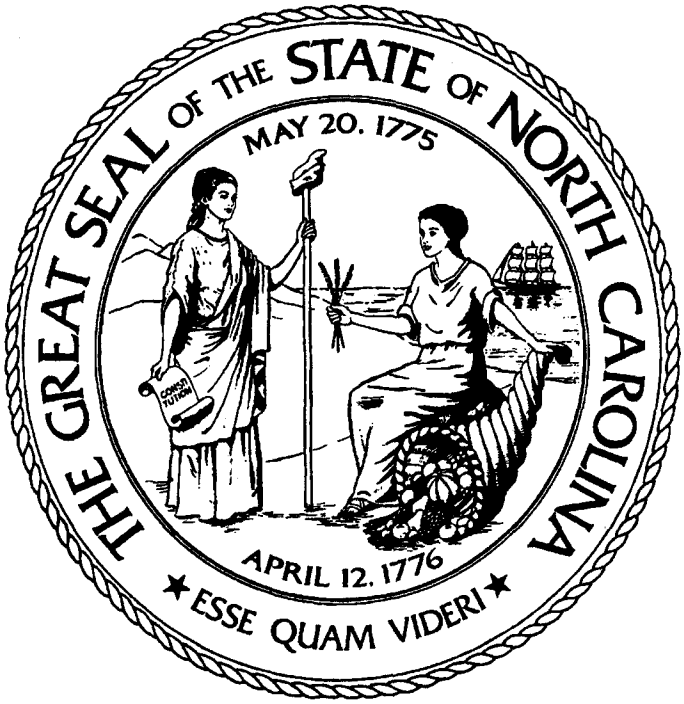
NORTH CAROLINA

STUDY COMMISSION ON AGING



REPORT TO THE GOVERNOR AND THE 1999 GENERAL ASSEMBLY OF NORTH CAROLINA

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North Carolina
Study Commission On Aging

January 27, 1999

To: Governor James B. Hunt, Jr.
President of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 1999 General Assembly

Attached is the *Report* to the North Carolina General Assembly, 1999 Session, from the North Carolina Study Commission on Aging, pursuant to North Carolina General Statute 120-187, which reads: "The Commission shall report to the General Assembly and the Governor the results of its study and recommendations."

The North Carolina Study Commission on Aging presents to you findings and recommendations based on extensive study and public hearings. Proposed legislation is contained within this report.

Respectfully submitted,

Senator Betsy L. Cochrane

Representative Debbie A. Clary

NORTH CAROLINA STUDY COMMISSION ON AGING
1997-1998
Membership List

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Sen. William R. Purcell
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Ms. Betty Rising
Lumberton, NC

The Honorable James D. Speed
Louisburg, NC

Ex Officio:
Ms. Karen Gottovi, Director
Division of Aging
Department of Health and Human Services

Speaker's Appointments

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Mr. George Wilson
Clinton, NC

Staff: John Young

Clerk: Phyllis Porter

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EXECUTIVE SUMMARY

The North Carolina Study Commission on Aging is an independent commission created by the Study Commissions and Committees Act of 1987, Chapter 873, Section 13.1. The charge to the 17-member Commission is to study issues of availability and accessibility of health, mental health, social, and other services needed by older adults.

The Commission met three times since its last *Report to the Governor and the 1997 General Assembly (1998 Regular Session).* The Commission has worked to establish itself as a substantial forum for North Carolina's concerns about older adults.

The Commission found that the primary areas of need were still in-home and caregiver and other community-based services. Meeting these needs is exacerbated by the lack of a long-term care plan for North Carolina. In its *Report to the Governor and the 1999 General Assembly,* the North Carolina Study Commission on Aging makes the following recommendations:

Recommendations

1. The Commission recommends that the 1999 General Assembly consider granting limited immunity to health care facilities and home care agencies that provide temporary shelter or services to handicapped individuals during a disaster or emergency. Since current rules prohibit temporary or non-screened admissions in a disaster or emergency, the Commission also recommends that the 1999 General Assembly consider allowing the Social Services Commission to adopt rules pertaining to the admission, capacity, staffing, services or census of the licensed facility or agency that prohibits temporary or non-screened admissions in a disaster or emergency.
2. The Commission recommends that the 1999 General Assembly authorize a time-limited demonstration project in a limited number of counties to test the feasibility and cost of giving elderly and disabled adults a choice of staying

at home or entering an adult care home using an income supplement paid from the Special Assistance Program.

