LEGISLATIVE

RESEARCH COMMISSION

MEDICAID COMMITTEE

REPORT TO THE
1995 GENERAL ASSEMBLY
OF NORTH CAROLINA

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STATE OF NORTH CAROLINA
LEGISLATIVE RESEARCH COMMISSION
STATE LEGISLATIVE BUILDING
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January 11, 1995

TO THE MEMBERS OF THE 1995 GENERAL ASSEMBLY:

The Legislative Research Commission herewith submits to you for your consideration its final report on Medicaid. The report was prepared by the Legislative Research Commission's Committee on Medicaid pursuant to G.S. 120-30.17(1).

Respectfully submitted,

Daniel T. Blue, Jr.
Speaker of the House

Marc Basnight
President Pro Tempore

Cochairmen
Legislative Research Commission

1993-1994

LEGISLATIVE RESEARCH COMMISSION

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PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is cochaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission, prompted by actions during the 1993 Session, has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Cochairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Cochairs, one from each house of the General Assembly, were designated for each committee.

The study of Medicaid would have been authorized by Subsections (64) and (92) of Section 2.1 of Part II of the 2nd Edition of House Bill 1319 which passed both chambers but inadvertently was among the bills not ratified at the end of the 1993 Session.

Part II of the 2nd Edition of House Bill 1319 would allow studies authorized by that Part for the Legislative Research Commission to consider Senate Bill 1251/House Bill 1412 in determining the nature, scope, and aspects of the study. Section 1 of Senate Bill 1251/House Bill 1412 reads:

"Section 1. The Legislative Research Commission may study Medicaid eligibility requirements for long-term care assistance, means of closing loopholes in eligibility requirements that allow divestiture or sheltering of assets, **Medicaid estate recovery,** ways of encouraging the development and use of private-sector resources for the provision and financing of long-term care, and related long-term care eligibility and financing issues." (Emphasis added.) The relevant portion of the 2nd Edition of House Bill 1319 is included in Appendix A.

The Legislative Research Commission authorized this study in the Fall of 1993 under authority of G.S. 120-30.17(1) and grouped this study in its Health and Human Resources grouping area under the direction of Representative Vernon G. James. (House Bill 1319 was later amended and ratified in 1994 with the Legislative Research Commission studies 2nd Edition language deleted because the Legislative Research Commission had already acted on these matters).

The Committee was chaired by Senator Elaine Marshall and Representative Edd Nye. The full membership of the Committee is listed in Appendix B of this report. A committee notebook containing the committee minutes and all information presented to the committee is filed in the Legislative Library.

COMMITTEE PROCEEDINGS

The Legislative Research Commission Study Committee on Medicaid met a total of five times, on April 21, 1994, September 15, 1994, October 27, 1994, November 14, 1994, and December 13, 1994.

The Committee's authorizing legislation, Senate Bill 1252/House Bill 1412, reads in pertinent part:

"Section 1. The Legislative Research Commission may study Medicaid eligibility requirements for long-term care assistance, means of closing loopholes in eligibility requirements that allow divestiture or sheltering of assets, **Medicaid estate recovery,** ways of encouraging the development and use of private-sector resources for the provision and financing of long-term care, and related long-term care eligibility and financing issues." (Emphasis added.)

The legislation arose out of concern that, under existing Medicaid law, it was possible that people with resources could so transfer or give these resources away as to enable them to qualify for Medicaid long-term care and pay nothing, rather than use their resources to pay for their care even though Medicaid was clearly designed to meet the medical needs of people without resources. Under existing law, also, property that was exempt for the Medicaid assets test could pass through the recipient's estate to the recipient's heirs and Medicaid was unable to get at the property to recoup benefits paid for the recipient's long term medical care. (All relevant materials presented to the Committee in its deliberations are in APPENDIX .)

After the establishment of the Committee, the federal Omnibus Budget Reconciliation Act of 1993 became effective. It put certain requirements into law that responded to all the Medicaid eligibility issues raised in the authorizing legislation, including mandating that all states have a Medicaid estate recovery plan. At the first

meeting of the Committee, the Committee decided that OBRA 1993 had indeed handled most of the concerns that had caused the creation of the Committee by attacking both asset transfers and asset giveaways to qualify for Medicaid long-term care and that only one major issue remained, that of putting into place a Medicaid estate recovery plan, although the Committee would remain open to hear other Medicaid issues as they related to the elderly and the disabled.

The Committee received testimony that the number of Americans 65 years of age and older has increased seven-fold since 1900. The fastest growing segment of our population is the group 85 years of age and older. As people age, their need for assistance in home-and community-based services increases. Forty-three percent of those who reach 65 will eventually require nursing home care. There are only three sources of payment for nursing home care: (1) out-of-pocket payment of approximately $36,000 per year or more, (2) long-term care insurance, which only about four percent of those people who are eligible purchase, and (3) Medicaid. In fiscal year 1993, there were approximately 40.150 people in nursing homes in North Carolina on Medicaid, costing the taxpayers of North Carolina $475,319,872. Some of this money could be recovered if North Carolina had a Medicaid estate recovery plan, as it was required to by OBRA 1993.

28 states had some form of Medicaid estate recovery when OBRA 1993 was enacted but North Carolina did not. Among the states that had estate recovery programs, a recovery on the average of about 1.5% of their long-term Medicaid budget was not uncommon. The most successful states recovered about 5.2% and the least successful recovered about .1% If North Carolina recovered the same amount as the most successful state, we would recover about $25,000,000 a year. If North Carolina recovered the average. we would recover about $3,000,000. Of the total sum recovered, the federal government is entitled to an amount equal to their participation

rate in the Medicaid program. In the 1994-95 fiscal year, the federal participation rate was 65 percent. Of greater value to the states than the actual dollars recovered are the programs' built-in incentives to encourage purchase of long-term care insurance by those can afford it and who thus can avoid any recovery against their estates.

The Committee learned that OBRA 1993 left a great deal of discretion with the states as to how to craft their own Medicaid estate recovery plan. For instance, states had to recover from property that was part of the recipient's estate, but states could go beyond this and recover from other property, if they saw fit. (The property most often available for this sort of recovery is the real property that is excluded from Medicaid asset tests at the time eligibility is determined, such as the homestead, in which a recipient's spouse or dependent child is residing, or "income-producing" real property, most often rented, often to a family member.) Also, the federal mandate left it up to the states to decide where to place Medicaid in the list of creditors recovering from an estate. Federal law left up to the states how to administer the recovery and how to determine what role the counties would play. Federal rules had not yet been adopted to help the states decide how to go ahead, although the Committee was reassured that a rule expanding the "hardship exemption" currently in place for the determination of Medicaid eligibility would be available to help when it was clear that part or whole recovery would be inequitable.

The Committee's next meeting followed the Special Crime Session. Because of this special session, the Committee recognized not only that it would not have sufficient time to develop a Medicaid estate recovery plan for recommendation to the Short Session but also that such a plan would have to be passed in the Short Session to meet the federal mandate. Therefore, it gave the Division of Medical Assistance, Department of Human Resources, and Committee staff guidelines it wished used in the development of any Medicaid estate recovery plan, which would be then prepared by

the agency involved and introduced by individual legislators. The Committee would review the law after its enactment in the Short Session to determine if any changes needed to be recommended to the 1995 General Assembly. The Committee recommended that only property that was part of a recipient's estate be included in recovery, to place Medicaid in the list of creditors taking from the estate in a lower position than that given to lienholders, such as people holding a mortgage, and to ensure that there was some authority given Medicaid not to recover if it would not be fair or cost-effective to do so. Staff informed the Committee that it would be necessary to ensure that the notification process for Medicaid eligibility included information that the recipient's estate could be recovered from and that the effective date of the act should be truly prospective in effectiveness, affecting applications for Medicaid made on or after the effective date.

After the Short Session, the Committee reviewed Section 25.47 of Chapter 769 of the 1993 Session Laws, Regular Session, 1994, which established the North Carolina version of the required Medicaid estate recovery plan. It differed from the the introduced bills Senate Bill 1640, introduced by Senator Elaine Marshall. and House Bill 2068, introduced by Representative Martha Alexander in two respects. Medicaid was moved down to fifth class creditor, with earlier judgments coming before it. The bills had placed Medicaid as a State creditor, a fourth-class creditor. The fifth-class creditor status was argued by the hospitals and the bankers, to ensure that their judgments had the priority current law would give them and were concerned that Medicaid recovery not interfere with their recovery. Also a provision was added to make clear that a nonprofit trust that contains those assets of a recipient who is mentally or physically disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, that are not retained by the nonprofit association as per the trust agreement are available for estate recovery.

The Committee heard that there were still big loopholes that enable propertied people to receive Medicaid long-term care assistance and still retain ownership in real property, although, now that property, if not transferred once Medicaid assistance begins, would be available for Medicaid estate recovery. As some such transfers remain legal, only giving Medicaid first class lienholder creditor status would keep property for Medicaid estate recovery by having the lien attach at the instant of the beginning of benefit receipt. The largest "loophole" still remaining is in the interpretation of the "income-producing" property exemption, which allows a person to rent a business property, such as a farm, for as little as one dollar over costs and have that property exempt from asset eligibility tests.

At the October and November meetings of the Committee, the Committee heard specifics of a proposed rule to plug the "income-producing" property loophole in the Medicaid eligibility test. The proposed rule was developed not only to plug this loophole but to harmonize it with the SSI eligibility rule.

The General Assembly moved in the Short Session, at the initiative of Senators Russell Walker and James Richardson, to go to "1634" status from "209b" status, making Medicaid automatically available to all elderly and disabled who are eligible for Supplemental Security Income under Social Security.

In general, the change in status will be of great benefit to the elderly and disabled of North Carolina. Prior to this change, there were 180,000 elderly and disabled SSI recipients, 110,000 of whom were receiving Medicaid. However, only half of these were receiving full benefits. The other half qualified only after accumulating a "spenddown", or a total of medical bills that reduced their income to $242,00 a month. Now, all SSI recipients will receive Medicaid with no "spending down.

This move to "1634" status forces Medicaid eligibility rules, including those for "income-producing" property, to be harmonious with SSI eligibility rules. (North

Carolina can be more liberal in its Medicaid eligibility rules but it cannot be more restrictive.) SSI eligibility policy with respect to income-producing property is a two-fold test. The first part is an equity test. SSI recipients cannot have property that is not their homesite and be eligible for SSI if the equity in the property exceeds $6,000. The second part is an income test. If the equity is $6,000 or less, the property must produce 6% net income based on the value of the property or the person will not be eligible. The income is, of course, treated as income for purposes of eligibility determination and offsetting. The proposed rule, effective January 1, 1995, could modify our Medicaid 'income producing' rule to make it like SSI's. The rule would adopt the income producing part of SSI's test, not the separate equity part, although equity is used in the determination. Simply put, the rule would require that a person can exempt income-producing property from Medicaid asset eligibility tests is by having that property produce net income that is equal to at least six percent of the equity the person has in the property. Initially, the rule did not specify how this equity determination would be reached and the Committee voiced its concern that, especially in application to farm land, the determination could easily be too harsh. The rule was modified to specify that "[f]or purposes of this Sub-item, equity of agricultural land, horticultural land, and forestland is the present use value of the land, as defined by G.S. 105-227.1A, et. seq., less the amount of debts, liens or other encumbrances." The Committee tentatively endorsed the rule, as modified, but decided to request that the General Assembly keep a close watch on the rule, to ensure that inequities did not develop in its application.

As SSI and Medicaid eligibility were now to be harmonized, the Department of Human Resources informed the Committee that it had worked out with Social Security to have both eligibilities determined at the local Social Security office, to get the determinations made the in the shortest time possible and to get benefits to recipients

as quickly as possible. Legal Services made objection, based on an ongoing court order. As of January 1, 1995, a current SSI recipient will automatically qualify for Medicaid with no further application and and the Department will allow new applicants for both Medicaid and SSI to apply at local county departments of social services for Medicaid. They can apply for both at the local Social Security office but will not be required to.

The Committee did request that a bill be recommended to the 1995 General Assembly to expand the move begun by the change in "1634" status by extending Medicaid coverage to all elderly and disabled with incomes at or below 100% of the federal poverty level. This increase would allow an individual with an income of up to $614.00 per month ($7.368 a year) and as couple with an income of up to $820.00 per month ($9,430 a year) to qualify for Medicaid. Total cost for this expansion, effective January 1, 1996, is $17,929,200 for fiscal year 1995-96 and $36,111,278 for fiscal year 1996-97. The federal, State, and county share break down as follows:

	FY 1995-96	FY 19996-97
Total Requirements	$17,926,200	$36,111,278
Federal	$11,535,510	$23,049,829
County	$ 958,603	$ 1,959,217
State	$ 5,432,087	$11,102,232.

The Committee, after completing its review of the new Medicaid estate recovery law, reconsidered whether to recommend a change in the new Medicaid estate recovery plan to grant Medicaid first class lienholder creditor status. The Committee was reminded of the hospitals' and bankers' opposition to such a change and decided to recommend no change to the law passed in the Short Session.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 1. THE LEGISLATIVE RESEARCH COMMISSION RECOMMENDS NO CHANGE IN THE MEDICAID ESTATE RECOVERY LAW PASSED IN THE 1994 SHORT SESSION OF THE 1993 GENERAL ASSEMBLY.

No legislative proposal.

After the establishment of the Committee, the federal Omnibus Budget Reconciliation Act of 1993 became effective. It put certain requirements into law that responded to all the Medicaid eligibility issues raised in the authorizing legislation, including mandating that all states have a Medicaid estate recovery plan. At the first meeting of the Committee, the Committee decided that OBRA 1993 had indeed handled most of the concerns that had caused the creation of the Committee by attacking both asset transfers and asset giveaways to qualify for Medicaid long-term care and that only one major issue remained, that of putting into place a Medicaid estate recovery plan, although the Committee would remain open to hear other Medicaid issues as they related to the elderly and the disabled.

The Committee received testimony that the number of Americans 65 years of age and older has increased seven-fold since 1900. The fastest growing segment of our population is the group 85 years of age and older. As people age, their need for assistance in home-and community-based services increases. Forty-three percent of those who reach 65 will eventually require nursing home care. There are only three sources of payment for nursing home care: (1) out-of-pocket payment of approximately $36,000 per year or more, (2) long-term care insurance, which only about four percent of those people who are eligible purchase, and (3) Medicaid. In fiscal year 1993, there were approximately 40,150 people in nursing homes in North Carolina on Medicaid, costing the taxpayers of North Carolina $475,319,872. Some of this money could be

recovered if North Carolina had a Medicaid estate recovery plan, as it was required to by OBRA 1993.

28 states had some form of Medicaid estate recovery when OBRA 1993 was enacted but North Carolina did not. Among the states that had estate recovery programs, a recovery on the average of about 1.5% of their long-term Medicaid budget was not uncommon. The most successful states recovered about 5.2% and the least successful recovered about .1% If North Carolina recovered the same amount as the most successful state, we would recover about $25,000,000 a year. If North Carolina recovered the average. we would recover about $3,000,000. Of the total sum recovered, the federal government is entitled to an amount equal to their participation rate in the Medicaid program. Of greater value to the states than the actual dollars recovered are the programs' built-in incentives to encourage purchase of long-term care insurance by those can afford it and who thus can avoid any recovery against their estates.

The Committee learned that OBRA 1993 left a great deal of discretion with the states as to how to craft their own Medicaid estate recovery plan. For instance, states had to recover from property that was part of the recipient's estate, but states could go beyond this and recover from other property, if they saw fit. (The property most often available for this sort of recovery is the real property that is excluded from Medicaid asset tests at the time eligibility is determined, such as the homestead, in which a recipient's spouse or dependent child is residing, or "income-producing" real property, most often rented, often to a family member.) Also, the federal mandate left it up to the states to decide where to place Medicaid in the list of creditors recovering from an estate. (North Carolina's laws relating to estate property and priority of creditors is included in APPENDIX C of this report.) Federal law left up to the states how to administer the recovery and how to determine what role the counties would play.

Federal rules had not yet been adopted to help the states decide how to go ahead, although the Committee was reassured that a rule expanding the "hardship exemption" currently in place for the determination of Medicaid eligibility would be available to help when it was clear that part or whole recovery would be inequitable.

The Committee's next meeting followed the Special Crime Session. Because of this special session, the Committee recognized not only that it would not have sufficient time to develop a Medicaid estate recovery plan for recommendation to the Short Session but also that such a plan would have to be passed in the Short Session to meet the federal mandate. Therefore, it gave the Division of Medical Assistance, Department of Human Resources, and Committee staff guidelines it wished used in the development of any Medicaid estate recovery plan, which would be then prepared by the agency involved and introduced by individual legislators. The Committee would review the law after its enactment in the Short Session to determine if any changes needed to be recommended to the 1995 General Assembly. The Committee recommended that only property that was part of a recipient's estate be included in recovery, to place Medicaid in the list of creditors taking from the estate in a lower position than that given to lienholders, such as people holding a mortgage, and to ensure that there was some authority given Medicaid not to recover if it would not be fair or cost-effective to do so. Staff informed the Committee that it would be necessary to ensure that the notification process for Medicaid eligibility included information that the recipient's estate could be recovered from and that the effective date of the act should be truly prospective in effectiveness, affecting applications for Medicaid made on or after the effective date.

In the Short Session, Representative Martha Alexander and Senator Elaine Marshall introduced companion bills to establish a Medicaid estate recovery plan. These pieces of legislation and all other relevant documents are in APPENDIX C of

this report. Both the House and Senate versions were included, with modifications, in the House and Senate budget bills and the budget conference committee included Medicaid estate recovery in its final version, enacted into law as Section 25.47 of Chapter 769 of the 1993 Session Laws, Regular Session 1994:

"Requested by: Representatives Nye, Easterling, Alexander, Dickson, Esposito, Senators Marshall, Richardson, Walker

MEDICAID ESTATE RECOVERY PLAN, AS REQUIRED BY FEDERAL LAW

Sec. 25.47. (a) Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

'**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Regarding trusts that contain the assets of an individual who is disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, if the trust is established and managed by a nonprofit association, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the nonprofit association, the trust pays to the Department from these remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the North Carolina Medicaid Program.'

