rebasing to reset the cumulative nature of inconsistent inflation factors.

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

Reimbursement and Rate Data Analysis

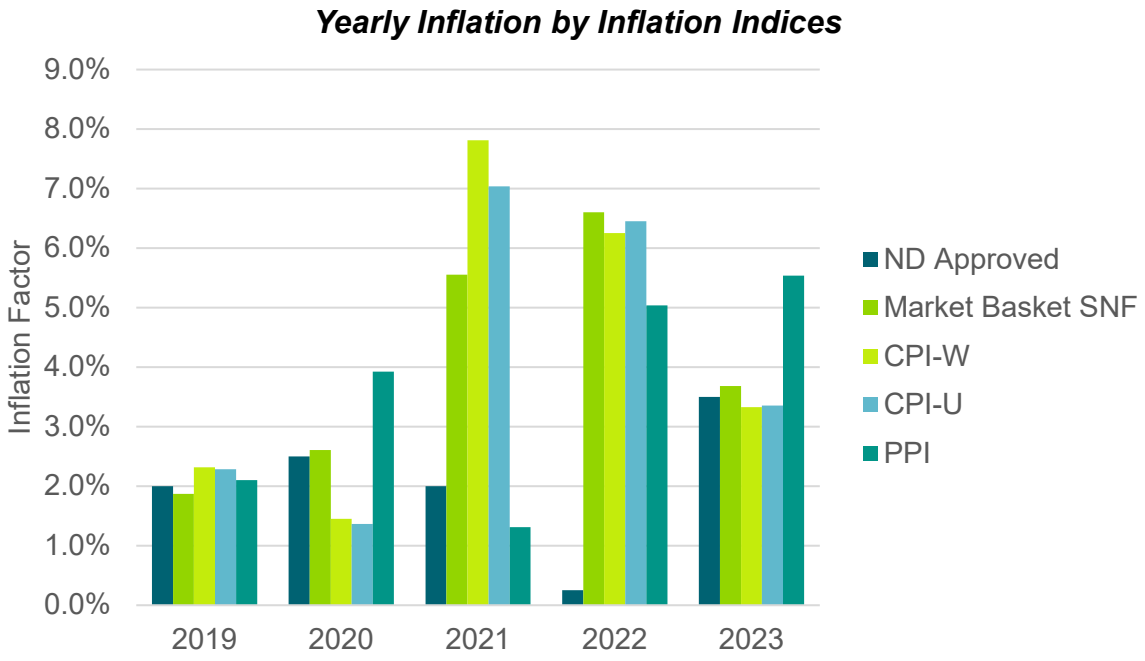
Inflation

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** 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.

- **CPI-U** measures the average change over time in what urban consumers pay for a market basket of consumer 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. 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.

- **The Producer Price Index** (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. PPI data is available only at the national level.