3. The Commission recommends that the 1999 General Assembly establish a study commission to investigate the issue of Medicaid estate recovery and additional issues of Medicaid abuse.

4. The Commission recommends that the 1999 General Assembly continue its support of community-based long-term care services by providing additional funds to the Department of Health and Human Services, Division of Aging, for adult day care and adult day health care programs. The Commission further recommends that the General Assembly include in the appropriation funds for technical support for the service providers to ensure success of individual adult day care and adult day health centers beyond the start-up phase of operation. This should include support to hire outside consultants to provide specialized technical assistance, on-site review of applications and sessions for groups before they submit any requests for funding.

5. The Commission recommends that the 1999 General Assembly increase its appropriation to the three Alzheimer's chapters in North Carolina so that each chapter receives $67,000.

6. The Commission recommends that the 1999 General Assembly place the Housing Trust Fund in the Continuation Budget so that local housing sponsors may plan ahead and improve their effectiveness in delivering housing for working families and the elderly.

NORTH CAROLINA'S OLDER ADULTS

Today's Older Population

In 1997, 946,000 of our State's 7,437,000 residents were age 65 and older (12.7%). Nearly 103,000 North Carolinians were 85 or older.

There are as many differences among seniors as is true of any age group. Still, there are some defining features:

- Older women outnumber older men. They represent 61% of those 65 and older, and 74% of the 85+ age group.
- About 18% are of a minority race, mostly African-American.
- Only about 5% live in institutions or group residences. More than half (58%) live with their spouse; almost 29% live alone.
- Nearly 57% did not complete high school.
- About 51% live in rural areas.
- About 79% own their homes, but with 33% living in housing built before 1950.

At the Turn of the Next Century

As we enter the 21st Century, we can expect the number of North Carolinians age 65 and older to grow to 1,005,000. They will represent 13% of our State's population. The number age 85 and older will rise to 115,000.

Why this demographic shift

There are many reasons for the shift toward an older society in numbers and proportionately. Greater longevity and in-migration of retirees play an important part in the growth of the senior population we are seeing now. North Carolina ranks 5th in the nation in attracting retirees. It is projected that the net gain of older migrants during the 90's (nearly 122,500) will be more than twice the number in the 1980's. Reduced birthrates also affect the

proportionate size of age groups. The looming Baby Boom generation (born 1946-1964) will have a staggering effect.

The Aging of the Baby Boomers

By 2010, as the oldest of the large Baby Boom generation nears age 65, we catch a glimpse of the dramatic changes to follow. It is projected that there will be 1,217,000 seniors in 2010 (14.2% of the State's population). Those age 85 and older will equal about 165,000. By 2025, projections show North Carolina with 2,004,000 people age 65 and older. This will represent nearly 21.4% of our State's population. The Baby Boom generation, by its sheer size, has had a staggering effect on every system it has encountered – from hospital delivery rooms...to classrooms...to the job market. We are already seeing how this generation is forcing serious policy discussions about the future of Medicare and Social Security.

What Are the Implications

While the aging of our society is a national trend, it is especially true of North Carolina. This has relevance to all areas of our public and private lives. Government faces decisions about the allocation of public resources. Families must consider living and caregiving arrangements. The health, human service, and education systems must adapt to changes in interests and needs. The business, cultural, and other communities must identify and respond to the challenges and opportunities of our State's demographic shift.

There are large numbers of seniors today who contribute to our families and communities as well as some who must ask for assistance. Our current experience, though, is nothing like what we will encounter in the near future. We must respond to the challenges of today and prepare to meet tomorrow's.

So What's the Bottom Line about the Aging of Our State

- Older adults are North Carolina's fastest growing population.
- Our State's senior population will more than double over the next 30 years. At least one in five North Carolinians will be age 65 or older in 2025.
- North Carolina is only one of three states projected to gain more than a million people between 1995 and 2025 through migration into the State. Many of these newcomers will be retirees.

There are large differences among seniors in terms of economic, health and social characteristics.

(See Appendix A for more statistical information on older adults in North Carolina.)