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994."

After the Short Session, the Committee reviewed Section 25.47 of Chapter 769 of the 1993 Session Laws. Regular Session, 1994, which established the North Carolina version of the required Medicaid estate recovery plan. It differed from the the introduced bills Senate Bill 1640, introduced by Senator Marshall. and House Bill 2068, introduced by Representative Alexander in two respects. Medicaid was moved down to fifth class creditor, with earlier judgments coming before it. The bills had placed Medicaid as a State creditor, a fourth-class creditor. The fifth-class creditor status was argued by the hospitals and the bankers, to ensure that their judgments had the priority current law would give them and were concerned that Medicaid recovery not interfere with their recovery. Also a provision was added to make clear that a nonprofit trust that contains those assets of a recipient who is mentally or physically disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, that are not retained by the nonprofit association as per the trust agreement are available for estate recovery.

The Committee, after completing its review of the new Medicaid estate recovery law, reconsidered whether to recommend a change in the new Medicaid estate recovery plan to grant Medicaid first class lienholder creditor status. The Committee was

reminded of the hospitals' and bankers' opposition to such a change and decided to recommend no change to the law passed in the Short Session.

RECOMMENDATION 2. THE LEGISLATIVE RESEARCH COMMISSION RECOMMENDS THE CLOSE MONITORING OF THE NEW RULE OF THE DIVISION OF MEDICAL ASSISTANCE, DEPARTMENT OF HUMAN RESOURCES, REGARDING THE EXEMPTION FROM MEDICAID ASSET-ELIGIBILITY "INCOME-PRODUCING" PROPERTY TO ENSURE THAT INEQUITIES DO NOT RESULT FROM ITS APPLICATION. (No legislative proposal.)

At the October and November meetings of the Committee, the Committee heard specifics of a proposed rule to plug the "income-producing" property loophole in the Medicaid eligibility test. The proposed rule was developed not only to plug this loophole but to harmonize it with the SSI eligibility rule.

The General Assembly moved in the Short Session, at the initiative of Senators Walker and Richardson, to go to "1634" status from "209b" status, making Medicaid automatically available to all elderly and disabled who are eligible for Supplemental Security Income under Social Security.

In general, the change in status will be of great benefit to the elderly and disabled of North Carolina. Prior to this change, there were 180,000 elderly and disabled SSI recipients, 110,000 of whom were receiving Medicaid. However, only half of these were receiving full benefits. The other half The other half qualified only after accumulating a "spenddown", or a total of medical bills that reduced their income to $242,00 a month. Now, all SSI recipients will receive Medicaid with no "spending down.

This move to "1634" status forces Medicaid eligibility rules, including those for "income-producing" property, to be harmonious with SSI eligibility rules. (North Carolina can be more liberal in its Medicaid eligibility rules but it cannot be more restrictive.) SSI eligibility policy with respect to income-producing property is a two-fold test. The first part is an equity test. SSI recipients cannot have property that is not their homesite and be eligible for SSI if the equity in the property exceeds $6,000. The second part is an income test. If the equity is $6,000 or less, the property must produce 6% net income based on the value of the property or the person will not be eligible. The income is, of course, treated as income for purposes of eligibility determination and offsetting. The proposed rule, effective January 1, 1995, could modify our Medicaid 'income producing' rule to make it like SSI's. The rule would adopt the income producing part of SSI's test, not the separate equity part, although equity is used in the determination. Simply put, the rule would require that a person can exempt income-producing property from Medicaid asset eligibility tests is by having that property produce net income that is equal to at least six percent of the equity the person has in the property. Initially, the rule did not specify how this equity determination would be reached and the Committee voiced its concern that, especially in application to farm land, the determination could easily be too harsh. The rule was modified to specify that "[f]or purposes of this Sub-item, equity of agricultural land, horticultural land, and forestland is the present use value of the land, as defined by G.S. 105-227.1A, et. seq., less the amount of debts, liens or other encumbrances." The Committee tentatively endorsed the rule, as modified, but decided to request that the General Assembly keep a close watch on the rule, to ensure that inequities did not develop in its application.

RECOMMENDATION 3. THE LEGISLATIVE RESEARCH COMMISSION RECOMMENDS THE ENACTMENT OF A BILL ENTITLED: "AN ACT TO EXPAND MEDICAID COVERAGE TO ALL ELDERLY AND DISABLED WITH INCOMES AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL AND TO APPROPRIATE FUNDS." (See Legislative Proposal 1.)

The Committee recommended to the 1995 General Assembly the expansion of the move begun by the change in "1634" status by extending Medicaid coverage to all elderly and disabled with incomes at or below 100% of the federal poverty level. SSI is not available to individuals with an income at or above 76% of poverty or $446.00 a month or to couples with an income at or above 83% of poverty or $786.00 per month. After the passage of the move to "1634" status, individuals with incomes above the SSI limits cannot qualify for Medicaid unless they accumulate medical bills that effectively reduce their income to 40% of poverty or $242.00 per month. The proposed legislation would allow an individual with an income of up to $614.00 per month ($7,368 a year) and as couple with an income of up to $820.00 per month ($9,430 a year) to qualify for Medicaid, with no deductible. This proposal would add an estimated 27,836 people to the list of those eligible for full Medicaid coverage. Total cost for this expansion, effective January 1, 1996, is $17,929,200 for fiscal year 1995-96 and $36,111,278 for fiscal year 1996-97. The federal, State, and county share break down as follows:

	FY 1995-96	FY 19996-97
Total Requirements	$17,926,200	$36,111,278
Federal	$11,535,510	$23,049,829
County	$ 958,603	$ 1,959,217
State	$ 5,432,087	$11,102,232.

APPENDIX A

HOUSE BILL 1319, 2ND EDITION

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE AND CONTINUE VARIOUS COMMITTEES AND COMMISSIONS, AND TO DIRECT VARIOUS STATE AGENCIES TO STUDY SPECIFIED ISSUES.
The General Assembly of North Carolina enacts:

PART I.-----TITLE

Section 1. This act shall be known as "The Studies Act of 1993".

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Sec. 2.1. The Legislative Research Commission may study the topics listed below. Listed with each topic is the 1993 bill or resolution that originally proposed the issue or study and the name of the sponsor. The Commission may consider the original bill or resolution in determining the nature, scope, and aspects of the study. The topics are:

. . .

(64) Medicaid (H.J.R. 1412 - Alexander),

. . .

(92) Medicaid Eligibility Requirements (S.B. 1251 - Marshall),

. . . .

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

S 1

SENATE JOINT RESOLUTION 1251*

Sponsors: Senators Marshall; Harris, Ballance, Johnson, Blackmon, Codington, Carpenter, and Daniel.

Referred to: Rules and Operation of the House.

June 24, 1993

A JOINT RESOLUTION AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY LONG-TERM CARE MEDICAID ELIGIBILITY, MEDICAID ESTATE RECOVERY, AND WAYS TO ENCOURAGE THE DEVELOPMENT AND USE OF PRIVATE-SECTOR RESOURCES IN THE PROVISION AND FINANCING OF LONG-TERM CARE.

Whereas, Medicaid was established in part to provide health insurance for the poor, including the elderly poor who need nursing home care; and

Whereas, a large and growing number of middle- and upper-income residents are qualifying for Medicaid through the divestment or sheltering of assets that might otherwise be used to provide appropriate care for those individuals; and

Whereas, in the 1991-92 fiscal year, North Carolina spent more than four hundred seventy-five million six hundred thousand dollars ($475,600,000) on nursing home care for 39,011 elderly people; and

Whereas, the providing of Medicaid assistance to persons who have divested or sheltered assets that could be used to support their care can be expected to impose an ever-increasing drain on limited Medicaid resources; and

Whereas, the fiscal effect of the above-mentioned practices could be reduced by clarifying provisions of existing eligibility requirements and closing loopholes in existing State laws governing Medicaid eligibility; and

Whereas, the fiscal effect of these practices could be further reduced by implementing a program for the recovery of nursing facility payments from the estates of Medicaid recipients; and

Whereas, federal law permits states to implement these estate recovery programs; and

Whereas, other states have implemented programs to encourage residents with assets sufficient to prepare for their own long-term care to invest in long-term care insurance rather than dispose of or shelter such assets; and

Whereas, these programs encourage the development of private-sector mechanisms for the provision and financing of long-term care;

Now, therefore, be it resolved by the Senate, the House of Representatives concurring:

Section 1. The Legislative Research Commission may study Medicaid eligibility requirements for long-term care assistance, means of closing loopholes in eligibility requirements that allow divestiture or sheltering of assets, Medicaid estate recovery, ways of encouraging the development and use of private-sector resources for the provision and financing of long-term care, and related long-term care eligibility and financing issues. The Commission may prepare an interim report of its study for the 1993 General Assembly, Regular Session 1994, and may make final recommendations to the 1995 General Assembly.

Sec. 2. This resolution is effective upon ratification.

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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H 1

HOUSE JOINT RESOLUTION 1412

Sponsors: Representatives Alexander; Hill, D. Brown, Church, Lutz, and Ives.

Referred to: Rules, Calendar, and Operations of the House.

May 17, 1993

A JOINT RESOLUTION AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY LONG-TERM CARE MEDICAID ELIGIBILITY, MEDICAID ESTATE RECOVERY, AND WAYS TO ENCOURAGE THE DEVELOPMENT AND USE OF PRIVATE-SECTOR RESOURCES IN THE PROVISION AND FINANCING OF LONG-TERM CARE.

Whereas, Medicaid was established in part to provide health insurance for the poor, including the elderly poor who need nursing home care; and

Whereas, a large and growing number of middle- and upper-income residents are qualifying for Medicaid through the divestment or sheltering of assets that might otherwise be used to provide appropriate care for those individuals; and

Whereas, in the 1991-92 fiscal year, North Carolina spent more than four hundred seventy-five million six hundred thousand dollars ($475,600,000) on nursing home care for 39,011 elderly people; and

Whereas, the providing of Medicaid assistance to persons who have divested or sheltered assets that could be used to support their care can be expected to impose an ever-increasing drain on limited Medicaid resources; and

Whereas, the fiscal effect of the above-mentioned practices could be reduced by clarifying provisions of existing eligibility requirements and closing loopholes in existing State laws governing Medicaid eligibility; and

Whereas, the fiscal effect of these practices could be further reduced by implementing a program for the recovery of nursing facility payments from the estates of Medicaid recipients; and

Whereas, federal law permits states to implement these estate recovery programs; and

Whereas, other states have implemented programs to encourage residents with assets sufficient to prepare for their own long-term care to invest in long-term care insurance rather than dispose of or shelter such assets; and

Whereas, these programs encourage the development of private-sector mechanisms for the provision and financing of long-term care;

Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission may study Medicaid eligibility requirements for long-term care assistance, means of closing loopholes in eligibility requirements that allow divestiture or sheltering of assets, Medicaid estate recovery, ways of encouraging the development and use of private-sector resources for the provision and financing of long-term care, and related long-term care eligibility and financing issues. The Commission may prepare an interim report of its study for the 1993 General Assembly, Regular Session 1994, and may make final recommendations to the 1995 General Assembly.

Sec. 2. This resolution is effective upon ratification.

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APPENDIX B

MEMBERSHIP OF LRC COMMITTEE ON MEDICAID

MEDICAID COMMITTEE
MEMBERSHIP
1993 - 1994

LRC MEMBER: Rep. Vernon G. James
1301 Salem Church Road
Elizabeth City, NC 27909
(919)330-4394

President Pro Tempore's Appointments

Sen. Elaine Marshall, Cochair
P.O. Box 1660
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(910)893-4000

Ms. Barbara Ricks Cole
Route 1, Box 211
Roper, NC 27932

Ms. Evelyn J. Devane
Route 2
Rose Hill, NC 28458

Sen. James Forrester
510 Hwy. 27 South
Stanley, NC 28164
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Mr. Calvin Knight
1444 Old Town Road
Winston Salem, NC 27106

Sen. R.L. Martin
P.O. Box 387
Bethel, NC 27812
(919)825-4361

Sen. Russell Walker
1004 Westmont Drive
Asheboro, NC 27203
(910)625-2574

Speaker's Appointments

Rep. Edd Nye, Cochair
P.O. Box 8
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(910)862-3679

Rep. Martha B. Alexander
1625 Myers Park Drive
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(704)365-1003

Rep. Ruth Easterling
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(704)375-5934

Rep. Robert C. Hayes
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Rep. William M. Ives
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Brevard, NC 28712
(704)884-4458

Ms. Nancy McAllister
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South Mills, NC 27976

Rep. William L. Wainwright
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Ms. Nina Yeager
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(919)733-4910

Ms. Susan Sabre
Bill Drafting Division
(919)733-6660

Clerk:
Ms. Jackie Pittman
Rm. 418B Legislative Office Bldg
(919)715-3011

APPENDIX C
BACKGROUND MATERIALS

Introduced Bill

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

S 1

SENATE BILL 1640*

Short Title: Medicaid Est. Rec./Funds. (Public)

Sponsors: Senator Marshall.

Referred to: Appropriations.

June 1, 1994

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE MEDICAID ESTATE RECOVERY PLAN AS REQUIRED BY THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993 AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"§ 108A-70.5. Medicaid Estate Recovery Plan.

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 USC 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical

institution and cannot reasonably be expected to be discharged to return home; or

b. If a recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fourth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, to implement this act.

Sec. 3. This act becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date.

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institution and cannot reasonably be expected to be discharged to return home; or

b. If a recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fourth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, to implement this act.

Sec. 3. This act becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date.

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Introduced Bill

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H 1

HOUSE BILL 2068*

Short Title: Medicaid Est. Rec./Funds. (Public)

Sponsors: Representative Alexander.

Referred to: Appropriations.

June 6, 1994

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE MEDICAID ESTATE RECOVERY PLAN AS REQUIRED BY THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993 AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"§ 108A-70.5. Medicaid Estate Recovery Plan.

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 USC 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical

institution and cannot reasonably be expected to be discharged to return home; or

b. If a recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fourth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, to implement this act.

Sec. 3. This act becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date.

institution and cannot reasonably be expected to be discharged to return home; or

b. If a recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fourth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, to implement this act.

Sec. 3. This act becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date.

Requested by: Senator Marshall

MEDICAID ESTATE RECOVERY PLAN

Sec. 101.1. (a) Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"§ 108A-70.5. Medicaid Estate Recovery Plan.

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 USC 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution and cannot reasonably be expected to be discharged to return home; or

b. If a recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a seventh-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

change from introduced Bill

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-

effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance."

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

Requested by: Representatives Nye, Easterling, Alexander

MEDICAID ESTATE RECOVERY PLAN, AS REQUIRED BY FEDERAL LAW

Sec. 169. (a) Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fourth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate.

Same as introduced by H

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-

effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Regarding trusts that contain the assets of an individual who is disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, if the trust is established and managed by a nonprofit association, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the nonprofit association, the trust pays to the Department from these remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the North Carolina Medicaid Program."

New to Senate version

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Regarding trusts that contain the assets of an individual who is disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, if the trust is established and managed by a nonprofit association, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the nonprofit association, the trust pays to the Department from these remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the North Carolina Medicaid Program."

new to house version

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

Requested by: Representatives Nye, Easterling, Alexander, Dickson, Esposito, Senators Marshall, Richardson, Walker

MEDICAID ESTATE RECOVERY PLAN, AS REQUIRED BY FEDERAL LAW

Sec. 25.47. (a) Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"§ 108A-70.5. Medicaid Estate Recovery Plan.

(a) There is established in the Department of Human Resources, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) As used in this section:

(1) 'Medical assistance' means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient is receiving these medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving these medical care services, including related hospital care and prescription drugs, for nursing facility services or home- and community-based services.

(2) 'Estate' means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

Compromise

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Regarding trusts that contain the assets of an individual who is disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, if the trust is established and managed by a nonprofit association, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the nonprofit association, the trust pays to the Department from these remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the North Carolina Medicaid Program."

Same as in House bill

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

(d) The Department of Human Resources shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Regarding trusts that contain the assets of an individual who is disabled as defined in Title 19 of Section 1014(a)(3) of the Social Security Act, as amended, if the trust is established and managed by a nonprofit association, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the nonprofit association, the trust pays to the Department from these remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the North Carolina Medicaid Program."

Same as in House version

(b) Of the funds appropriated in this act from the General Fund to the Department of Human Resources, Division of Medical Assistance, the sum of one hundred four thousand seven hundred fifty dollars ($104,750) for the 1994-95 fiscal year, of which fifty thousand dollars ($50,000) is nonrecurring, shall be used to implement this section.

(c) Subsection (a) of this section becomes effective October 1, 1994, and applies to individuals who apply for medical assistance on or after that date. The remainder of this section becomes effective July 1, 1994.

§ 28A-19-6. Order of payment of claims.

After payment of costs and expenses of administration, the claims against the estate of a decedent must be paid in the following order:

First class. Claims which by law have a specific lien on property to an amount not exceeding the value of such property.

Second class. Funeral expenses to the extent of two thousand dollars ($2,000). This limitation shall not include cemetery lot or gravestone. The preferential limitation herein granted shall be construed to be only a limit with respect to preference of payment and shall not be construed to be a limitation on reasonable funeral expenses which may be incurred; nor shall the preferential limitation of payment in the amount of two thousand dollars ($2,000) be diminished by any Veterans Administration, social security or other federal governmental benefits awarded to the estate of the decedent or to his or her beneficiaries.

Third class. All dues, taxes, and other claims with preference under the laws of the United States.

Fourth class. All dues, taxes, and other claims with preference under the laws of the State of North Carolina and its subdivisions.

Fifth class. Judgments of any court of competent jurisdiction within the State, docketed and in force, to the extent to which they are a lien on the property of the decedent at his death.

Sixth class. Wages due to any employee employed by the decedent, which claim for wages shall not extend to a period of more than 12 months next preceding the death; or if such employee was employed for the year current at the decease, then from the time of such employment; for medical services within the 12 months preceding the decease; for drugs and all other medical supplies necessary for the treatment of such decedent during the last illness of such decedent, said period of last illness not to exceed 12 months.

Seventh class. All other claims.

§28A-15-1. Assets of the estate generally.