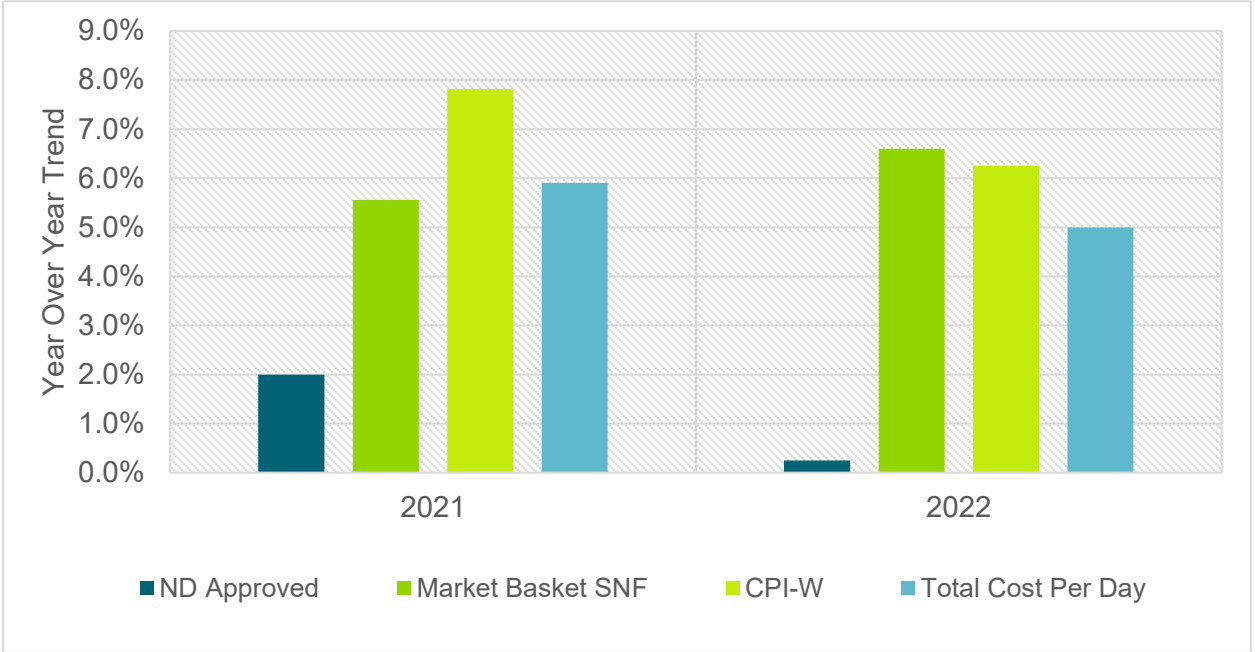
Reimbursement and Rate Data Analysis

Inflation

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.

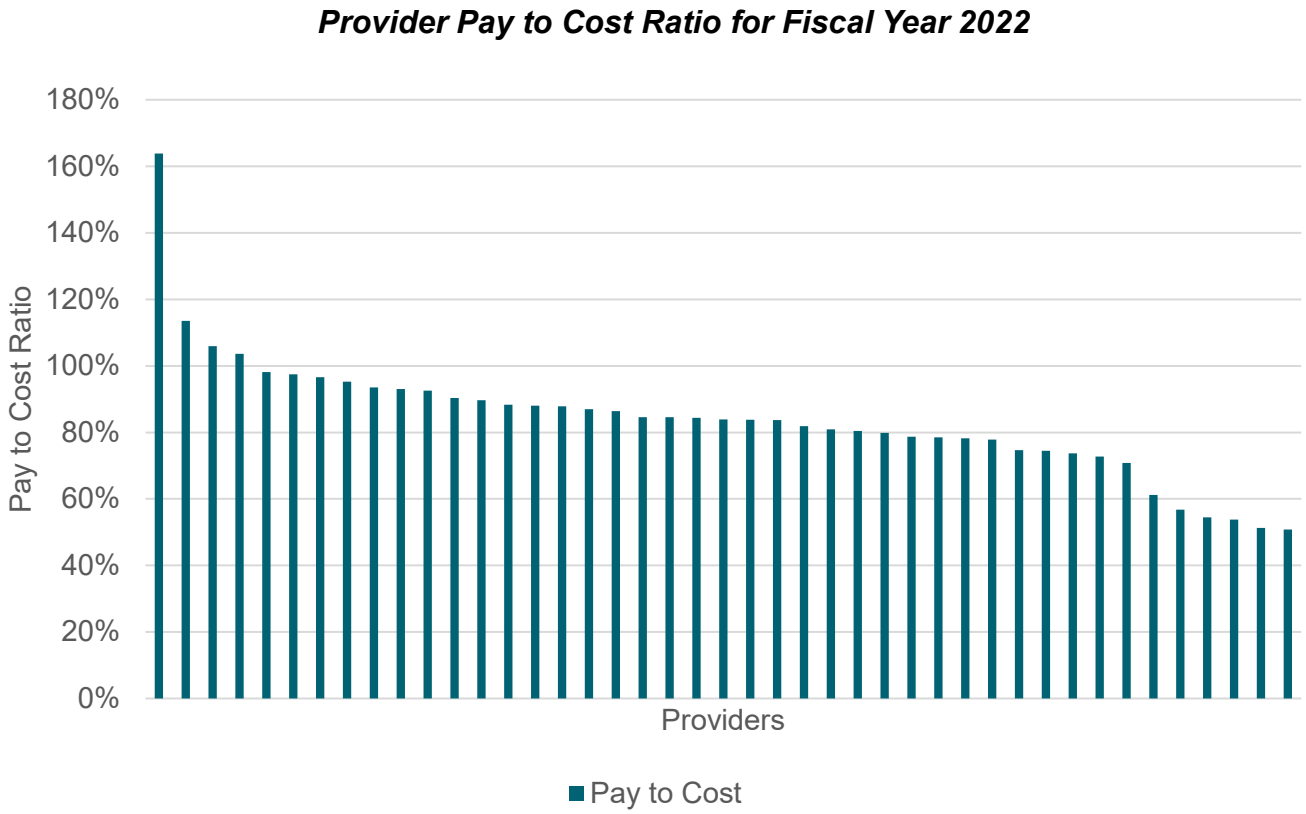
Year Over Year Inflation Indices and Total Cost Per Day Trends for 2021 and 2022



Reimbursement and Rate Data Analysis

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 (see graph to right) 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.