(a) All of the real and personal property, both legal and equitable, of a decedent shall be assets available for the discharge of debts and other claims against his estate in the absence of a statute expressly excluding any such property. Provided that before real property is selected the personal representative must determine that such selection is in the best interest of the administration of the estate.

(b) In determining what property of the estate shall be sold, leased, pledged, mortgaged or exchanged for the payment of the debts of the decedent and other claims against his estate, the personal representative shall select the assets which in his judgment are calculated to promote the best interests of the estate. In the selection of assets for this purpose, there shall be no necessary distinction between real and personal property, absent any contrary provision in the will.

(c) If it shall be determined by the personal representative that it is in the best interest of the administration of the estate to sell, lease, or mortgage any real estate or interest therein to obtain money for the payment of debts and other claims against the decedent's estate, the personal representative shall institute a special proceeding before the clerk of superior court for such purpose pursuant to Article 17 of this Chapter, except that no such proceeding shall be required for a sale made pursuant to authority given by will. A general provision granting authority to the personal representative to sell the testator's real property, or incorporation by reference of the provisions of G.S. 32-27(2) shall be sufficient to eliminate the necessity for a proceeding under Article 17.

(d) The crops of every deceased person, remaining ungathered at h death, shall, in all cases, belong to the personal representative or collector, as part of the personal assets of the decedent's estate; and shall not pass to the devisee by virtue of any devise of the land, unless such intent be manifest and specified in the will. (1868-9, c. 113, ss. 14, 15; Code, ss. 1406, 1407; Rev., ss. 45, 47; C.S., ss. 52, 54; 1973, c. 1329, s. 3; 1975, c. 300, s. 5; 1985, c. 426.)

§28A-15-10. Assets of decedent's estate for limited purposes.

(a) When needed to satisfy claims against a decedent's estate, assets may be acquired by a personal representative or collector from the following sources:

(1) Tentative trusts created by the decedent in savings accounts for other persons;
(2) Gifts causa mortis made by the decedent;
(3) Joint deposit accounts with right of survivorship created by decedent pursuant to the provisions of G.S. 41-2.1 or otherwise; and joint tenancies with right of survivorship created by decedent in corporate stocks or other investment securities.

Such assets shall be acquired solely for the purpose of satisfying such claims, however, and shall not be available for distribution to heirs or devisees.

(b) Where there are not sufficient personal and real assets of the decedent to satisfy all the debts and other claims against his estate, the personal representative shall have the right to sue for and recover any and all personal property or real property, or interes

§28A-15-1. Assets of the estate generally.

(a) All of the real and personal property, both legal and equitab of a decedent shall be assets available for the discharge of debts and other claims against his estate in the absence of a statute expressly excluding any such property. Provided that before real property is selected the personal representative must determine that such selection is in the best interest of the administration of the estate.

(b) In determining what property of the estate shall be sold, leased, pledged, mortgaged or exchanged for the payment of the debts of the decedent and other claims against his estate, the personal representative shall select the assets which in his judgment are calculated to promote the best interests of the estate. In the selection of assets for this purpose, there shall be no necessary distinction between real and personal property, absent any contrary provision in the will.

(c) If it shall be determined by the personal representative that it is in the best interest of the administration of the estate to sell, lease, or mortgage any real estate or interest therein to obtain money for the payment of debts and other claims against the decedent's estate, the personal representative shall institute a special proceeding before the clerk of superior court for such purpose pursuant to Article 17 of this Chapter, except that no such proceeding shall be required for a sale made pursuant to authority given by will. A general provision granting authority to the personal representative to sell the testator's real property, or incorporation by reference of the provisions of G.S. 32-27(2) shall be sufficient to eliminate the necessity for a proceeding under Article 17.

(d) The crops of every deceased person, remaining ungathered at h death, shall, in all cases, belong to the personal representative or collector, as part of the personal assets of the decedent's estate; and shall not pass to the devisee by virtue of any devise of the land, unless such intent be manifest and specified in the will. (1868-9, c. 113, ss. 14, 15; Code, ss. 1406, 1407; Rev., ss. 45, 47; C.S., ss. 52, 54; 1973, c. 1329, s. 3; 1975, c. 300, s. 5; 1985, c. 426.)

§28A-15-10. Assets of decedent's estate for limited purposes.

(a) When needed to satisfy claims against a decedent's estate, assets may be acquired by a personal representative or collector from the following sources:

(1) Tentative trusts created by the decedent in savings accounts for other persons;
(2) Gifts causa mortis made by the decedent;
(3) Joint deposit accounts with right of survivorship created by decedent pursuant to the provisions of G.S. 41-2.1 or otherwise; and joint tenancies with right of survivorship created by decedent in corporate stocks or other investment securities.

Such assets shall be acquired solely for the purpose of satisfying such claims, however, and shall not be available for distribution to heirs or devisees.

(b) Where there are not sufficient personal and real assets of the decedent to satisfy all the debts and other claims against his estate, the personal representative shall have the right to sue for and recover any and all personal property or real property, or interes

therein, which the decedent may in any manner have transferred or conveyed with intent to hinder, delay, or defraud his creditors, and any personal property or real property, or interest therein, so recovered shall constitute assets of the estate in the hands of the personal representative for the payment of debts and other claims against the estate of the decedent. But if the alienee has sold the personal property or real property, or interest therein, so fraudulently acquired by him from the decedent to a bona fide purchaser for value without notice of the fraud, then such personal property or real property, or interest therein, may not be recovered from such bona fide purchaser but the fraudulent alienee shall be liable to the personal representative for the value of the personal property or real property, or interest therein, so acquired and disposed of to a bona fide purchaser. If the whole recovery from the fraudulent alienee shall not be necessary for the payment of the debts and other claims against the estate of the decedent, the surplus shall be returned to such fraudulent alienee or his assigns.

(c) Where there has been a recovery in an action for wrongful death, the same shall not be applied to the payment of debts and other claims against the estate of decedent or devises, except as to the payment of reasonable burial and funeral expenses and reasonable hospital and medical expenses incident to the injury resulting in death and as limited and provided in G.S. 28-18-2 [G.S. 28A-18-2]. (1973, c. 1329, s. 3.)

MEDICAID ESTATE RECOVERY
STATUS OF IMPLEMENTATION

July 1994

Formed interdepartmental workgroup for information and advice on implementation plans and formulation of procedures

Workgroup includes representatives from:

Administrative Office of the Courts
County Clerks of Court
Attorney General's Office
County Directors of Social Services
Division of Aging
Institute of Government
Association of County Attorneys
Legal Services
NC County Commissioners Association
Division of Medical Assistance

August, 1994

Workgroup met and formed three subcommittees to make recommendations on:

Recipient Notice and Appeal Rights;
Administrative Rules;
Filing Claims Against Estate

(Charge to subcommittees and membership attached)

September, 1994

Received written guidance from HCFA for implementing estate recovery (copy attached)

Workgroup to meet on 9/20 for subcommittee reports and recommendations for policy/procedures in NC

Future Plans:

October, 1994

Publish proposed administrative rules

Draft Medicaid State Plan Amendment

Inform County Departments of Social Services of notice and hearing requirements pending rulemaking

Design system supports for automated production of claim against estate and management report for tracking claims and receipts

Coordinate notification of Medicaid estate recovery requirments to County Clerks of Court with Administrative Office of the the Courts and to County Attorneys with Attorney's Association

November, 1994	Hire administrator and hearing officer for estate recovery provisions
	Route Medicaid State Plan Amendment for DHR and State Budget Office reviews
	Draft procedures for filing claims
	Draft procedures for determinations and due process rights on undue hardship
December, 1994	Submit State Plan Amendment to HCFA
	Conduct public hearing on proposed rules
	Respond to comments on proposed rules
	Finalize plans for appeals on determinations of permanent institutionalization

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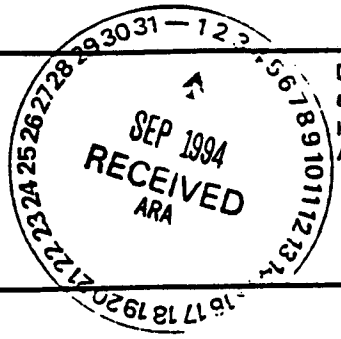
MEDICAID ESTATE RECOVERY

SUBCOMMITTEE TITLE	MEMBERS	CHARGE
Recipient Notices	Joe Whitley, Chair Mason Hogan Claude Whitner Rosemary Long Debbie Brantley Bob Mercer Geneva Ray	Draft proposed notice for: 1. Individuals determined to be permanently institutionalized. 2. Individuals who require nursing level of care or CAP services at age 55 or after. 3. Make recommendations on when and how the notice will be given. 4. Begin defining procedures for filing and conducting appeals re: permanent institutionalization.
Administrative Rules	Rosemary Long, Chair Gwynn Swinson Andy Wilson Barbara Brooks	Draft basic provisions of APA rules for: 1. Definition of permanently institutionalized. 2. Circumstances that would result in a hardship to heirs (degree of relationship) 3. Basis for waiver of recovery due to not being cost effective.
Filing Claims	Don Best, Chair John Kennedy Gwynn Swinson Larry Crandall Alene Matthews	Draft recommendations for: 1. Agency responsible for filing a claim. 2. Form letter to make claim. 3. Method for determining amount of Medicaid payments subject for recovery. 4. Reporting 5. Agency responsible for filing a suit if personal representative refuses claim or disregards.

state medicaid manual
Part 3 — Eligibility

Department of Health and Human Services
Health Care Financing Administration



Transmittal No. 63 Date SEPTEMBER 1994

REVISED MATERIAL	REVISED PAGES	REPLACED PAGES
Table of Contents		
Chapter 3	3-9-1 (1 p.)	3-9-1 (1 p.)
Sec. 3810	3-9-3 - 3-9-7 (5 pp.)	

NEW IMPLEMENTING INSTRUCTIONS--EFFECTIVE DATE: 10/1/93

Section 3810, Medicaid Estate Recoveries.--These instructions provide guidance for meeting the requirements in §13612 of OBRA 1993. Section 13612 amends §1917(b) of the Act to require adjustments or recoveries of Medicaid benefits correctly paid on behalf of an individual. These instructions do not alter the regulations in 42 CFR 433.36 which permit States to recover benefits incorrectly paid.

If legislation other than for appropriating funds is needed in order to meet these requirements, the State may request a delayed compliance date through the HCFA regional office. Provide sufficient documentation, including an Attorney General's opinion, to demonstrate that State legislation is required. If legislation is needed, States will not be penalized for failing to comply with the terms of OBRA 1993 until the date specified in §13612(d)(1)(B). Since the Federal compliance remedy under the Medicaid statute is a prospective one, these States need not make their legislation incorporating the new statutory provisions retroactive to October 1, 1993. However, States that want to enact statutes retroactive to October 1, 1993, may do so.

CHAPTER IX

GENERAL FINANCIAL ELIGIBILITY REQUIREMENTS AND OPTIONS

3810. MEDICAID ESTATE RECOVERIES

Under the estate recoveries provisions in §1917(b) of the Act, you must recover certain Medicaid benefits correctly paid on behalf of an individual. The following instructions explain the rules under which you must recover from an individual's estate Medicaid benefits correctly paid and incorrectly paid.

A. Adjustment and Recovery.--You must seek adjustment or recovery of medical assistance correctly paid on behalf of an individual under your State plan as follows.

1. Permanently Institutionalized Individuals.--In the case of permanently institutionalized individuals who the State determines cannot reasonably be expected to be discharged and return home, including individuals who qualify as both permanently institutionalized individuals and who are at least 55 years old, you must seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien, at a minimum, of amounts spent by Medicaid on the person's behalf for services provided in a nursing facility, ICF/MR, or other medical institution. These amounts also include Medicare cost sharing for qualified Medicare beneficiaries (QMBs) to the extent that the Medicare cost sharing was for these institutional services. At your option, you may also recover amounts up to the total amount spent on the individual's behalf for medical assistance for other services under the State plan. The date on which you determine the individual to be permanently institutionalized does not affect which expenditures you must or may recover from the individual or his or her estate. If you elect to recover all medical assistance, it would include assistance furnished prior to the time you determined the individual to be permanently institutionalized. If you only elect to recover for expenditures for institutional services, you must recover for all institutional services furnished to the individual, regardless of whether they were furnished during the current stay in the facility. Your State plan must reflect the medical assistance subject to recovery. Recoveries must be made from the individual's estate (after death) or from the proceeds of the sale of the property on which a lien has been placed.

Permanently institutionalized individuals are persons of any age who are inpatients in a nursing facility, ICF/MR, or other medical institution as defined in 42 CFR 435.1009, and who must, as a condition of receiving services in the institution under your State plan, apply their income to the cost of care, as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832. You must specify in your State plan the process by which you will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home, the notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. States are not required to use the supplemental security income intent to return home rule for purposes of determining whether an individual is permanently institutionalized for purposes of estate recovery. This rule applies only to eligibility determinations.

2. Individuals Age 55 or Older.--You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance. You must recover up to the total amount spent by Medicaid on the person's behalf, but only for spending on nursing facility services, (which includes skilled nursing facility and intermediate care facility for the mentally retarded services), home and community based services, as defined in §§1915(c) and (d), 1929, and 1930 of the Act, and

related hospital and prescription drug services. Related hospital and prescription drug services are any hospital care or prescription services provided to an individual while receiving nursing facility services and home and community-based services. These amounts also include Medicare cost sharing for QMBs to the extent that the Medicare cost sharing was for nursing facility services, home and community-based services, and related hospital and prescription drug services described above. At your option, you may also recover additional amounts up to the total amount spent on the individual's behalf for medical assistance for any other items or services under your State plan. List these other items and services in your State plan. Recovery is limited to medical assistance for services received at age 55 or thereafter.

3. Individuals With Long Term Care Insurance Policies.--

a. Adjustment or Recovery Required.--Except as provided in §3810.A.3.b, you must seek adjustment or recovery from the individual's estate for all Medicaid costs for nursing facility and other long term care services if (1) assets or resources are disregarded to the extent of payments made under a long term care insurance policy, or (2) assets or resources are disregarded because the individual received (or is entitled to receive) benefits under a long term care insurance policy.

b. Assets or Resources Disregarded/Not Disregarded.--If you had an approved State plan, as of May 14, 1993, (California, Connecticut, Indiana, Iowa, and New York) which provided for the disregard of assets or resources in determining eligibility for medical assistance either to the extent that payments are made under a long term care insurance policy, or because an individual has received or is entitled to receive benefits under such a policy, you are not required to seek adjustment or recovery from the individual's estate for Medicaid costs for nursing facility and other Medicaid long term care expenses. While HCFA cannot compel you to recover any amounts from the estates of these individuals, you are free to do so if consistent with the terms of your State plan.

4. Adjustment or Recovery Limitations.--Adjustment or recovery can only be made after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21, or a blind or disabled child as defined in §1614 of the Act. For Guam, Puerto Rico, and the Virgin Islands, any surviving child's blindness or permanent or total disability would be determined under the definitions found in the State plan program for providing assistance to the blind or permanently and totally disabled. If a lien is placed on an individual's home, adjustment or recovery can only be made when (1) there is no sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time, and (2) there is no son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she has been providing care which permitted the individual to reside at home rather than in an institution.

B. Definition of Estate.--Specify in your State plan the definition of estate that will apply.

1. Probate Definition.--At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law.

2. Optional Definition.--In addition to property and assets under the probate definition, you may include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

3. Special Rule for Individuals With Long Term Care Insurance.--In the case of individuals described in §3810.A.3.a, you must use the definition of estate as described in subsection B.2.

C. Undue Hardship.--Where estate recovery would work an undue hardship, adjustment or recovery is waived. Establish procedures and standards for waiving estate recoveries when they would cause undue hardship. You may limit the waiver to the period during which the undue hardship circumstances continue to exist. Describe your policy in your State plan. You have flexibility in implementing an undue hardship provision. However, your undue hardship waiver protection does not apply to individuals with long term care insurance policies who became Medicaid eligible by virtue of disregarding assets because of payments made by a long term care insurance policy or because of an entitlement to receive benefits under a long term care insurance policy. California, Connecticut, Indiana, Iowa, and New York must apply their undue hardship rules to all individuals, including those eligible for Medicaid by virtue of State plan provisions related to the purchase of a long term care insurance policy.

1. Undue Hardship Defined.--Undue hardship might exist when the estate subject to recovery is the sole income-producing asset of the survivors and income is limited (e.g., a family farm or other family business which produces a limited amount of income when the farm or business is the sole asset of the survivors). The legislative history of §1917 of the Act states that the Secretary should provide for special consideration of cases in which the estate subject to recovery is (1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, (2) a homestead of modest value, or (3) other compelling circumstances. HCFA suggests that you consider the examples listed above in developing your hardship waiver rules, but does not require you to incorporate these examples once you have considered whether they are appropriate for determining the existence of an undue hardship.

In considering your criteria, you may conclude that an undue hardship does not exist if the individual created the hardship by resorting to estate planning methods under which the individual divested assets in order to avoid estate recovery. You may adopt a rebuttable presumption that if the individual obtained estate planning advice from legal counsel and followed this advice, the resulting financial situation would not qualify for an undue hardship waiver.

D. Collection Procedures.--You must adopt procedures under which individuals who will be affected by recovery of amounts of medical assistance will have the right to apply for an undue hardship waiver. These procedures must, at a minimum, provide for advance notice of any proposed recovery. They must also specify the method for applying for a waiver, the hearing and appeal rights, and the time frames involved. You should specify the procedures used for collection, which must be reasonable. In the situation where recovery is not waived because of undue hardship and heirs of the estate from which recovery is sought wish to satisfy your recovery claim without selling a non-liquid asset subject to recovery, you may establish a reasonable payment schedule subject to reasonable interest. You may also undertake partial recovery to avoid an undue hardship situation.

E. Adjustment or Recovery Not Cost Effective.--You may waive adjustment or recovery in cases in which it is not cost effective for you to recover from an individual's estate. The individual does not need to assert undue hardship. You may determine that an undue hardship exists when it would not be cost effective to recover the assistance paid. You may adopt your own reasonable definition of cost effective. However, any methodology you use for determining cost-effectiveness must be included in your State plan. If you made individuals eligible for Medicaid because of a long term care insurance policy or disregard of income because of the purchase of long term care insurance, you are restricted from using this waiver authority unless you had as of May 14, 1993, an approved State plan which provided for long term care insurance-related disregards from income. In that event, you can use the undue hardship exception as a basis for applying a cost effectiveness test to individuals who became eligible based upon long term care insurance-related disregards.

F. Placement of TEFRA Liens.--You are not required to use TEFRA liens in §1917(a) of the Act. Section 13612 of OBRA 1993 did not mandate the use of TEFRA liens. The TEFRA liens allow you to place liens on certain types of property and recover specific types of payments as described in subsections F.1 and F.2. You may use liens as a mechanism/tool to recover medical assistance incorrectly paid as indicated in F.1, or correctly paid on behalf of certain permanently institutionalized individuals, as indicated in subsection F.2.

1. Incorrect Payments.--You may place a lien against an individual's property, both personal and real, before his or her death because of Medicaid claims paid or to be paid on behalf of that individual if a court determines that benefits were incorrectly paid for that individual.

2. Correct Payments.--You may place a TEFRA lien against the real property of an individual at any age before his or her death because of Medicaid claims paid or to be paid for that individual when (1) he/she is an inpatient of a medical institution and must, as a condition of receiving services in the institution under your State plan, apply his/her income to the cost of care (as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832), and (2) the agency determines that the person cannot reasonably be expected to return home as specified in §3810.A.1. The State's authority to place a lien after the individual's death is not restricted by the TEFRA lien provisions.

G. Restriction on Placement of TEFRA Liens.--You may not place a TEFRA lien, as indicated in subsection F.2, on an individual's home if any of the following individuals are lawfully residing in the home: (1) the spouse, (2) the individual's child who is under age 21 or blind or disabled, as defined in §1614 of the Act, in States (or blind or permanently and totally disabled in Guam, Puerto Rico, and the Virgin Islands), or (3) the individual's sibling (who has an equity interest in the home and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution).

H. Termination of Liens.--You must dissolve any lien imposed as provided in subsection F.2 on an individual's real property when that individual is discharged from the medical institution and returns home.

I. Notice.--

1. General Notice.--You should provide notice to individuals at the time of application for Medicaid that explains the estate recovery program in your State.

2. Recovery or Adjustment Notice.--You should give a specific notice to individuals affected by the proposed recovery whenever you seek adjustment or recovery. In the case that the individual is dead, the notice should be served on the executor or legally authorized representative of the individual's estate. The executor or legally authorized representative should be required to notify individuals who would be affected by the proposed recovery. In the situation where there is no executor or legally authorized representative, the State should notify the family or the heirs. The notice should include, at a minimum, the action the State intends to take, reason for the action, individual's right to a hearing, method by which he/she may obtain a hearing, procedures for applying for a hardship waiver, and the amount to be recovered. An administrative hearing is not required if State law provides for court review as the next appellate step.

J. Effective Date of New Provision.--Section 13612 of OBRA 1993 does not apply to individuals who died before October 1, 1993. This section applies to Medicaid payments beginning on or after October 1, 1993.

K. Delayed Compliance Date.--If legislation other than for appropriating funds is needed in order to meet these requirements, you may request a delayed compliance date through the HCFA regional office.

L. Effective Date - States With Estate Recovery Programs in Effect Prior to October 1, 1993.--If you had an estate recovery program approved under your State plan and in operation prior to October 1, 1993, for individuals of any age who are determined permanently institutionalized prior to October 1, 1993, you may recover from the estate or upon sale of the property subject to a lien for all services correctly paid before October 1, 1993. You may also recover for services paid for before October 1, 1993, from the estate of an individual age 65 or older when that person received medical assistance. Recovery for these services is in accord with the features of your approved plan in effect prior to October 1, 1993.

COMPARISON OF MEDICAID ESTATE RECOVERY AND LIEN RECOVERY

	ESTATE RECOVERY	LIENS
Statutory Basis :	Mandated by Section 1917 of the Act as amended by OBRA 1993	Option in Section 1917 of the Act
Applies to:	(1) Permanently institutionalized (2) Age 55 and above who receive Medicaid for long term care or Community Alternatives Services	Patients in long term care institutions who own real property
When Filed:	90 days after publication of public notice to creditors	At time Medicaid is approved for long term care services
Place Filed:	To individual named as executor or personal representative	Clerk of Court
Recovery:	After death from assets subject to probate	When real property sold or transferred or after death as part of estate recovery
Limits:	Cannot pursue if spouse, minor or disabled/blind child lives in homesite	Cannot file lien if spouse or dependent minor or adult disabled/blind child lives on property
	Amount recovered limited to Medicaid payments made on behalf of the individual for long term care and CAP	Same as estate recovery
Dissolution:	State may waive recovery if it would create hardship or is not cost-effective to recover	Disolves if long term care patient is discharged to return home, otherwise is subject to estate recovery provisions. State must define what constitutes discharge to return home.
Priority of Claim :	Medicaid is a 5th class creditor	Uncertain of lien changes class of creditor to 4th
Required Action to implement :	NA Action approved by 1994 Legislature	Implementing legislation

STATES WITH MEDICAID ESTATE RECOVERY PROGRAM

STATE	ESTABLISHED ESTATE RECOVERY	PRIORITY OF CLAIM	DEFINITION OF ESTATE: PROBATE LAW OR MORE	FY 93 TOTAL RECOVERY	STATE SHARE
* California	1981	1. IRS 2. Funeral Expenses 3. Medicaid 4. Heirs	All in Probate	$21M	$10.5 K
*Connecticut	at least past 25 yrs.	1) Funeral Expenses 2) Final Illness 3) IRS 4) Medicaid	State probate law	in excess $10 M	$5 M
*Indiana	20+ yrs.	Preferred	State probate law	$3 M	$1.1 M
Illinois	40+ yrs.	6th	State probate law	$9 M	$4.5 M
*Maryland	7/1/76	General creditor	State probate law	$1.3 M (+ lien program = $1.5 M)	$1.4 M
*Massachusetts	allowed into law 1969 agressive use 1989	1) Adm. Costs/ Funeral Cost 2) IRS 3) Medicaid	State probate law	$10.6 M	$5.3 M
*Minnesota	1967	4th	State probate law	$6.7 M	$1.8 M
**Missouri	1979-80	7th	State probate law	$1.3 M	$520 K

* States with lien law

** Law [illegible] oks but not implemented

STATES WITH MEDICAID ESTATE RECOVERY PROGRAM

STATE	ESTABLISHED ESTATE RECOVERY	PRIORITY OF CLAIM	DEFINITION OF ESTATE: PROBATE LAW OR MORE	FY 93 TOTAL RECOVERY	STATE SHARE
* New Hampshire	1973	1. Funeral Expenses 2. Any Previous Illness 3. All Adm. Expenses 4. Medicaid	State probate law	(1973-$370 K) 1993-$3.4 M	$1.6 M
New Jersey	1971-72	1. Funeral Expenses 2. Adm. Expenses 3. IRS 4. Medicaid	State probate law	(before '85 $722 K) 1st 4 mo.'94 $742 K	$390K
*New York	15-20 yrs. ago	Whoever files 1st, however, NY attaches upon admission to LTC	State probate law	$80 M	$20 M
* Utah	1980	1. Funeral Expenses 2. Attorney's Fees 3. Taxes State/Federal 4. Medicaid	Everything in Estate	$400 K	$99 K

* States with lien law

North Carolina Hospital Association

Mailing Address:
Post Office Box 80428
Raleigh, NC 27623-0428

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2400 Weston Parkway
Cary, NC 27513

Phone: 919/677-2400
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September 14, 1994

Susan Sabre
Staff Attorney
Legislative Bill Drafting Division
Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603-5925

Dear Susan,

Thank you for the opportunity to comment on the new state statute authorizing estate recovery for Medicaid.

As you know, hospitals are under increasing pressure from payers and others to aggressively collect outstanding debts to the hospital for health care services. Often, because of the patient's poor health or age, hospitals are unable to do as good a job as other businesses. After all, most hospitals in North Carolina are either public or private nonprofit corporations who are organized and operated for a charitable purpose. It is difficult many times to draw the line where charity ends and bad debt begins.

One of the collection practices employed by some hospitals is to allow very sick patients to confess judgment for the amount of the hospital debt in exchange for the hospital agreeing to forego execution on the judgment. Upon the patient's death, the hospital would file a claim against the patient's estate.

This practice benefits both the patient and the hospital. The hospital avoids the expense and time of filing a lawsuit, obtaining a judgment, and executing on the judgment. As you know, a debtor who does not wish to pay a creditor is able to delay this procedure for several months. In addition, the debtor has other means to avoid payment, including North Carolina's homestead exemption and federal bankruptcy.

Hospital officials tell us that most patients are concerned about their bills and many go to extreme lengths to see that the hospital is paid in full. The practice of allowing a patient to confess judgment and to have the bill later paid by the patient's estate is a convenience for the patient. The patient avoids the hassle and embarrassment of debt collection at a time when the patient is in poor health.

The North Carolina Hospital Association believes that the current law, giving a Medicaid claim the same status as a judgment creditor, is an appropriate public policy. To give Medicaid a higher priority would supersede properly docketed judgment creditors who were owed money by the decedent before Medicaid had provided services.

The new law recognizes North Carolina's long-standing tradition as a "race to the courthouse" state, whereby lien creditors are given priority according to the date and time of their filing. To adopt a different policy would undermine years of legal tradition and put creditors who acted in good faith at risk of having their claims foreclosed by the state. "Notice" is an important part of our legal heritage. Without proper notice—filing in the courthouse for all to see—unintended harm may occur to innocent parties.

We believe the General Assembly has made the correct choice.

Sincerely,

William A. Pully
Vice President & General Counsel

INCOME PRODUCING PROPERTY POLICY

AGED, BLIND AND DISABLED CATEGORIES

Current Policy	Policy 1/1/95	Who is Affected	Phase in Implementation
Exclude value of rental property if produces <u>any</u> net profit after expenses. <u>EXAMPLE</u>: Equity Value Property = $50,000 Taxes = 1,000 Annual Rent = <u>1,100</u> Net Profit = $ 100 Yrly	Exclude value of rental property if it produces net profit of at least <u>6% equity</u> value <u>after</u> expenses. <u>EXAMPLE</u>: Equity Value = $50,000 <u>x 6%</u> Minimum Net Profit = $ 3,000 Taxes = <u>1,000</u> Total Rent = $ 4,000 (Versus $1,100 under current policy.)	Does affect: . Medically Needy group. . Typically rental property is the home of a nursing home recipient. The net rental income helps to pay their cost of care. Does not affect: . Actual homesite of a recipient or spouse. . Property used in a business.	. Affects all medically needy persons with rental property who appy 1/1/95 or later. . Current recipients with rental property will be phased in when eligibility redetermined <u>or</u> when current lease expires, if later (under certain conditions, property needing renovation may be excluded while renovations made)

C-28

1 EXPANSION BUDGET REQUEST

Priority No. 17 of 68

2 BUDGET CODE: 14445 DEPARTMENT: Human Resources DIVISION/ INSTITUTION: Division of Medical Assistance

3 FUND NUMBER: 1310 FUND TITLE: Medical Assistance Payments

4 PROGRAM NUMBER: 1 PROGRAM TITLE: Health and Safety

5 TITLE OF REQUEST: Increase Population of Aged, and Disabled Eligible for Medicaid, Effective: 01/01/96

6a STATUTORY CHANGES/SPECIAL PROVISIONS REQUIRED TO IMPLEMENT?

7a YES [X] NO [ ]

8a IF YES, ATTACH A COPY OF THE DRAFT.

9a

		1995-96	1996-97
6b	TOTAL REQUIREMENTS	17,926,200	36,111,278
7b	TOTAL RECEIPTS	12,494,113	25,009,046
8b	APPROPRIATION	5,432,087	11,102,232
9b	TOTAL POSITIONS	0.0	0.0

10 **NARRATIVE: This program is proposed to expand the population of Aged and Disabled people who qualify for Medicaid benefits, effective 01/01/96, by providing Medicaid coverage to all Aged and Disabled individuals whose incomes are equal to or less than 100% of the Federal Poverty Level. Currently, the Aged, Blind and Disabled who do not receive SSI payments are eligible for Medicaid only after they have spent down their countable incomes to approximately 40% of the Federal Poverty Level. Under this provision, aged and disabled people whose monthly incomes are between $242.00 and $614.00 will qualify for medicaid without a deductible. The estimated incremental number people who would be eligible for Medicaid services is 7,000. In addition, approximately 20,836 Medicare Qualified Beneficiaries would qualify for full Medicaid.**

INCOME AND ASSET LEVELS

	FAMILY SIZE	MEDICALLY NEEDY	SSI RECIPIENTS	75% OF POVERTY	100% OF POVERTY
		Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.
INCOME	1	$242 / 2,900	$446 / 5,352	$460 / 5,520	$614 / 7,360
	2	$317 / 3,800	$669 / 8,028	$615 / 7,380	$820 / 9,840
ASSETS	1	$1,500	$2,000	$2,000	$2,000
	2	$2,250	$3,000	$3,000	$3,000

(1) The client's income exceeds the income level and he must spend down the excess income for medical care. The client shall be authorized on the day his incurred medical care costs equal the amount of the excess income.

(2) The assets of AFDC related cases, or cases protected by grandfather provisions, and all Medically Needy cases are reduced to the assets limit during the month. The client shall be authorized on the day the assets are reduced, or incurred medical care costs equal the amount of the excess income, whichever occurs later.

(c) Medicaid coverage shall end on the last day of the last month of eligibility except for those individuals eligible for emergency conditions only as described in Rule .0302 of this Subchapter. The last month of eligibility shall be:

(1) The month in which timely notice of termination expires; or

(2) The month in which adequate notice of termination expires; or,

(3) The last month of the certification period.

Authority G.S. 108A-54; 42 C.F.R. 435.914; 42 C.F.R. 435.919.

.0207 REFERRALS

For all Medicaid applicants and recipients for whom the county department of social services determines eligibility, the ~~The~~ Income Maintenance Caseworker shall explain and make referrals for:

(1) Healthy Children and Teen Program;

(2) Family planning services;

(3) Food stamps;

(4) Governmental benefits including RSDI, SSI, VA;

(5) Vocational rehabilitation services;

(6) Protective services if the client has reason to believe a child receiving assistance has been neglected, abused, or exploited;

(7) Women, Infants and Children Program (WIC).

Authority G.S. 108A-54; 42 C.F.R. 441.56; 42 U.S.C. 1396a(a).

SECTION .0300 - CONDITIONS FOR ELIGIBILITY

.0311 RESERVE

North Carolina has contracted with the Social Security Administration under Section 1634 of the Social Security Act to provide Medicaid to all SSI recipients. Resource eligibility for individuals under any Aged, Blind, and Disabled coverage group is determined based on standards and methodologies in Title XVI of the Social Security Act except as specified in Items (4) and (5) of this Rule. ~~elected the option under Section 1902(f) of the Social Security Act to limit Medicaid eligibility for the aged, blind or the disabled to individuals who meet eligibility requirements more restrictive than those under Supplemental Security Income.~~ Applicants for and recipients of Medicaid shall use their own resources to meet their needs for living costs and medical care to the extent that such resources can be made available. Certain resources shall be protected to meet specific needs such as burial and transportation and a limited amount of resources shall be protected for emergencies.

(1) The value of resources currently available to any budget unit member shall be considered in determining financial eligibility. A resource shall be considered available when it is actually available and when the budget unit member has a legal interest in the resource and he, or someone acting in his behalf, can take any necessary action to make it available.

(a) Resources shall be excluded in determining financial eligibility when the budget unit member having a legal interest in the resources is incompetent unless:

(i) A guardian of the estate, a general guardian or an interim guardian has been lawfully appointed and is able to act on behalf of his ward in North Carolina and in any state in which such resources are located; or

(ii) A durable power of attorney, valid in North Carolina and in any state in which such resource is located, has been granted to a person who is authorized and able to exercise such power.

(b) When there is a guardian, an interim guardian, or a person holding a valid, durable power of attorney for a budget unit member, but such person is unable, fails, or refuses to act promptly to make the resources actually available to meet the needs of the budget unit member, a referral shall be made to the county department of social services of a determination of whether the guardian or attorney in fact is acting in the best interests of the member and if not, contact the clerk of court

by the clerk of court. The resources shall be excluded in determining financial eligibility pending action

(c) When a Medicaid application is filed on behalf of an individual who:

(i) is alleged to be mentally incompetent,

(ii) has or may have a legal interest in a resource that affects the individual's eligibility, and

(iii) does not have a representative with legal authority to use or dispose of the individual's resources, the individual's representative or family member shall be instructed to file within 30 calendar days a judicial proceeding to declare the individual incompetent and appoint a guardian. If the representative or family member either fails to file such a proceeding within 30 calendar days or fails to timely conclude the proceeding, a referral shall be made to the services unit of the county department of social services for guardianship services. If the allegation of incompetence is supported by a physician's certification or other competent evidence from sources including but not limited to physicians, nurses, social workers, psychologists, relatives, friends or others with knowledge of the condition of the individual, the resources shall be excluded except as provided in Sub-items (1)(d) or (e) of this Rule.

(d) The budget unit member's resources shall be counted in determining his eligibility for Medicaid beginning the first day of the month following the month a guardian of the estate, general guardian or interim guardian is appointed, provided that after the appointment, property which cannot be disposed of or used except by order of the court shall continue to be excluded until completion of the applicable procedures for disposition specified in Chapters 1 or 35A of the North Carolina General Statutes.

(e) When the court rules that the budget unit member is competent or no ruling is made because of the death or recovery of the member, his resources shall be counted except for periods of time for which it can be established by competent evidence from sources including but not limited to physicians, nurses, social workers, psychologists, relatives, friends or others with knowledge of the condition of the individual that the member was in fact incompetent. Any such showing of incompetence is subject to rebuttal by competent evidence as specified herein and in Sub-item (1)(c) of this Rule.