Recommendations

Recommendations

Overview

- The recommendations presented here 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.

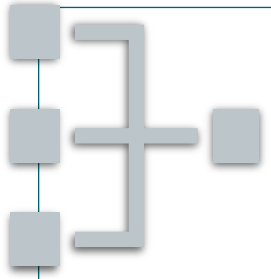
- Throughout the project, Guidehouse provided preliminary findings to HHS and met with industry stakeholders incorporating their feedback while providing that the recommendations were formulated from an independent analysis. Consequently, **these should be viewed as independent recommendations.**

- As specified in the RFP and aligned with the study's objectives, each recommendation was evaluated for its potential impact across identified topic areas, detailed in the following two slides. This **holistic approach** allows for proposed changes that are well-suited to **enhance service delivery** and **meet the diverse needs of North Dakotans.**

Recommendation Topic Areas

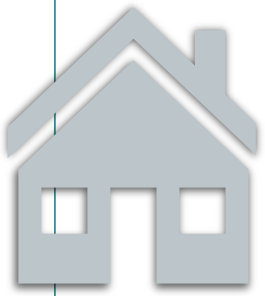
Licensing Requirements

- 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.



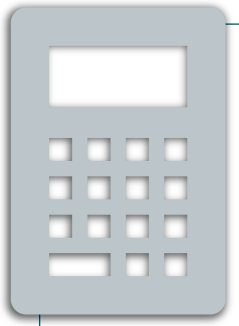
Delivery in Integrated Settings

- 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.



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.



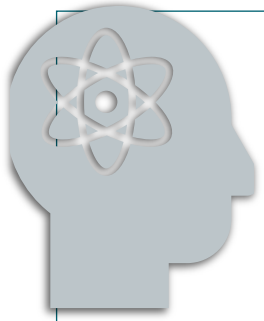
Present Day Basic Care Rate Setting

- 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.

Recommendation Topic Areas – Cont'd

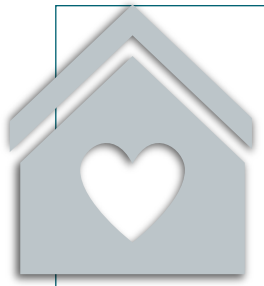
Eligibility

- 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.
- 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.



Address Gaps for 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 Within the Continuum of Care

- 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.
- 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.

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.
- State staff and providers noted that the differences between Assisted Living and Basic Care have become increasingly indistinct, **complicating licensure and regulatory enforcement**. 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.
- 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.

Recommendation #1 – Cont'd

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

Definitions

The policy analysis indicated a need for clearer policy language to distinguish between Assisted Living and Basic Care. 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.

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.