(2) The limitation of resources held for reserve for the budget unit shall be as follows:

(a) For Family and Children's related categorically needy cases, one thousand dollars ($1,000) per budget unit;

(b) ~~For aged, blind or disabled cases and~~ Family and Children's related medically needy cases, one thousand five hundred dollars ($1,500) for a budget unit of one person, two thousand two hundred fifty dollars ($2,250) for a budget unit of two persons and increases of one hundred dollars ($100.00) for each additional person in the budget unit over two, not to exceed a total of three thousand, fifty dollars ($3,050); ;

(c) For aged, blind, and disabled cases, two thousand dollars ($2000) for a budget unit of one and three thousand dollars ($3000) for a budget unit of two.

(3) If the value of countable resources of the budget unit exceeds the reserve allowance for the unit, the case shall be ineligible:

(a) For Family and Children's related cases and aged, blind or disabled cases protected by grandfathered provisions, and medically needy cases not protected by grandfathered provision, eligibility shall begin on the day countable resources are reduced to allowable limits or excess income is spent down, whichever occurs later;

(b) For categorically needy aged, blind or disabled cases not protected by grandfathered provisions, eligibility shall begin no earlier than the month countable resources are reduced to allowable limits as of the first moment of the first day of the month.

(4) Resources counted in the determination of financial eligibility for categorically needy ~~and medically needy aid to the aged, blind, or disabled cases protected by grandfathered provisions are~~ aged, blind and disabled cases is based on resource standards and methodologies in Title XVI of the Social Security Act except for the following methodologies:

(a) The value of personal effects and household goods are not counted.

(b) Value of tenancy in common interest in real property is not counted.

(c) Value of life estate interest in real property is not counted.

~~(a) Cash on hand;~~

~~(b) The current balance of savings accounts, except savings of a student saving his earnings for educational purposes;~~

~~(c) The current balance of checking accounts;~~

~~(d) Cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand five hundred dollars ($1,500);~~

~~(c) Equity in motor vehicles, including motor homes, determined to be non-essential according to Rule .0403 of this Subchapter;~~

~~(f) Equity in excess of one thousand dollars ($1,000) in motor vehicles, including motor homes, determined to be essential according to Rule .0403 of this Subchapter;~~

~~(g) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;~~

~~(h) Negotiable and salable promissory notes and loans;~~

~~(i) Trust funds;~~

~~(j) The portion of lump sum payments remaining after the month of receipt;~~

~~(k) Individual Retirement Accounts or other retirement accounts or plans;~~

~~(l) Equity in real property not used as the homesite or not producing net income;~~

~~(m) Value of burial spaces other than spaces reserved for the eligible individual, the eligible individual's spouse, and the eligible individual's immediate family which includes the eligible individual's minor and adult children, stepchildren, and adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons;~~

~~(n) Salable remainder interest in life estate property not used as the budget unit's homesite;~~

~~(o) Patient accounts in long-term care facilities.~~

(5) Resources counted in the determination of financial eligibility for ~~aid to categorically needy aged, blind or disabled cases not protected by grandfathered provisions are~~ medically needy aged, blind and disabled cases is based on resource standards and methodologies in Title XVI of the Act except for the following methodologies:

(a) The value of personal effects and household goods are not counted.

(b) Personal property is not a countable resource if it:

(i) is used in a trade or a business; or

(ii) is used to produce goods and services for personal use; or

(iii) produces a net annual income.

(c) Real property not exempted under homesite rules is not a countable resource if it:

(i) is used in a trade or business; or

(ii) is used to produce goods and services for personal use; or

(iii) is non-business income producing property that produces net annual income after operational expenses of at least six percent of equity value per methodologies under Title XVI of the Social Security Act.

(d) Value of tenancy in common interest in real property is not counted.

(e) Value of life estate interest in real property is not counted.

(f) Individuals with resources in excess of the resource limit at the first moment of the month may become eligible at the point that resources are reduced to the allowable limit.

~~(a) Cash on hand;~~

~~(b) The balance of savings accounts, except savings of a student saving his earnings for educational purposes;~~

~~(c) The balance of savings account, except for aged, blind or disabled individuals who have a plan for achieving self support (PASS) that is approved by the Social Security Administration;~~

~~(d) The balance of checking accounts less the current monthly income which had been deposited to meet the budget unit's needs when reserve was verified or lump sum income from self employment deposited to pay annual expenses;~~

~~(e) Cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand five hundred dollars ($1,500);~~

~~(f) Trust funds;~~

~~(g) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;~~

~~(h) Negotiable and salable promissory notes and loans;~~

~~(i) Revocable burial contracts and burial trusts;~~

~~(j) The portion of lump sum payments remaining after the month of receipt;~~

~~(k) Individual Retirement Accounts or other retirement accounts or plans;~~

~~(l) Patient accounts in long-term care facilities;~~

~~(m) Equity in motor vehicles determined to be non-essential under Rule .0403 of this Subchapter or, if no motor vehicle is excluded as essential, any equity in excess of four thousand five hundred dollars ($4,500) in a motor vehicle;~~

~~(n) Equity in real and/or personal property when the combined equities is six thousand dollars ($6,000) or less and the property does not yield a net annual income of at least six percent of the equities;~~

~~(o) Equity in real and/or personal property when the combined equities exceed six thousand dollars ($6,000);~~

~~(p) Equity in personal property subject to (5) (m) and (n) of this Rule, is limited to:~~

~~(i) Mobile homes not used as homesite;~~
~~(ii) Boats, boat trailers and boat motors;~~
~~(iii) Campers;~~
~~(iv) Farm and business equipment;~~

~~(c) Equity in real property, subject to (5) (m) and (z) of this Rule, is limited to:~~
~~(i) Value of burial spaces other than spaces designated for the eligible individual, the eligible individual's spouse, and the eligible individual's immediate family which includes the eligible individual's minor and adult children, stepchildren, and adopted children, brothers, sisters, parents, adoptive parents, and the spouses of these persons;~~
~~(ii) Fee simple interest;~~
~~(iii) Salable remainder interest;~~
~~(iv) Tenancy by the entireties interest only.~~

~~(6) Resources counted in the determination of financial eligibility for aid to medically needy aged, blind or disabled cases not protected by grandfathered provisions are:~~
~~(a) Cash on hand;~~
~~(b) The balance of savings accounts, except savings of a student saving his earnings for educational purposes;~~
~~(c) The balance of savings accounts, except for aged, blind or disabled individuals who have a plan for achieving self support (PASS) that is approved by the Social Security Administration;~~
~~(d) The balance of checking accounts less the current monthly income which had been deposited to meet the budget unit's needs when reserve was verified or lump sum income from self employment deposited to pay annual expenses;~~
~~(e) Cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand dollars ($1,000);~~
~~(f) Trust funds;~~
~~(g) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;~~
~~(h) Negotiable and salable promissory notes and loans;~~
~~(i) Revocable burial contracts and burial trusts;~~
~~(j) The portion of lump sum payments remaining after the month of receipt;~~
~~(k) Individual Retirement Accounts or other retirement accounts or plans;~~
~~(l) Patient accounts in long term care facilities;~~
~~(m) Equity in motor vehicles determined to be non essential under Rule .0403 of this Subchapter or, if no motor vehicle is excluded as essential, any equity in excess of four thousand five hundred dollars ($4,500) in a motor vehicle;~~
~~(n) Equity in real property and personal property that does not produce a net annual income;~~
~~(o) Equity in personal property, subject to (6)(m) of this Rule, is limited to:~~
~~(i) Mobile homes not used as homesite;~~
~~(ii) Boats, boat trailers and boat motors;~~
~~(iii) Campers;~~
~~(iv) Farm and business equipment;~~
~~(p) Equity in real property, subject to (6)(m) of this Rule, is limited to interest in real estate other than that used as the budget unit's homesite and includes:~~
~~(i) Fee simple interest;~~
~~(ii) Tenancy by the entireties interest only;~~
~~(iii) Salable remainder interest;~~
~~(iv) Value of burial spaces other than spaces designated for the eligible individual, the eligible individual's spouse, and the eligible individual's immediate family which includes the eligible individual's minor and adult children, stepchildren, and adopted children, brothers, sisters, parents, adoptive parents, and the spouses of these persons.~~

(6) ~~(7)~~ Resources counted in the determination of financial eligibility for categorically needy Family and Children's related cases are:
(a) Cash on hand;
(b) The balance of savings accounts, including savings of a student saving his earnings for school expenses;
(c) The balance of checking accounts less the current monthly income which had been deposited to meet the budget unit's monthly needs when reserve was verified;
(d) The portion of lump sum payments remaining after the month of receipt;
(e) Cash value of life insurance policies owned by the budget unit;
(f) Revocable trust funds;
(g) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;

(h) Negotiable and salable promissory notes and loans;
(i) Revocable pre-paid burial contracts;
(j) Patient accounts in long term care facilities;
(k) Individual Retirement Accounts or other retirement accounts or plans;
(l) Equity in non-essential personal property limited to:
(i) Mobile homes not used as home,
(ii) Boats, boat trailers and boat motors,
(iii) Campers,
(iv) Farm and business equipment;
(v) Equity in excess of one thousand five hundred dollars ($1,500) in one motor vehicle determined to be essential under Rule .0403 of this Subchapter;
(vi) Equity in motor vehicles determined to be non-essential under Rule .0403 of this Subchapter;
(m) Equity in real property is limited to interest in real estate other than that used as the budget unit's homesite and is limited to:
(i) Fee simple interest,
(ii) Tenancy by the entireties interest only,
(iii) Salable remainder interest,
(iv) Value of burial plots.

(7) ~~(8)~~ Resources counted in the determination of financial eligibility for medically needy Family and Children's related cases are:
(a) Cash on hand;
(b) The balance of savings accounts, including savings of a student saving his earnings for school expenses;
(c) The balance of checking accounts less the current monthly income which had been deposited to meet the budget unit's monthly needs when receive was verified or lump sum income from self-employment deposited to pay annual expenses;
(d) Cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand five hundred dollars ($1,500);
(e) Trust funds;
(f) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;
(g) Negotiable and salable promissory notes and loans;
(h) Revocable prepaid burial contracts;
(i) Patient accounts in long term care facilities;
(j) Individual Retirement Accounts or other retirement accounts or plans;
(k) Equity in non-essential, non-income producing personal property limited to:
(i) Mobile home not used as home,
(ii) Boats, boat trailers and boat motors,
(iii) Campers,
(iv) Farm and business equipment,
(v) Equity in motor vehicles determined to be non-essential under Rule .0403 of this Subchapter;
(l) Equity in real property is limited to interest in real estate other than that used as the budget unit's homesite and is limited to:
(i) Fee simple interest,
(ii) Tenancy by the entireties interest only,
(iii) Salable remainder interest,
(iv) Value of burial plots.

Authority G.S. 108A-54; 108A-55; 108A-58; 42 U.S.C. 703, 704 1596; 42 C.F.R. 435.121; 42 C.F.R. 435.210; 42 C.F.R. 435.711; 42 C.F.R. 435.712; 42 C.F.R. 435.734; 42 C.F.R. 435.823; 42 C.F.R. 435.840; 42 C.F.R. 435.841; 42 C.F.R. 435-845; 42 C.F.R. 445.850; 42 C.F.R. 435.851; 45 C.F.R. 233.20; 45 C.F.R. 233.51.

.0313 INCOME

(a) For family and children's cases, income ~~Income~~ from the following sources shall be counted in the calculation of financial eligibility:
(1) Unearned.
(A) RSDI,
(B) Veteran's Administration,
(C) Railroad Retirement,
(D) Pensions or retirement benefits,

Modified Proposed Rule

(5) ~~Resources counted in the determination of financial eligibility for aid to categorically needy aged, blind or disabled cases not protected by grandfathered provisions are:~~

Resources counted in the determination of financial eligibility for medically needy aged, blind and disabled cases is based on resource standards and methodologies in Title XVI of the Social Security Act except for the following methodologies:

(a) The value of personal effects and household goods are not counted.

(b) Personal property is not a countable resource if it:

(i) Is used in a trade or a business; OR

(ii) Is used to produce goods and services for personal use; OR

(iii) Produces a net annual income.

(c) Real property not exempted under homesite rules is not a countable resource if it:

(i) Is used in a trade or business; OR

(ii) Is used to produce goods and services for personal use; OR

(iii) Is non-business income producing property that produces net annual income after operational expenses of at least 6 percent of equity value per methodologies under Title XVI of the Social Security Act. For purposes of this Sub-item, equity of agricultural land, horticultural land, and forestland is the present use value of the land, as defined by G.S. 105-277.1A., et. seq., less the amount of debts, liens or other encumbrances.

(d) Value of tenancy in common interest in real property is not counted.

(e) Value of life estate interest in real property is not counted.

(f) Individuals with resources in excess of the resource limit at the first moment of the month may become eligible at the point that resources are reduced to the allowable limit.

~~(a) Cash on hand;~~

~~(b) The balance of savings accounts, except savings of a student saving his earnings for educational purposes;~~

~~(c) The balance of savings account, except for aged, blind or disabled individuals who have a plan for achieving self support (PASS) that is approved by the Social Security Administration;~~

~~(d) The balance of checking accounts less the current monthly income which had been deposited to meet the budget unit's needs when reserve was verified or lump sum income from self employment deposited to pay annual expenses;~~

~~(e) Cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand five hundred dollars ($1,500);~~

~~(f) Trust funds;~~

~~(g) Stocks, bonds, mutual fund shares, certificates of deposit and other liquid assets;~~

~~(h) Negotiable and salable promissory notes and loans;~~

~~(i) Revocable burial contracts and burial trusts;~~

~~(j) The portion of lump sum payments remaining after the month of receipt;~~

~~(k) Individual Retirement Accounts or other retirement accounts or plans;~~

~~(l) Patient accounts in long term care facilities;~~

~~(m) Equity in motor vehicles determined to be non essential under Rule .0403 of this Subchapter or, if no motor vehicle is excluded as essential, any equity in excess of four thousand five hundred dollars ($4,500) in a motor vehicle;~~

DEFINITIONS

Homesite -

1. Currently the homesite includes

   a. The house, and

      (1) In the city, the lot on which it sits and all buildings on the lot;

      (2) Outside the city, the acre on which it sits and all buildings on the acre;

      plus

   b. Up to $12,000 in equity of contiguous real property.

2. Effective 1/1/95 the homesite includes

   a. The house, and

      (1) In the city, the lot on which it sits and all buildings on the lot;

      (2) Outside the city, the acre on which it sits and all buildings on the acre;

      plus

   b. All real property contiguous to the homesite.

Income Producing Property - Applicable prior to 1/1/95. Any property used to produce income. It may be excluded if it produces a profit of at least $1 per year. (Beginning 1/1/95 income producing property is divided into business property and non-business income producing property. See below.)

Business Property - Applicable beginning 1/1/95. Property used in a trade or business, such as the land farmed by a farmer, the garage owned by a mechanic, houses or apartments owned by a person who is in the business of renting property, or woodland owned by a person who is in the logging business and cuts timber from the land. Business property is excluded regardless of income produced.

Non-business Income Producing Property - Property that produces income but is not used in the person's trade or business. This would include any property that a person rents when the person is not in the business of renting property. Examples include: A former homesite that is now rented; a piece of rental property owned by a person whose primary business is not renting property; land that a person used to farm that he now rents to someone else; and woodland that is leased to someone else to cut timber. Non-business income producing property must produce annual income of at least 6% of the equity to be excluded.

Equity - For Medicaid purposes equity is determined by subtracting the value of encumbrances on the property (mortgages and other liens or judgments) from the tax assessed value of the property.

Fair Market Value - As used in this document the "fair market value" is a reasonable rate of return based on the amount of income produced by similar property in the same area.

MEDICAID EXCLUSION OF NON-HOME, NON-BUSINESS INCOME PRODUCING REAL PROPERTY

Treatment of Real Property by Other State Medicaid Programs

Arkansas - Uses SSI $6000 equity value and 6% income production rule. Up to $6000 in equity in the real property is excluded if the property produces annual profit of at least 6% of equity.

Florida - Property must produce a "fair market value." The "fair market value" is determined by what other property in the area produces.

Georgia - Uses the SSI $6,000/6% rule.

Kentucky - Uses the SSI $6,000 equity rule. Non-homesite property must produce a "fair market value".

The former homesite of an institutionalized individual is not required to produce income, however, if rented, the income is counted.

Montana - Count equity even if income producing.

Homesite is excluded as long as the recipient has a stated intent to return home.

Tennessee - Must produce a "fair market value" similar to Florida.

Vermont - Must produce a "fair market value" similar to Florida.

MEDICAID EXC N OF REAL PROPERTY

Homesite	Farmland/Openland	Woodland	Vacation Home
Current: . Exclude if the person lives there. . If in a nursing home: - Exclude if expected to return home in 6 mo. - Exclude if spouse or dependents continue to live there. . Exclude former housesite if it is rented and produces a net profit of at least $1 per year.	**Current:** . Exclude up to $12,000 in equity of any real property that is contiguous to the homesite. (Does not include former homesite now income producing.) For property not contiguous to the homesite or for the value of contiguous property in excess of $12,000 equity: . Exclude if it produces a profit through farming rental, etc. Must produce $1 profit per year.	. Exclude if it produces a profit through renting, lumbering, etc. Must produce $1 profit per year.	**Current:** . Exclude if it produces a profit.
After 1/1/95 With 6% Rule: . Exclude if the person lives there. . If in a nursing home: - Exclude if expected to return home in 6 mo. - Exclude if spouse or dependents continue to live there. . Exclude former homesite as non-business income producing property if it produces an annual profit of 6% of equity.	**After 1/1/95 With 6% Rule:** . Exclude all real property contiguous to the homesite. (Does not include former homesite now income producing.) If not contiguous to the homesite: . Exclude if business property (e.g. the person is a farmer and he farms it) regardless of income produced. . Exclude if it is non-business income producing property (e.g. rented) and it produces an annual profit of 6% of equity.	. Exclude business property (e.g. the person is a logger and cuts and sells wood from the land) regardless of income produced. . Exclude if it is non-business income producing property (e.g. rented) and it produces an annual profit of 6% of equity.	**After 1/1/95 With 6% Rule:** . Exclude if it produces a profit of 6% of equity.

EFFECT OF 6% INCOME PRODUCTION RULE

Type of Property and Value	Income Production Under Current Rule	Income Production Under 6% Rule
10 acres of farmland = $15,200 27.75 20 acres of farmland = 13,200 7.75 acres of woodland = 2,103 1.95 acres of farmland = 1,800 1.32 acres (homesite & contiguous) = $19,600	- Client tends 10 acres - Son rents 20 acres for $10 - All tended land produces $2,874 after expenses	TV $32,303 x 6% $ 1,938 or $168/Mo.
Former homesite & contiguous property 1.84 acres - TV $ 3,300 1 acre - TV $12,600	Child leases for $5/Mo.	TV $15,900 x 6% $ 954 or $79.50/Mo.
2 lots each 1.82 One is homesite where spouse lives Total tax value $23,100	Homesite for spouse; contiguous property less than $12,000	N/A
3 acres $48,500, includes homesite	Home for spouse	N/A
Former homesite and contiguous 3.35 acres - TV $15,373	Child rents for $2/Mo. Also pays taxes and insurance	$15,373 x 6% $ 922 or $77/Mo.
Former homesite (house and lot) TV $8,634	Child rents for $12/Mo. and pays taxes and insurance	$8,634 x 6% $ 518 or $43/Mo.
Former homesite TV $14,686 2 vacant lots TV $ 3,374	Rents all property for $45/Mo.	$14,686 + 3,374 18,060 x 6% $ 1,084 or $90/Mo.
Former homesite and contiguous TV $7,292	Rents for $5/Mo.	$7,292 x 6% $ 437 or $36/Mo.
House and lot - former homesite TV $35,570	Rents for $110/Mo.	$35,570 x 6% $ 2,134 or $177.83/Mo.

TV = Tax Value

EFFECT OF 6% : E PRODUCTION RULE

Type of Property and Value	Income Production Under Current Rule	Income Production Under 6% Rule
114.50 acres $151,300 (includes 2 houses) 37.82 acres, wood & open 114,400 $265,700	Rented to son for $10/Mo.	$15,942 or $1328.50/Mo.
Former homesite and farmland/woodland 75.10 acre = $84,100 House and 1 acre = $28,300	Rented by child for $2,157/Yr. $179.73/Mo. after expense	$84,100 $28,300 6% 6% $ 5,046 or 420/Mo. $ 1,698 or 1,415/Mo $5,046 1,698 $6,744 or 562/Mo.
Former homesite and homeland/woodland 44.65 acres open and 10 acres woodland $19,830 33.65 open and former homesite 50,920 $70,750	Rented by child for $903 annually or $75.30/Mo. after expenses	$70,170 6% $ 4,210 or $351/Mo.
House & .6 acres former homesite Tax Value = $82,500 Taxes = 687 Insurance = 435	Children pay taxes, insurance & $10 per month to make property exempt as income-producing. Grandchild rents home from parent and aunt and pays them $400 per month.	Tax Value = $82,500 Mortgage -26,780 Equity Value = $55,720 x 6% Net Profit = 3,343 Ins. & Taxes = + 1,122 Income & Req. = $ 4,465 or $372/Mo.
Former homesite & farmland totaling 137 acres. 32 acres are in 2 parcels separate from homesite. Tax value of house = $ 23,230 Tax value of 55 acres of cleared land = 51,500 Tax value of 50 acres of woodland cut in 1980 = 18,850 Tax value of 32 acres of cleared land = 23,150 Taxes = $872.62 Total TV = $116,730	Son rents cleared land for $3,075 annually. Woodland not used. Homesite vacant. Total property considered income producing and is exempt as an asset	TV $116,730 x 6% $ 7,004 or $584/Mo.

TV = Tax Value

(Section 25.13 of Chapter 769 of the 1993 Session Laws, Regular Session 1994)

Representatives Nye, Easterling, Diamont

MEDICAID COVERAGE FOR ELDERLY, BLIND, AND DISABLED

Sec. 25.13. Effective January 1, 1995, the Department of Human Resources, Division of Medical Assistance, shall provide Medicaid coverage to all elderly, blind, and disabled people who receive Supplemental Security Income (SSI).

1634 IM[illegible]MENTATION

Eligibility Policy

- Meeting and conferences with HCFA to establish mandated eligibility policy- November 1993 to current date.
- Meetings with SSA to confirm SSA roles and responsibilities - November 1993 to current date.
- Developed notice of change between county dss and SSA - August.
- Signed 1634 agreement - August.
- APA rules published for comment - August.
- Limited spenddown for SSI cases thru 12/94 - August.
- Draft eligibility policy changes shared with county committees for comments - Sept.
- Manual changes finalized for print - October - November.
- State plan amendment to HCFA - November.

Information System

- Phase I - Dec. 20, 1994
  - Match SDX to EIS.
  - Lock in SSI status.
  - Program to use SDX to update EIS daily.
  - Automated client notices of Medicaid eligibility based on SSI Status.
  - Issuance of Medicaid ID cards daily as new SSI recipients are added.
  - Update Medicaid claims system nightly.
  - Report conversion of EIS record to SSI record to county dss.
  - Test system processing and outputs.
- Phase II - April 1, 1995
  - Complete programming to fully apply SDX data for updating case record in EIS.

Training

- Teleconference for county directors of social services and key staff - August.
- Developed training plan and illustrations for statewide use - September - October.
- Training of trainers - October.
- Training for county dss supervisors with concentration on planning and organizing for orientation of local advocacy groups and work flow after implementation - November.
- Policy training for county dss supervisors and caseworkers - 2nd day sessions November - December.
- SSA to conduct training for their field staff - November - December.

Outreach

- Computer generated notice about automatic eligibility - November - December.
- Flier informing recipients of covered services and how to use Medicaid ID Card - January.
- Orientation of state-based advocacy groups - December.
- Orientation of local advocacy groups - December.
- Posters mailed to local dss offices, health departments, Legal Services, etc.

Eligibility Policy	Information System	Training	Outreach
	. Phase III - April 1, 1995 - Eliminate reporting SSI cases on county management reports and actions.		
	. Phase IV - July 1, 1995 - Produce reports of third party insurance information received in SDX.		

1634 PROJECT WORKGROUPS - EIS

STEERING COMMITTEE	POLICY WORKGROUP	AUTOMATION WORKGROUP
SCOPE	SCOPE	SCOPE
• Approve Implementation Strategies • Oversee activities of workgroup • Ensure county involvement • Ensure critical dates met • Resolve conflicts	• Review policy drafts • Make recommendations to Steering Committee and DMA Management for optional methodologies • Amend APA rules • Amend Medicaid State Plan • Recipient Notice Text • 1634 Contract	• Requirements definition • Test plans and testing • User instructions • System conversion • Medicaid ID card issuance • Impact on DIRM operation • Impact on MMIS and Medicare Buy-In
MEMBERSHIP:	MEMBERSHIP:	MEMBERSHIP:
Alene Matthews, Chair, DMA Barbara Brooks, DMA Jon Brookshire, SSA Harry Foard, Tyrrell County DSS Kay Fields, DSS Fred Beckham, DDS John Harrison, DIRM Kathy Tamsberg, Legal Services Howard Horton, DIRM	Andy Wilson, Advisor, DMA Laurie Giles, DMA Julia McCollum, DMA Jon York, DMA Deborah Matthews, DMA Mary Pergerson, DSS Karen Scarborough, Montgomery County DSS B.J. Hodges Guilford County DSS Bill Horne, Guilford County DSS Linda Cooke, Mecklenburg County DSS Jo Ellen Smith, Pasquotank County DSS Appeal and Disability Staff, DSS	Tom Lambert, Advisor, DMA Jonnette Earnhardt, DMA Kathy Barnett, DMA Donna Pittman, DMA Laura Bryant, DSS Belinda Autry, DSS Rex Woodlief, DIRM Bob Breed, DIRM Maxine Norwood, DIRM Mike Mason, DIRM Operations Staff, DIRM

1634 PROJECT WORKGROUPS

TRANSITIONAL WORKGROUP	TRAINING WORKGROUP
SCOPE	SCOPE
• Plan and conduct teleconference briefing • Recipient orientation and education • Planning for resolution of system discrepancies • Impact on county dss operations providing services to SSI recipients • Interim plans to reduce mass case reviews by county dss • Coordination with other agencies who serve the recipient population • Orientation for advocacy groups	• Establish training team • Develop training agenda and plan • Conduct statewide training for counties
MEMBERSHIP:	MEMBERSHIP:
Marjorie Morris, Advisor, DMA Carolyn McClanahan, DMA Ann Harris, DMA Jo Ellen Smith, Pasquotank County DSS B.J. Hodges, Rockingham County DSS Linda Norman, Rockingham County DSS Bill Horne, Guilford County DSS Linda Cooke, Mecklenburg County DSS Shelley Gettys, Mecklenburg County DSS Karen Scarborough, Montgomery County DSS Patti Held, Disability Hotline Yolanda Walker, DHR Office of Citizen Affairs Debbie Brantley, Division of Aging	Marjorie Morris, Advisor, DMA Charlotte Cooke, DMA Diana Howard, DMA Mary Simmons, DMA Kathie Barnett, DMA Belinda Autry, DSS Mary Pergerson, DSS

What else do I need to know about Medicaid?

- If you receive SSI, you will not have a Medicaid deductible.
- When you receive Medicaid, you may be eligible for help with transportation to medical appointments or services. Contact your local Department of Social Services for assistance. You must be a current Medicaid recipient.
- Medicaid only covers medical bills. If you need help with other household expenses, contact your local Department of Social Services. There may be other programs which can help you.
- If you need assistance with nursing home care, you must contact your local Department of Social Services.
- You may live in a county which requires enrollment in a managed care plan such as an HMO or Carolina ACCESS.

Información en Español

Comenzando enero 1995, las personas que reciben SSI autómaticamente recibiran una tarjeta de Medicaid mensualmente. Para más información llame a CARELINE 1-800-662-7030 de lunes a viernes de 8-5.

WHAT ARE MY RESPONSIBILITIES?

- As long as you receive an SSI check and Medicaid card, you must report any change in your situation to Social Security. This includes changes in:
  - –Income
  - –Address
  - –Assets
  - –Living arrangement
- You must show your Medicaid card to a provider before you receive a medical service. **If you do not, you may be billed for the service.**

QUESTIONS ABOUT SSI?

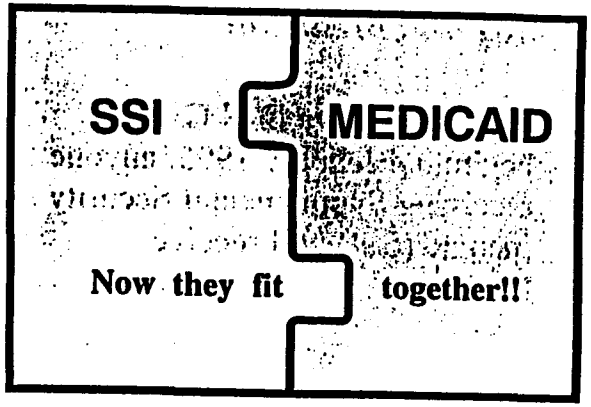
Call 1-800-772-1213 or your local Social Security office.

QUESTIONS ABOUT MEDICAID?

Call or visit your local Department of Social Services or call CARELINE at 1-800-662-7030.

150,000 copies of this document were printed at a cost of $.026 cents per copy.

NORTH CAROLINA MEDICAID



AUTOMATIC ELIGIBILITY FOR SSI RECIPIENTS

What is Medicaid?

Medicaid is a program that pays medical bills for eligible low-income people who cannot afford the cost of health care.

SSI and Medicaid

Due to a change in N.C. law, beginning January 1995, anyone receiving Supplemental Security Income (SSI) will receive Medicaid.

If you think you may be eligible for SSI, you must apply at the Social Security office. The SSI application is also an application for Medicaid.

If you are not eligible for SSI, you must apply for Medicaid at your lo Department of Social Servic

What Bills Will Medicaid Pay?

- → Prescription drugs
- → Doctor visits, if the doctor accepts you as a Medicaid patient.
- → Hospital care, inpatient and outpatient
- → Medicare premiums, copayments and deductibles
- → Dental care
- → Lab and X-ray
- → Eye exams and glasses
- → Home health and Hospice
- → Nursing home care
- → Mental health care
- → Dialysis

Medicaid does not cover all medical bills. Your doctor or other provider can tell you if a service is covered by Medicaid. Some services require prior approval. Your doctor must request approval **before** providing the treatment or vice.

MEDICAID WILL NOT COVER:

- ♦ Bills for services received during a time you were not eligible for Medicaid
- ♦ Care or services not covered by Medicaid
- ♦ Care or services received from a provider who does not accept Medicaid
- ♦ Medicaid copayments on services such as prescriptions, dental visits or doctor visits

  Copayments range from $1.00 to $3.00

How Do I Use My Medicaid Card?

You will receive a Medicaid card in the mail each month as long as you receive an SSI check.

You must show your Medicaid card each time you visit a health care provider.

If you do not show your card, you may be responsible for the bill.

Your pharmacist will keep the stub from your card. You may not change pharmacists until you get a new card the next month.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
FILE NO. C-C-74-183-M

BEFORE THE SPECIAL MASTER

CLARA ALEXANDER, et. al.,

Plaintiffs,

vs.

ROBIN BRITT, Secretary, North Carolina Department of Human Resources, in his official capacity and MARY DEYAMPERT, Director, Division of Social Services, N.C. Department of Human Resources, in her official capacity[1]

Defendants.

PLAINTIFFS' REQUEST FOR DISPUTE RESOLUTION TO REQUIRE DEFENDANTS TO CONTINUE TO PERMIT MEDICAID APPLICATIONS BY THE AGED, BLIND, AND DISABLED

I. INTRODUCTION

1. Now come the plaintiffs, pursuant to Section IX.C. of the March 20, 1992 consent order, and request the Special Master to issue a proposed order to enjoin defendants from instructing county departments of social services (DSS's) not to accept applications for Medicaid from aged, blind, and disabled persons. Unless enjoined, defendants will issue such instructions next month, to be effective January 1, 1995. The instructions violate the terms of the consent order and, if they become effective, will cause

[1] This suit was filed against the named defendants' predecessors in their official capacities as Secretary of the North Carolina Department of Human Resources and Secretary of the Division of Social Services of the North Carolina Department of Human Resources. Because Mr. Britt and Ms. Deyampert now serve in those capacities, they are automatically substituted as the defendants in this suit pursuant to Fed.R.Civ.P. 25(d)(1).

irreparable harm to thousands of class members. Therefore, plaintiffs request an immediate hearing by the master to determine whether the instructions are consistent with the terms of the consent order.

2. Defendants' instructions purport to be based upon a provision of the appropriations bill passed by the North Carolina General Assembly in July 1994. The provision states in its entirety: "Effective January 1, 1995, the Department of Human Resources, Division of Medical Assistance, shall provide Medicaid coverage to all elderly, blind, and disabled persons who receive Supplemental Security Income (SSI)." 1993 (Reg. Sess., 1994) Session C. 769, Sec. 25.13 (attached as Exhibit A). The legislation thus expanded Medicaid eligibility in North Carolina. It did not eliminate any of the multiple existing N.C. Medicaid categories for aged, blind and disabled persons which are not dependent upon receipt of SSI. 1993 Session C. 321, Sec. 222(d) (attached as Exhibit B); see also, N.C. Medicaid Eligibility Manual, MA-2200 (attached as Exhibit C). Nonetheless, defendants' instructions state that persons who may be eligible for SSI may not apply for Medicaid at their county DSS.

3. These instructions are fundamentally contrary to the purpose of the consent order, namely, to assure that individuals have a right to apply at DSS for any category of AFDC or Medicaid for which they may be eligible and receive a proper determination of their eligibility within the time standards specified in the consent order. 1992 Consent Order, ¶ 7, p.3. Specifically,

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plaintiffs allege that the proposed instructions violate the terms of the consent order as follows:

II. DISCOURAGEMENT OF APPLICATIONS

4. The instructions require county DSS's to discourage all aged, blind and disabled individuals who "potentially" may be eligible for SSI benefits from filing Medicaid applications at DSS. The instructions require DSS workers not to accept applications from these individuals but instead to inform them that they may only apply for Medicaid by applying for SSI benefits through the Social Security Administration (SSA). Proposed MA-2300, §III.B.1.a; MA-2301, §§ I.B.8.b (p.5), II.B.1.c.(7)(p.13). (Portions of defendants' proposed instructions are attached hereto as Exhibit D.) The instructions permit DSS's to accept an application only if an individual "insists" on applying after being specifically discouraged from doing so. Proposed MA-2301, §§ I.A.1 (p.1), I.C.3 (p.9).

5. These instructions are in direct contravention of Section II. of the consent order. Section II.A. requires defendants

> to assure that all DSS's accept public assistance applications on the first day a person appears desiring to apply. Specifically, the defendants shall assure that DSS's do not refuse to accept an application and that DSS's do not discourage potential applicants from applying. For the purposes of this order, discouragement by DSS shall be presumed if DSS (a) requires or suggests that the individual wait to apply until other benefits have been applied for or approved (or denied) . . . .

1992 Consent Order, § II.A (emphasis added).

6. The instructions also are in conflict with Section II.C. of the consent order. This section requires that a potential

applicant "be informed of his right to file applications in more than one program category. . . . DSS must explain all available programs and options and discuss the advantages and disadvantages of each program or option for which a potential applicant may qualify." 1992 Consent Order, § II.C (emphasis added). By contrast, defendants' instructions state that if the individual is potentially eligible for Medicaid as an SSI recipient, that individual has no right to apply for Medicaid at the county DSS. Proposed MA-2301, § I.A.8.b (p.5).[2]

7. Defendants' instructions state that individuals potentially eligible for SSI "must apply for Medicaid through the Social Security Administration" by filing an application for SSI at an SSA office. Proposed MA-2300, III.B.1. Defendants assert that such individuals need not apply for Medicaid at DSS because their SSI application will serve as a Medicaid application. Id. But the policy requires DSS to refuse to accept a Medicaid application without any assurance that the SSA process will protect the individual's right to receive Medicaid in a timely manner for all months he may be Medicaid eligible. This is true for at least four reasons.