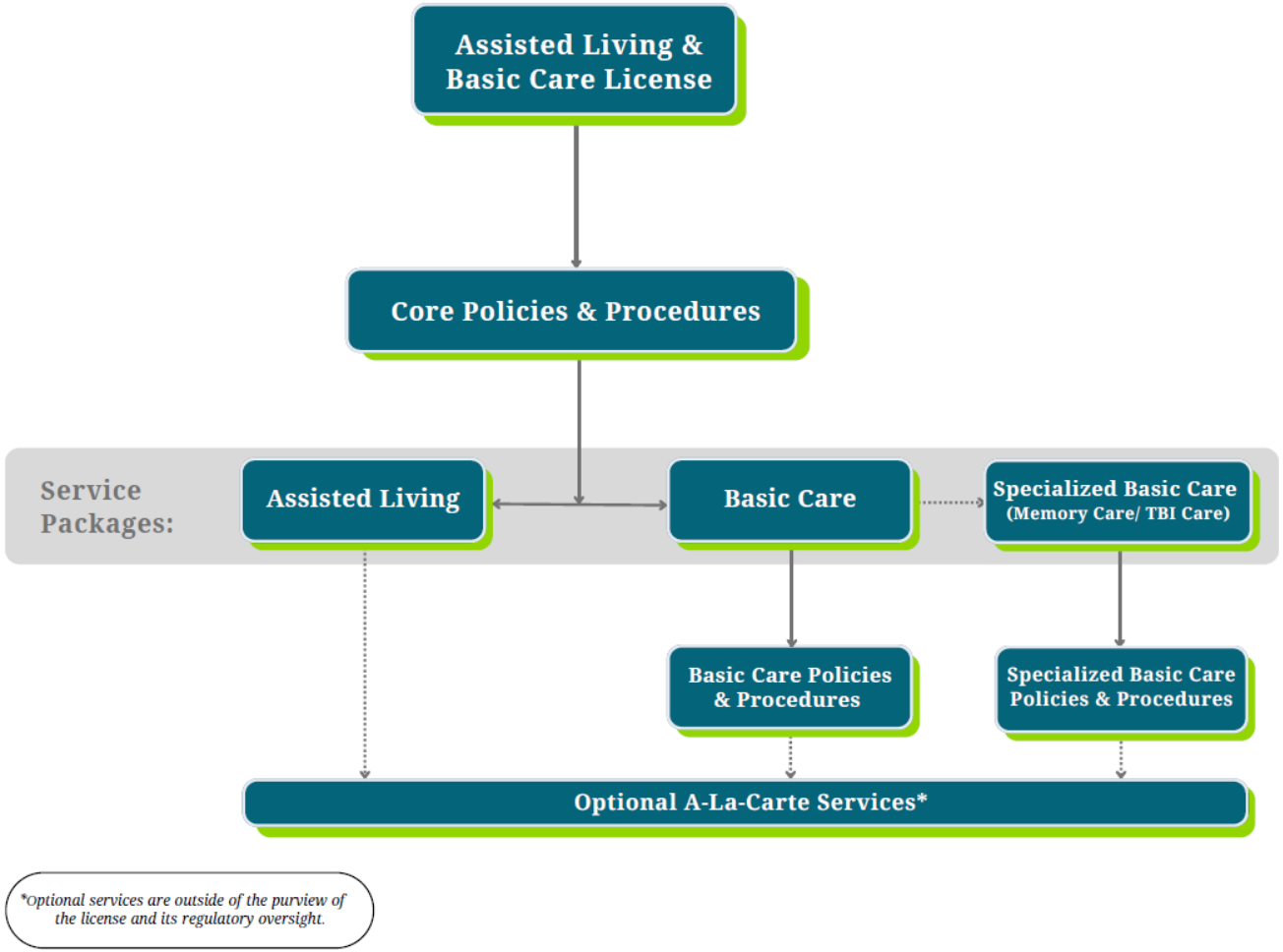
Specialized Basic Care

A Basic Care facility that provides specialized services for treatment of Alzheimer's, dementia, special memory care, or traumatic brain injury.

Recommendation #1 – Cont'd

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

Licensure Structure



Recommendation #1 – Cont'd

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

Universal Policies

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.

Recommendation #1 – Cont'd

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

Regulatory Enforcement Actions

The move to consolidate Basic Care under one license type necessitates a more nuanced approach to regulatory enforcement. 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.

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.

Recommendation #1 – Cont'd

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

Regulatory Enforcement Actions – Cont'd

Action Type	Description
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 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	• 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.

Recommendation #1 – Cont'd

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

Topic Areas Impacted

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 allows for facilities to understand and comply with the relevant licensing standards. This clarity will further aid in streamline regulatory processes and enhancing facility compliance.

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.

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 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.

Recommendation #1 – Cont'd

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

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.

- 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. 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.

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.

- 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.*

Policy Area	Key Recommendations
Admissions and Discharges	• 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. • Include a Statewide-standard admission agreement document to be signed by the individual and provider to promote continuity in agreement language across facilities.
Quality Assurance and Monitoring	• 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.

*Table only includes the policy areas that **require significant revisions or creation of policy**. Refer to the Report for more information on the remaining policy areas that only require minor revisions.

Recommendation #2 – Cont'd

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.

Policy Area	Key Recommendations
Response to Critical Incidents	• 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.
Participant Directed Services	• 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.
Tenancy Rules	• Develop a policy for rent subsidization for individuals eligible for Basic Care services to standardized tenancy / leasing rules.
Co-Located Services	• 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.