A. First, any delay between the date of the DSS discouragement and the date that the individual is able to apply for SSI could result in a loss of Medicaid coverage for one or more

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[2] Defendants will accept an application if the individual has minor children and will accept an application for limited Medicaid benefits if the individual receives Medicare. Proposed MA-2301, §I.C.3. However, these exceptions will rarely apply.

months. This is because Medicaid coverage cannot be provided any earlier than three calendar months preceding the month that an application is accepted. 42 C.F.R. §435.914. If the individual comes to DSS on the last day of December and needs coverage for medical bills incurred in October, even a one day delay in applying for SSI will cause him to lose Medicaid coverage for those bills.

B. Second, an SSI application, even if filed immediately after the DSS discouragement, is not subject to the time limits for determining Medicaid eligibility set out in Section V. of the consent order. Thus, the discouragement may substantially delay a determination of Medicaid eligibility beyond the time standards within which defendants agreed to determine Medicaid eligibility.

C. Third, if SSI is eventually denied, or is denied for some months covered by the SSI application, the individual will never receive Medicaid based on the SSI application for all months in which the individual is potentially Medicaid eligible. This is because, if an individual applies for Medicaid only by applying for SSI, he cannot receive Medicaid for any month in which he is not an SSI recipient. 42 C.F.R. 435.909(b)(1); Proposed MA-1000, §I. Yet the individual may have been Medicaid eligible during those SSI-ineligible months under a different Medicaid category.[3]

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[3] For example, an individual with fluctuating income or resources may be found by SSA to have been SSI eligible in only some of the months for which he applied. But Medicaid has more liberal rules than SSI regarding resource eligibility and permits an individual with excess income to qualify for Medicaid by meeting a deductible. See, e.g., Proposed MA-2120, II.C. and G.

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D. Fourth, SSA will not determine Medicaid eligibility for the three month retroactive period prior to the SSI application. 20 C.F.R. §416.2130(b)(2). Thus an application at DSS will always be necessary to determine retroactive eligibility. Yet defendants' policy prohibits such an application at DSS from being filed until after SSI has been approved or denied. Proposed MA-2100, §II.A.

8. Defendants have tried to disguise their policy of discouragement by characterizing persons who are eligible for but not yet receiving SSI as not eligible for Medicaid. Proposed MA-2300, §III.B.1. As explained in paragraph 2 above, this is incorrect since under North Carolina law, Medicaid eligibility for the aged, blind, and disabled is not dependent upon receipt of or eligibility for SSI. See, Exhibits A, B, and C.

9. Even assuming that defendants could legally deny Medicaid to persons who are eligible for but not receiving SSI, the instructions nonetheless would violate Section II of the consent order for two reasons. First, DSS will not know whether the individual is an SSI recipient. The DSS worker cannot determine whether an individual will be an SSI recipient in the month he seeks to apply for Medicaid; only SSA can do that. If the individual files an SSI application before the end of the month and the application is approved, he will be an SSI recipient and will be Medicaid eligible for the month for which he seeks to apply for

Medicaid. Proposed MA-1000, §I.[4] Section III.D. of the consent order thus prohibits defendants from denying a Medicaid application until SSA determines whether the applicant is entitled to SSI for that month, or until the application has pended for three months (or six months if a disability determination is needed) awaiting the SSI determination. Yet, defendants' instructions require DSS's to refuse to accept an application without knowing what decision will be made on the SSI application. This procedure violates Section II.A.(b) of the consent order, which prohibits DSS from discouraging an application by prematurely, incorrectly informing the individual that he is not eligible for Medicaid.

10. Second, DSS will not know whether the prospective applicant is eligible for SSI. According to federal law, eligibility for SSI can be determined only by SSA and only upon the filing of an SSI application. 20 C.F.R. §416.105, .200-202. DSS workers do not have the authority to determine SSI eligibility, will not be aware of the many, complex requirements for SSI eligibility, and will have almost none of the voluminous information and verification necessary for an accurate SSI eligibility determination. See, generally, 20 C.F.R. Part 416 and SSI Program Operations Manual. Yet, the instructions require DSS's to make a determination summarily that the prospective applicant is "potentially" eligible for SSI, without even accepting a Medicaid

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[4] This manual section states: "Eligibility for Medicaid begins with the first day of the month in which SSI eligibility begins and continues as long as the individual remains eligible for SSI."

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application, and without awaiting an SSI eligibility determination by SSA. Proposed MA-2301, §I.C.8.b (p.5). This on-the-spot, hypothetical guess about potential SSI eligibility will, in turn, determine whether the individual is permitted to apply for Medicaid. Id. Such a procedure violates Section II.A.(b) of the consent order, by requiring DSS's to discourage applications by incorrectly stating that individuals are not eligible for Medicaid because they are eligible for SSI in circumstances in which DSS worker cannot possibly be certain of either SSI eligibility or Medicaid ineligibility.

11. Defendants' instructions also bar individuals who wish to apply for retroactive Medicaid coverage from applying for that assistance until after their SSI applications have been approved or denied by SSA. Proposed MA-2100, §II.A. This is despite the fact that defendants' proposed policy concedes that the individual wishing to apply for retroactive coverage may be eligible for retroactive Medicaid whether or not his SSI is ever approved. Id. The effect of requiring the individual to wait to apply for retroactive Medicaid will be to delay the filing of the application. The apparent purpose of the policy is thus to circumvent the consent order's requirement to timely process the Medicaid application.

12. This instruction delaying the filing of retroactive Medicaid applications directly violates Section II.A. of the consent order, which, in subsection (a), specifically prohibits the DSS from requiring or suggesting that the individual wait to apply

for Medicaid until other benefits have been applied for or approved (or denied). It also violates Section II.C. of the consent order, which permits an individual to file without delay for any Medicaid category for which he may be eligible.

III. IMPROPER DENIAL OF APPLICATIONS

13. For those individuals who do "insist" on applying for Medicaid despite DSS discouragement, defendants' proposed instructions continue to disregard the terms of the consent order by requiring that such applications be summarily denied without a determination of whether the individual is eligible for Medicaid under all possible categories of eligibility. Proposed MA-2301, §§I.C.3 (p.9), II.B.1 (p.12); Proposed MA-2100, §I.B.3. This summary denial is required in circumstances, as explained in paragraphs 8, 9, and 10 above, in which the DSS has not yet determined Medicaid ineligibility. This violates Section III.D. of the consent order.

14. When an individual applies for SSI or Social Security benefits based on disability as well as filing a Medicaid application, defendants have chosen, in most cases, to adopt the disability determination by SSA for purposes of determining Medicaid eligibility. MA-2525. However, federal regulations mandate that if an individual who has not been approved for SSI applies with the state agency for Medicaid, the Medicaid agency must make its own determination of disability unless it can adopt the SSA disability determination within the ninety day time standard for processing the Medicaid application. 42 C.F.R.

§435.541(c)(1) and (2) (attached as Exhibit E). This requirement assures that a decision on Medicaid eligibility is made within the federal processing time standard regardless of when SSA makes its eligibility decision. The consent order also specifies that delay by SSA in determining disability does not excuse compliance with the order's processing time standards. Consent Order, § V.B.(4).

15. Despite these requirements, defendants' instructions require DSS's to summarily deny Medicaid applications based on disability without awaiting the SSA disability determination and without making their own disability determination if it appears to the DSS worker that the applicant's income and resources make him or her financially eligible for SSI. Proposed MA-2301, §II.B.1; MA-2100, §I.B.3; MA-2304, III.B.3.b. These instructions violate Section III.D.(4) of the consent order, which prohibits denial of an application until after waiting up to six months for a disability determination if a determination that the individual is disabled (either by SSA or by the state) would make the individual eligible for Medicaid.

16. Moreover, defendants' proposed procedure violates Section III.D.(1) of the consent order, which prohibits defendants from denying a Medicaid application unless ineligibility has been verified. To this end, Sections III.D.(1) and II.C of the consent order have been interpreted by the parties in joint instructions to the monitors to require that, prior to denial, ineligibility must be verified for "all other potentially relevant Medicaid programs for both on-going and retroactive Medicaid." Monitoring

Guidelines, Attachment II, Improper Denials, Medicaid Application Only, ¶ 1 (emphasis added) (attached as Exhibit F). "All Medicaid programs" certainly must include Medicaid eligibility based on disability (either based on approval for SSI or a separate state determination). "All Medicaid programs" also is specified by the monitoring instructions to include retroactive coverage, for which the applicant may be eligible regardless of his SSI eligibility. Yet, defendants would require summary denial of an applicant who may be eligible for these Medicaid programs.

17. Even assuming that defendants could deny Medicaid to these applicants based on a hypothetical DSS determination of financial eligibility for SSI without awaiting a decision on the SSI application, the instructions nonetheless would violate the Section III.D.(1) of the consent order. This is because the instructions require such a denial without obtaining sufficient information to verify that the applicant is financially eligible for SSI benefits. Even under defendants' instructions, Medicaid ineligibility is dependent on verification of SSI financial eligibility. Proposed MA-2304, §III.B.3.e. Because the proposed procedures do not actually verify SSI financial eligibility, such a denial will necessarily violate Section III.D.(1) of the consent order by requiring the denial of Medicaid applications without first verifying Medicaid ineligibility.

18. For example, SSI financial eligibility cannot be determined for any month without knowing whether the SSI applicant will be found eligible for Social Security (Title II) disability

insurance benefits and the amount of those benefits. This is because an award of Social Security benefits may cause the individual to be over the income limit for SSI for all months applied for. SSI Program Operations Manual, SGN 02610.005, et seq (attached as Exhibit G). Yet, defendants intend to require DSS's to deny Medicaid applications based on supposed financial eligibility for SSI without any information at all about the applicant's eligibility for Social Security benefits. Proposed MA-2260. Significantly, Social Security eligibility for the months at issue will be dependent upon the determination of the onset date of the disability, the very determination defendants refuse to await before denying the Medicaid application. 20 C.F.R. §§404.320(b), 404.316(a) (attached as Exhibit H).

IV. NEED FOR IMMEDIATE HEARING: SEVERE IRREPARABLE HARM

19. Plaintiffs request that a hearing on this matter be scheduled for no later than November 18, 1994 in order to resolve this matter as soon as possible.[5] A prompt hearing is necessary to permit the Master sufficient time to issue a ruling and defendants sufficient time to issue legal instructions prior to January 1, 1995. Enjoining these instructions from taking effect on that date is necessary to prevent irreparable harm to thousands of potential Medicaid applicants.

20. If defendants are not enjoined from issuing this policy, thousands of class members who attempt to apply for Medicaid based

[5] Plaintiffs will conduct depositions prior to the hearing and do not believe testimony at the hearing will be necessary.

on their age, blindness or disability after January 1, 1995 will suffer irreparable harm. Under this policy, class members will be denied the right to a determination of their Medicaid eligibility within the time standards set out in Section V. of the consent order. They will be discouraged from applying for, or summarily denied, Medicaid without a consideration of all categories of the Medicaid program for which they are potentially eligible. They will be discouraged from applying for, or summarily denied, retroactive Medicaid coverage for which they are potentially eligible.

21. Class members who are required to apply first at the Social Security Administration and receive a decision on that application before even applying for Medicaid will suffer a substantial delay in the determination of their Medicaid eligibility beyond the time standards set out in the consent order. The average processing time for SSI disability claims in 1993 was 111 days. Government Accounting Office Report, Social Security: Increasing Number of Disability Claims and Deteriorating Service (Nov. 1993) (attached in part as Exhibit I).

22. In addition, in many cases defendants' policy will cause individuals to lose Medicaid benefits entirely for months in which they are Medicaid eligible. This is because if SSI is denied or denied for some months, it will be too late for the previously discouraged individual to apply at DSS for Medicaid coverage for all of those months.

23. Affected members of the plaintiff class are individuals

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applying for Medicaid based on age, blindness, or disability. Almost by definition, these individuals are indigent, medically uninsured, disabled from working, and in need of medical care. Because defendants' discouragement or denial will be based on a lack of income and resources, those affected will be the poorest of those seeking defendants' assistance. Because of the delay and loss of benefits caused by the illegal procedure, class members will be unable to obtain essential medical care or purchase necessary prescription drugs to treat and control their disabling conditions. Class members thus will be threatened with long-term harm to their health and even death. Immediate injunctive relief is necessary to avoid substantial and irreparable harm to the plaintiff class.

V. RELIEF REQUESTED

24. For the foregoing reasons, plaintiffs request the Special Master to enter a proposed order enjoining defendants: (1) not to issue any instructions to DSS's which could be interpreted to require or permit the discouragement or denial of any Medicaid application on the basis that the individual is potentially or financially eligible for SSI benefits; (2) to reopen any application denied on the basis of such instructions, if issued, pursuant to Section III.D.(5) of the consent order; (3) to retroactively accept applications for all individuals discouraged from applying under such instructions, if issued, pursuant to Section II.A. of the consent order; (4) to pay remedial fines to all discouraged and improperly denied applicants who are

subsequently approved pursuant to Section VI.A. of the consent order.

This the 14th day of October, 1994.

ATTORNEYS FOR PLAINTIFFS

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Transylvania County

September 2, 1994

Alene Matthews,
Assistant Director Recipient/Provider Services
N.C. Dept. of Human Resources
Division of Medical Assistance
P.O. Box 29529
1985 Umstead Dr.
Raleigh, NC 27626-0529

RE: Implementation of SB 1505

Dear Ms. Matthews:

My congratulations to the Division on achieving its long-sought goal of eliminating North Carolina's 209(b) status. This should significantly assist both applicants/recipients and communities through simplification and expanded benefits. Obviously with such a large reorganization many parties will identify issues that may portend difficulties. In planning for this change, I would point out several substantive questions that individuals and organizations have raised while discussing the implementation of §25.13 of SB 1505 which mandates "Medicaid coverage of all elderly, blind, and disabled people who receive Supplemental Security Income (SSI)." These questions come from individuals in and outside the public assistance system who desire to balance the competing needs of applicants/recipients and county departments of social services.*

These questions fall into two broad categories:

* How will any new processes seek to ensure that applicants do not bounce back and forth between the offices of Social Security and Social Services?
* How will any new processes seek to ensure that applicants preserve their access to health care in a manner no more limited than at the present?

In raising these questions in a timely fashion, hopefully, the Division can eliminate potential problems prior to issuing policy to counties.

* I do not discuss any issues which may arise from the Alexander consent decree, as these fall outside my bailiwick. Nor do I broach any type of procedural issues.

How will any new processes seek to ensure that applicants do not bounce back and forth between the offices of Social Security and Social Services?

This question touches on a variety of sub-issues surrounding what many refer to as the ***single portal*** plan. As described by Division staff during the August 16 teleconference, the single application portal for Medicaid for all elderly, blind, and disabled people who may receive Supplemental Security Income (SSI) lies through local Social Security Administration offices. Successful SSI applicants will automatically receive Medicaid benefits with no further action on their part. Those denied SSI will receive notices from both Social Security and the State noting the denial of both SSI and Medicaid and advising the applicant of the possibility of Medicaid under a different category requiring a subsequent separate Medicaid application.

Inasmuch as the impetus for the conversion to 1634 status largely arose from a desire for simplicity, any processes which result in applicants being referred from Social Services offices to Social Security and then back to Social Services evidences serious problems.

RETROACTIVE COVERAGE. The most significant matter concerns retroactive coverage of Medicaid subsequent to the approved SSI application. The information imparted during the teleconference described a process that would require a separate, later application for retroactive Medicaid benefits. Division staff noted during the teleconference the ongoing effort with Social Security to develop questions for Social Security staff to elicit information from applicants about their unmet medical expenses. Many worry that Social Security's own Procedures Operations Manual (POM) does not provide direction to its staff on the assessment of applicants' need for retroactive coverage.

POM §SI 01715.001 C.3. notes that "[r]etroactivity is very important" and states that the applicants' need for such coverage can affect the selection of the "effective date" of SSI. SI 00601.045 ("Effective Filing") allows the SSI applicant to "choose any date from the filing date through the end of the following month." The section fails to mention retroactivity. SI 00604.120 ("Filing for Medicaid Based On SSI") points out that "[I]f unpaid medical expenses exist for the period prior to the month of the SSI application, the State may require a separate Medicaid application." (Emphasis in the original) But then in SI 00604.078 discussing the SSI application's questions concerning Medicaid, no mention exists of the unpaid medical expenses.

While these instructional deficiencies are possibly alleviated by the regulatory statement in 20 CFR 416.2145(b) that, by the 1634 agreement, Social Security may provide information concerning the need for retroactive Medicaid coverage, other sections create problems for applicants and agencies. Specifically, 20 CFR 416.2130 notes that Social Security "will not" determine "whether a person is eligible for Medicaid for any period before he or she applied for SSI... ." Thus for the 40% of Medicaid applicants requesting retroactive coverage, the "single portal" will be closed.

SUBSEQUENT MEDICAID APPLICATIONS. The difficulties surrounding the single portal concept arise anew for individuals needing Medicaid but who are denied SSI benefits by Social Security for reasons other than disability. Assuming that these individuals will need to return to the local department of social services for a subsequent Medicaid application (as noted during the teleconference), then the issue of protected application status (ie., taking the SSI application date as the Medicaid application date) comes to the fore. Without this protected date, applicants will lose periods of eligibility due to Medicaid's inability to cover more than three months prior to the date of application.

One cannot overestimate the importance of this issue. Moving an application date one day (from the end of one month to the beginning of the next month) could result in the denial of an applicant's request for coverage for a hospital bill. To the extent the local department can access the SSI application date, the problem's severity is reduced.

Query, to what extent the State needs a subsequent application. Clearly, the SSI application stands as the Medicaid application (42 CFR 435.541 & SI 00604.120 C. & D.). 20 CFR 416.2116 notes that Social Security determines only ***eligibility***. This section notes when Social Security does not make "the determination, we notify the State of that fact." The provision seems to leave it to the State to make its own Medicaid denial determinations. The accuracy of this hypothesis becomes clear with consideration of 42 CFR 435.451(c)(1):

> [The State must make its own determination of disability and eligibility when] the individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

The plain meaning of these provisions would indicate that the State can, even should, act on the single application taken by Social Security.

INCOMPATIBLE INCOME/RESOURCE STANDARDS. As noted above, Social Security can deny (on non-disability grounds) an individual SSI but she may still receive Medicaid benefits. The challenge lies in devising a means of independently establishing the individual's Medicaid eligibility while not losing the individual in a bureaucratic shuffle nor burdening local departments of social services. Requiring another application of the individual serves no purpose other than placing a hurdle over which a possibly eligible person must jump.

For instance, a disabled individual could have worked a long enough period of time to establish an entitlement for Title II Social Security Disability Insurance Benefits. Assuming the individual's entitlement amount and/or household income surpasses the SSI income ceiling Social Security would deny the individual's SSI application. Yet the individual could easily receive Medicaid in the Medically Needy category, especially in a retroactive coverage scenario. Alternatively, a disabled person could not receive SSI as a result of the ownership of excess real property. Again, the individual could establish Medicaid by utilizing North Carolina's more lenient income producing property exclusionary rules.

Assuming that local departments of social services will attempt to screen individuals upon their inquiry into Medicaid to avoid pointlessly referring such cases to Social Security, then Eligibility Specialists will require a great deal more training to assess the individual's Title II status, income and resources. For the assessment to have value, the effort expended will need to resemble the present application intake process.

DELAYED DECISIONS. The directives of 42 CFR 435.451 also lead to another category of cases where the State must act independently of Social Security's processes: where Social Security fails to make a disability decision in less than 90 days (which happens in roughly 30% of cases) "from the date of the individual's application for Medicaid." Unless the State acts upon the SSI application, the mandate makes no sense and the individual does not receive the protection of a timely decision.

Further, basic practical considerations direct that the State act upon the SSI application. As the calendar runs down toward the 90th day, the State cannot expect to have local departments of social services trying to contact individuals to have them come in to make an application for the agency's consideration.

How will any new processes seek to ensure that applicants preserve their access to health care in a manner no more limited than at the present?

In converting to a 1634 state and utilizing the Social Security Administration to determine Medicaid disability (MAD) eligibility, the gains made in administrative simplicity could come with the costs of denying thousand of the sickest individuals access to medical care during the Social Security appeal process. This would occur as a result of switching to a system which either failed to consider the SSI application as the Medicaid application or which refused to allow a separate Medicaid application. Without either provision, individuals could not appeal denials of MAD benefits outside Social Security's process.

In the last fiscal year, the State's appeal system decided more than 4800 MAD appeals. These decisions resulted in an approval for 80% of the applicants (roughly 3800 cases). Currently, the State hearing process (mandated by N.C. Gen. Stat. §108A-79) requires on average 131 days for a decision. Where evidence exists to allow a favorable decision without a hearing (true in roughly 40% of MAD cases), the processing time falls to only 39 days.

In the Social Security appeal process, after the initial denial (taking 60-90 days), the next level of review (Reconsideration) adds, at least, an additional 3 months to the process. Assuming applicants proceed to an administrative law judge hearing, it takes upwards of 5-6 months to *schedule* a hearing and then an additional 4-6 months for a decision. Social Security's own national statistics note that appeals at the administrative law judge level take more than 300 days with the delays expected to increase in the upcoming year.

The systems' time differences (6 months v. 12 months) constitute the potential harm. Under the plan described during the teleconference, individuals would go without medical coverage for the entire 12-18 month Social Security appeal process. This would mean that 3800 individuals who currently get coverage would do without. These 3800 would then be without nursing facility care (and as such, would be difficult to remove from costly hospital beds), drugs to manage chronic care problems, and physicians to handle chronic care needs such as arthritis, orthopedic needs, diabetes and many coronary problems. Care needs would be handled through hospital emergency rooms at acute care payment rates.

Conversion to 1634 status in no way changes the State's ability to maintain a means of assisting those most in need. This can happen by either deeming the SSI application as the Medicaid application or allowing those that wish to make a separate application to do so.

42 USC §1396a(v) entitled, **State agency determination of disability and blindness and provision of medical assistance prior to final determination by Administration**, allows that

> A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

The legislative history of this provision clearly demonstrates that Congress allowed states to retain the option of providing independent disability determination despite Health Care Financing Administration's (HCFA's) rules at 42 CFR 435.541. The Senate Conference Report comments that

> that a State may furnish Medicaid to an otherwise eligible person on the basis of the State's own determination of disability or blindness during the period before SSA makes a final determination of disability or blindness, provided that the State uses the criteria set forth in SSI law.

Cong. Rec., H 12669 (10/26/90). The Secretary has noted that "final determination" describes the final Social Security administrative decision.

Thus North Carolina can avoid a great deal of suffering by allowing individuals the option of contesting their denial of disability through the State's own hearing system. This process, with its shorter decision-making time frames, would help to ensure that individuals can access much needed health care while preserving much desired administrative simplification.

While many important questions remain unresolved in this most important program transition, the solutions hopefully remain within grasp. The twin goals of increasing assistance to those in need of medical care and reducing the administrative burdens on state and local agencies do not exist as

mutually exclusive choices. In each instance noted above answers exist and while we may not possess the findings to make balanced decisions quickly, patient exploration will surface them. I appreciate the difficulties faced by the agency in this task and offer to help to make the transition as smooth as possible for all the parties involved.

Sincerely yours,

Curtis B. Venable
Attorney at Law

CBV/idi

cc. Mary Deyampert
Jack Jenkins
John Blair
Bob Blum

North Carolina Department of Human Resources
Division of Medical Assistance

P. O. Box 29529 • 1985 Umstead Drive • Raleigh, N.C. 27626-0529 • Courier Service 56-20-06

Barbara D. Matula, Director

James B. Hunt, Jr., Governor
C. Robin Britt, Sr., Secretary

November 18, 1994

Mr. Curtis B. Venable
Pisgah Legal Services
P. O. Box 2276
Asheville, NC 28802

Dear Mr. Venable: Curtis

I appreciate your taking the time to drive to Raleigh recently to meet with me and other state level staff on implementation of our change to 1634 status. We have a strong desire to address your concerns and move forward. This response addresses those issues you raised in your September letter to me. Obviously, the responses herein will be altered based on the agreements reached this week to continue coverage of the optional categorically needy group through March 31, 1995. The responses will apply beginning April 1 in the event the optional group is eliminated.

Subsequent to our October 13 meeting, we mailed a copy of the 1634 agreement signed by Secretary Britt to you and Mr. Redpath. We also have reviewed our understandings of SSI/Medicaid application processing with the Region IV HCFA staff. We are modifying the retroactive eligibility policies for consistency with HCFA's directions. The following responses reflect our most recent discussion with HCFA. For purposes of brevity, I have made a general reference to your stated concern.

A. Ensure that applicants do not bounce back and forth between SSA and DSS

Application for SSI and Medicaid may be made in person at the SSA District Office (or a field office), or by telephone. A few counties and District Offices have arranged for SSA staff to take SSI/Title II applications at the DSS office. Application for Title II benefits, Medicare A and B coverage, and Food Stamps also is made to SSA, basically giving SSI eligibles one stop shopping, except for retroactive Medicaid coverage.

Adequate screening by all agencies who are advocates for this population can help to ensure that proper referrals are made. Referrals are driven in part based on which agency the applicant initially contacts. Thus referrals cannot be totally eliminated. SSA will refer individuals ineligible for SSI/Title II to the county dss offices, just as they do now. County dss offices will refer individuals to SSA to apply for SSI, Title II and Medicare coverage, just as they do now. The simplicity of 1634 is that the individual makes a single SSI/Medicaid application at SSA only. Separate application and supplying information for a determination of Medicaid eligibility only is eliminated for those eligible for SSI.

C-90

D. Retroactive Coverage

County dss offices will take and process applications for retroactive Medicaid coverage for:

1. All medically needy individuals;

2. Aged individuals who are categorically needy and have filed an SSI/Medicaid application to SSA;

3. Aged, disabled and blind individuals whose application for SSI/Medicaid is approved by SSA.

SSI applicants who are not eligible in the month of application may choose an effective date later than the filing month to protect entitlement in a later month. In this event, eligibility for retroactive Medicaid coverage is based on the the latter filing month.

NC SSA staff will receive information and training on their responsibility for Medicaid applications, including retroactive medical needs. NC will reimburse SSA for this additional task.

C. Subsequent Medicaid applications

Individuals denied SSI/Medicaid for reasons other than no disability or blindness will not lose the SSA filing date if they contact the county dss within 60 days after notice of SSI/Medicaid denial. We will protect the initial filing date for Medicaid to determine if the individual can qualify for another benefit.

A signed application for retroactive coverage appears to be essential under the current Alexander Consent Order. Tracking is required for the retroactive portion of an application.

D. Incompatible income/resource standards

County dss offices will not attempt to screen for potential Title II eligibility. Referrals to SSA will be made for individuals whose income and resources are within SSI limits. The SSI resource standards of $2000/$3000 will apply to aged, blind and disabled Medicaid cases whether categorically needy or medically needy. The more liberal Medicaid resource methodologies are related to income producing property. Such property is most likely owned by those who are medically needy rather than categorically needy individuals because of the SSI $6000/6% methodology. We do not plan to apply the $6000 equity test for medically needy cases. County income maintenance caseworkers will receive training on new Medicaid policy based on SSI methodologies which they must apply for retroactive determinations after Jan. 1, 1995. Most of the same policies will apply to the medically needy.

E. Delayed decisions

42 CRF 435.451 is not applicable if the state does not cover the optional categorically needy coverage group described at 435.210. This interpretation has been confirmed with HCFA.

F. Ensure that applicants preserve access to healthcare in a manner no more limited than at present

The "sickest" individuals should not be denied disability. Denials result when the person fails to attend scheduled medical exams or the medical evidence fails to adequately support a finding of disability. In fact SSA approves 39% of its disability cases at the initial level while only 29% of the state Medicaid disability determinations are approved. As you are aware, the disability criteria for SSI and Medicaid are the same. Approximately 25% of Medicaid disability denials and 48% of SSA disability denials are appealed. A fairly high number of the Medicaid denials are reversed upon appeal to the DSS Hearings Office. Similarly, a fairly high number of the SSA denials are reversed at the ALJ level of hearing.

The optional categorically needy coverage group forces duplicate application processing for (1) those who are financially eligible for SSI but have not filed an application, (2) those who have filed an application for SSI and are waiting for a decision, and (3) those who were denied SSI and Medicaid for no disability, but were subsequently approved for Medicaid only through appeal to the DSS Hearings Office. Some of these individuals never qualify for SSI, but continue to receive Medicaid coverage as disabled individuals based on the hearing decision.

As you know, SSA has published an extensive description of its plans to streamline its disability determination and appeal process. Appeal to an Administrative Law Judge is the second level of appeal, thus it is comparable to appeal to NC Superior Court. In fiscal year 1994, only 5 disability appeals to the Superior Courts of NC were filed. Four of those five appeals were resolved by adopting an SSI approval of disability. One is still pending.

You contend that 3800 denied disability applicants will be without nursing facility care and will be difficult to remove from costly hospital beds. According to Medicaid data, less than 10% of Medicaid patients in nursing facilities are disabled. It would be rare that an individual so sick or debilitated as to require care in a skilled or intermediate nursing home would be determined not disabled. Hospitals cannot bill acute care for patients who no longer require acute level of care. Nor can the hospital discharge patients who require nursing facility level of care until a placement is located. Medicaid does pay claims from hospitals, physicians and nursing homes that are filed months after the dates of service, but could not be submitted until eligibility was established.

C. State agency determination of disability and blindness

42 USC 1396(a)(v) is optional to states. NC has not chosen this option. It is not applicable if the optional categoricaly needy coverage group described at 435.210 is not covered.

I trust this adequately addresses your questions. It is important to remember that approximately 180,000 SSI recipients will receive continuous Medicaid coverage. Nearly 40,000 do not currently receive any Medicaid benefits. Many other SSI recipients receive limited coverage as qualified Medicare beneficiaries or must spenddown non-SSI income before they can qualify. As an advocate for the poor, I am sure you are as concerned that they obtain needed income from SSI or Title II as quickly as possible to help meet basic necessities of life as in getting past medical bills paid.

Sincerely,

Alene C. Matthews

Alene C. Matthews

cc: Jack Jenkins
Bob Blum
File

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November 18, 1994

Robert J. Blum
N.C. Dept. of Justice
Raleigh, N.C.
FAX--919-715-3849

RE: 11/17/94 Meeting Concerning Alexander v. Britt and 1634 Implementation

Dear Bob:

This is to memorialize our understanding of the verbal agreement reached yesterday pertaining to Plaintiffs' October 14, 1994 Special Master petition and to initiate broader discussions about this case.

1. The Department of Human Resource will implement the 1634 agreement with the Social Security Administration and 1994 Session Ch. 769, Sec. 25.13 while retaining the current optional categorical coverage permitting eligibility for those eligible for SSI but not receiving [42 USC §1396a(a)(10)(A)(ii)(I)] through March 31, 1995.
2. Monitoring, pursuant to the 1992 Alexander v. Flaherty Consent will immediately cease for cases processed during the 3rd Quarter of 1994 and will not occur for the 4th Quarter 1994. These cases will never be subject to monitoring by the independent monitors.
3. Remedial fines due between November 1, 1994 and March 31, 1994 pursuant to the 1992 Alexander v. Flaherty Consent Order will not be paid.
4. All matters of litigation in Alexander v. Britt pending before either the Special Master or the Court will be stayed for the purpose of negotiations and will remained stayed so long as negotiations continue.
5. Applications dispositioned prior to issuance of policy (March 1, 1993) after receipt of the Special Master's ruling dated November 11, 1992 will not be reopened to document that no special medical condition existed.

6. Applications dispositioned prior to receipt of the Special Master's ruling dated July 21, 1993 will not be reopened to pend for disability when the individual failed to respond to two requests for information.
7. Mail-in applications and those taken at voluntary outstationed provider locations will be considered taken on the date received in the county department of social services office and will not be monitored for offer of all possible options subject to discouragement citations.
8. Applications taken without an interview may be denied following the scheduling of three appointments for interviews where the applicant does not respond, assuming all other requirements of the 1992 Consent Order, other than holding the applications pending, are satisfied.
9. Applications may be denied on the 45th day if the applicant has not supplied requested rebuttal evidence concerning excess reserve assuming all other requirements of the 1992 Consent Order, other than holding the application pending, are satisfied.

The provisions noted in Paragraphs 5, 6, 7, 8 and 9 are permanent, assuming agreement as to all other matters noted above.

If this does not reflect the agreement contact us immediately. If it does, please sign below and return.

Sincerely yours,

Barbara J. Degan
Attorney at Law

Sincerely yours,

Curtis B. Venable
Attorney at Law

November 21, 1994
Date

Robert J. Blum
Special Deputy Attorney General

APPENDIX D

LEGISLATIVE PROPOSAL 1

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

H **D**

DRAFT FOR REVIEW ONLY

95-LFZ-009(1-1)

(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Elderly and Disabled Medicaid Funds. (Public)

Sponsors: Representative Nye

Referred to:

A BILL TO BE ENTITLED

AN ACT TO EXPAND MEDICAID COVERAGE TO ALL ELDERLY AND DISABLED WITH INCOMES AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 1996, The Division of Medical Assistance, Department of Human Resources, shall provide Medicaid coverage to all elderly and disabled people who have incomes at or below the federal poverty level as determined annually.

Sec. 2. There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of five million four hundred thirty-two thousand eight-seven dollars ($5,432,087) for the last six months of the 1995-96 fiscal year and the sum of eleven million one hundred two thousand two hundred thirty-two dollars ($11,102,232) for the 1996-97 fiscal year to provide the State share needed to implement this act.

Sec. 3. This act becomes effective July 1, 1995.

SECTION-BY-SECTION SUMMARY

Section 1 specifies that, effective January 1, 1996, Medicaid coverage will be provided, without deductibles, to all elderly and disabled people who have incomes at or below the federal poverty level, as determined annually.

Section 2 appropriated $5,432,087 for the 1995-96 fiscal year and $11,102,232 for the 1996-97 fiscal year to provide the State share needed to implement Section 1.

Section 3 makes the act effective July 1, 1995.

Legislative Proposal 1 Fiscal Research Summary
MEDICAID EXPANSION
ELDERLY AND DISABLED

Effective January 1, 1994, all beneficiaries of the Supplemental Security Income program (SSI) qualify for Medicaid automatically. Supplemental Security Income is a cash payment, financed and administered by the federal government, which supplements an elderly, or disabled person's income up to a level established by the federal government. The maximum payment for a single SSI beneficiary is equal to 76% ($446 per month) of the federal poverty guidelines and 83% ($669) for a couple. By contrast, elderly and disabled persons who do not receive SSI can not qualify for Medicaid unless they accumulate medical bills which effectively reduce their income to 40% ($242 per month) of the poverty guidelines. The following example illustrates the problem.

	Mr. Jones	Mr. Smith	Mr. Brown
Income Sources	SSI: $446	Social Security: $300 SSI: $146	Social Security: $446
Total Income	$446	$446	$446
Eligibility Threshold	$446	$446	$242
Qualifies for Medicaid:	Yes	Yes	not until medical bills exceed $204/mo.

In this example, all three cases have incomes totaling $446 per month. However, Mr. Brown's medical "spend down" effectively reduces his income for living expenses to $242/mo. or 40% of the poverty guidelines. In this way, current policy discriminates

among applicants based on the source of their income as opposed to the amount of their income. In addition, this eligibility policy favors more costly services where bills quickly accumulate, such as hospital and nursing care, and works against people who need assistance with less costly services such as pharmacy and in-home services.

RECOMMENDATIONS

Elderly and disabled persons who do not receive Supplemental Security Income (SSI) payments are eligible for Medicaid only after they have accumulated medical bills that reduce their incomes to approximately 40% of the poverty level. The LRC recommends extending coverage to aged, blind and disabled people whose monthly incomes are below 100% of the federal poverty guidelines (or $614/mo. for a single person and $820/mo. for a couple). This recommendation adds an estimated 27,836 people for full Medicaid coverage. Costs reflect an implementation date of January 1, 1996.

	FY 95-96	FY 96-97
Total Requirements	$17,926,200	$36,111,278
Federal	$11,535,510	$23,049,829
County	$ 958.603	$ 1,959,217
STATE	$ 5,432,087	$11,102,232