*Table only includes the policy areas that **require significant revisions or creation of policy**. Refer to the Report for more information on the remaining policy areas that only require minor revisions.

Recommendation #2 – Cont'd

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.

Topic Areas Impacted

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. 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.

Continuum of Care

- The proposed policy changes and additions are designed to solidify and expand the roles of Assisted Living and Basic Care. These recommendations provide clear guidelines and requirements for service provision. These revisions aim to meet individuals' needs more effectively.

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. Training topics include:

Differences between Assisted Living and 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

Training on what Assisted Living and Basic Care is, the eligibility requirements, and how to access it would increase awareness of the program.

Gathering and responding to individual input and grievances

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

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 supports

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.

Recommendation #3 – Cont'd

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

Topic Areas Impacted

Licensing Requirements

- Understanding the difference and requirements 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.

Eligibility

- As individuals and/or their families are exploring options for care, training and educational materials can be beneficial in describing the differences between Assisted Living and Basic Care.

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.

HCBS Settings Rule

- With the focus on community integration, 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.

Integrated Settings

- 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

- 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

- 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.

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.

- 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.

- 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.

Partnership and cross-training with community behavioral health providers

- 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.

Prioritize community integration through developing partnerships and linking with community-based networks

- 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.

Pilot a Housing with Supports program with a provider of rent-subsidized housing

Recommendation #4 – Cont'd

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.

Topic Areas Impacted

HCBS Settings Rule

- 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.

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.

Continuum of Care

- 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.. In conjunction with the behavioral health training for facility staff 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.

- 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.

- 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.

- 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.

Recommendation #5 – Cont'd

Update regulatory oversight process based on implementation of recommendations.

Topic Areas Impacted

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, 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. Guidehouse recommends that HHS consider requiring Assisted Living and Basic Care facilities to **adopt formal Quality Assurance and Performance Improvement (QAPI) initiatives**. This can be achieved through updates to policies and procedures, with ongoing monitoring through programmatic oversight.

- Individuals residing in Basic Care or Assisted Living are afforded a set of Rights and should have care provided in a person-centered manner. **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.

Recommendation #6 – Cont'd

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

Topic Areas Impacted

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, the inflation factor is set by the Legislative Assembly. 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**.
- Two publicly available indexes that are potentially applicable to the Basic Care setting are: 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.
- **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. This characteristic results in **less volatility** than CPI-U. 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 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.**

Recommendation #7 – Cont'd

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

Topic Areas Impacted

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 – Cont'd

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. 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.

Recommendation #8 – Cont'd

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

Topic Areas Impacted

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**. 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. 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, **year-over-year update** typically involves less administrative burden, data gathering requirements, and calculation processes than traditional cost-based rates.

Recommendation #9

Implement tiered add-on payments for residents with increased Activities of Daily Living (ADLs) service need and align reimbursement methodologies.

- 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.

Example of Tiered Add-On Payment Implementation

- **Base Tier** – Residents that either do not qualify for a higher tier or have not been assessed
- **Tier 1** – (A%) to (B%) of residents, ($X) per day increase
  - Residents with clinically complex ADL and IADL
- **Tier 2** – (C%) to (D%) of residents, ($Y) per day increase
  - Residents with increased Cognitive Performance Scale scores and clinically complex ADL and IADL needs
  - Residents that receive at least XX minutes of rehabilitative therapy weekly, have an increased ADL and IADL need

Recommendation #9 – Cont'd

Implement tiered add-on payments for residents with increased Activities of Daily Living (ADLs) service need and align reimbursement methodologies.

- Guidehouse recommends **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.

Recommendation #9 – Cont'd

Implement tiered add-on payments for residents with increased Activities of Daily Living (ADLs) service need and align reimbursement methodologies.

Topic Areas Impacted

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 for which facilities may be required to be in compliance.

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

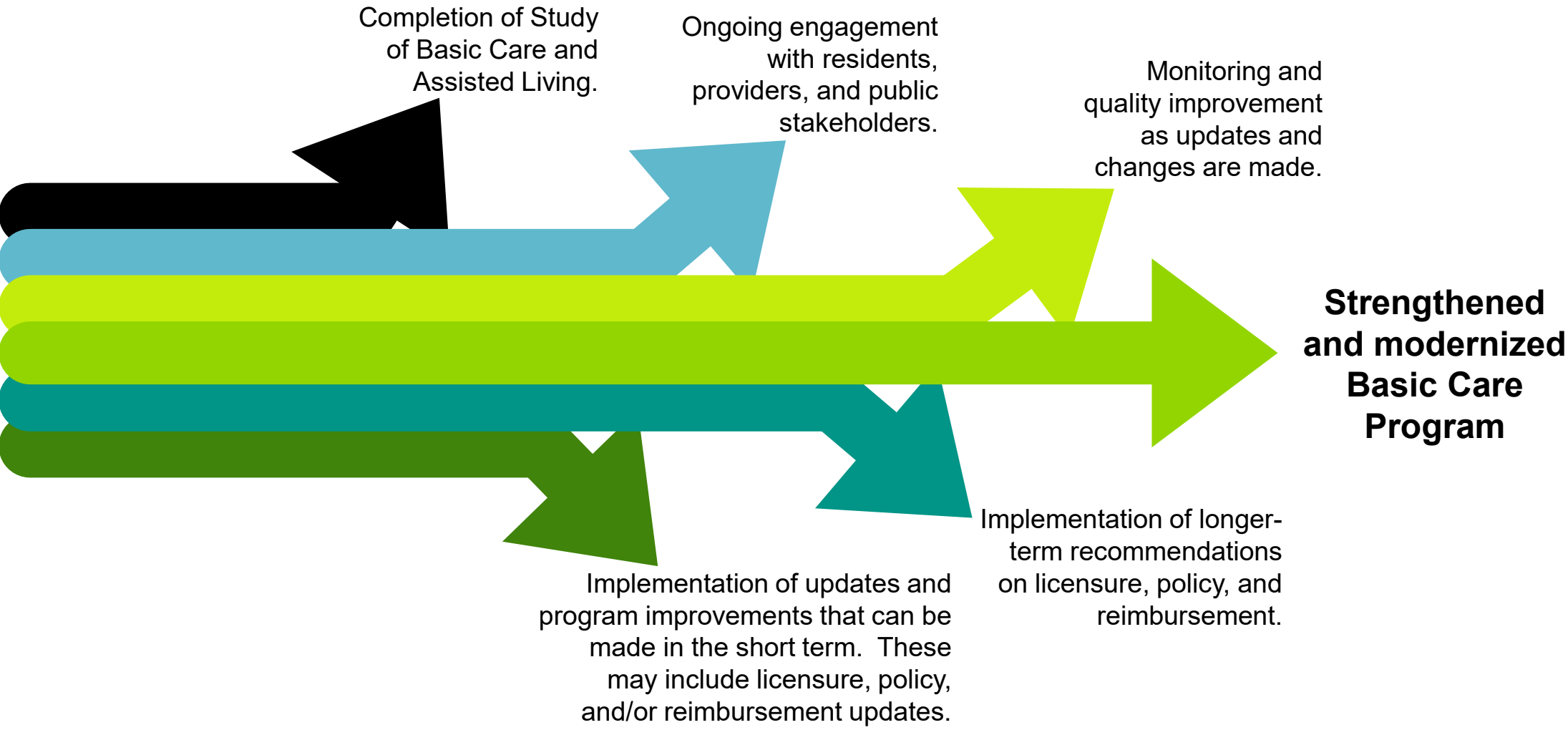
Assessments are currently only completed for Basic Care residents who are receiving services through Medicaid. The State will need to **consider how and by who individual assessments will be completed**. Time to allow for the **mapping of the current assessment** would also need to be considered. The **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.

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.

Summary of Recommendations

Recommendation #	Recommendation
1	Streamline licensing by creating a new single licensure type to cover both assisted living and Basic Care facilities.
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.
3	Develop and implement State-led universal assisted living and Basic Care training and materials to educate all stakeholders.
4	Adopt strategies to improve and expand the current service and programmatic array within Basic Care to integrate residents more comprehensively into the community.
5	Update regulatory oversight process based on implementation of recommendations.
6	Implement quality improvement initiative requirements for Basic Care facilities to improve quality of care and align facilities with best practices.
7	Update regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs.
8	Implement a Fair Rental Value (FRV) methodology to reimburse Basic Care provider property costs.
9	Implement tiered add-on payments for residents with increased ADLs care need and align reimbursement methodologies.

Direction of Basic Care Program Evaluation



Additional Questions and Feedback

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Thank You