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 1

The Commission recommends that the 1999 General Assembly consider granting limited immunity to health care facilities and home care agencies that provide temporary shelter or services to handicapped individuals during a disaster or emergency. Since current rules prohibit temporary or non-screened admissions in a disaster or emergency, the Commission also recommends that the 1999 General Assembly consider allowing the Social Services Commission to adopt rules pertaining to the admission, capacity, staffing, services or census of the licensed facility or agency that prohibit temporary or non-screened admissions in a disaster or emergency. (See Appendix B)

As required by statute, the Commission moves its public hearing process away from Raleigh in order to achieve a balanced and broader view of issues and needs. Therefore, one of the cities that was chosen since the 1997 Report for a public hearing was Wilmington. At that hearing, the New Hanover Department of Emergency Management testified that over the years it has had concerns about the safest and most practical means to provide shelter for the aging and special needs citizens within the county when an emergency or disaster arises. Recent experience with hurricane events all across North Carolina clearly establishes the fact that citizens with special needs cannot be adequately cared for in conventional public shelters under the best circumstances. Therefore, after hurricane Fran, a Special Needs Task Force was formed in New Hanover County to help emergency management find a better way to meet the needs of the aging and special needs population before, during and immediately following a hurricane or other disaster

The nursing homes, adult care homes and others who participated in the New Hanover County Task Force had expressed a willingness to assist the community by

participating in a local mutual assistance network concept. The network concept allowed health and human service agencies working in partnership with public and private facilities to triage an evacuee's needs and medical condition, and out-place the evacuee into a non-threatened facility for temporary refuge. This method provided better care for the needy individual than a cold gymnasium floor and a damaged military surplus cot typically found at most disaster shelters.

At the public hearing in Wilmington, the Department of Emergency Management brought to the Commission the results of the tested draft concept that had worked exceptionally well during hurricane Bonnie. The Department of Emergency Management sought the help of the Commission because many public and private facilities are prohibited from helping the community or helping their neighbors during times of crisis because of several factors. Since these emergency situations could apply to any part of the State, the Commission heard this testimony. The Commission believes that the 1999 General Assembly should take corrective action to help all of our communities in time of disaster. The Commission suggests that the 1999 General Assembly waive State rules that prohibit facilities from volunteering much needed space and expertise during disaster events, and modify the Good Samaritan Act to encompass facilities making a good-faith effort to serve the community. This would greatly reduce the traumatic mental and physical effects a disaster can have on the senior population by providing sheltering options more sensitive to their needs.

RECOMMENDATION 2

The Commission recommends that the 1999 General Assembly authorize a time-limited demonstration project in a limited number of counties to test the feasibility and cost of giving elderly and disabled adults a choice of staying at

home or entering an adult care home using an income supplement paid from the Special Assistance Program. (See Appendix C)

The 1997 General Assembly included a special provision in S.L. 1997-443, Section 11.73 that required the Department of Health and Human Services to study ways to provide assistance that supports a range of living arrangements for elderly and disabled adults who are eligible for Medicaid or State/County Special Assistance for Adults. The legislation required the report to include recommendations on whether changes are needed in the Medicaid or Special Assistance programs to support alternative living arrangements and the costs associated with these changes. DHHS was also required to report to the Commission. This report was presented to the Commission at its meeting on December 10, 1998.

Many types of living arrangements are used by aged, blind and disabled adults: their own homes, relatives' or friends' homes, apartments, elderly apartments, congregate housing, multi-unit assisted housing with services, public housing, subsidized housing, shared group residences, home sharing, supervised apartments for developmentally disabled adults, family care homes and larger adult care homes. The ability of aged, blind or disabled adults to remain in or move to appropriate housing which can enable them to delay or avoid going to an adult care home depends on many factors.

Currently, the Special Assistance program provides an income supplement paid to elderly and disabled adults who do not have sufficient income to pay for the cost of care and the payment is limited to use in State licensed adult care homes. Adult care homes include family care homes, group homes for developmentally disabled adults or for adults with mental illness and adult care homes (the larger facilities).

In its public hearings over a number of years, the Commission has learned that older adults want to have a choice about where they live. If elderly and disabled adults can only use Special Assistance for an adult care home, that is where they will likely go when they can no longer remain at home. Individuals with low incomes have limited choices today and often enter an adult care home because that is the only source of public funding available to help them meet their housing and care needs.

The issue of choice is an important public policy issue that is growing in importance, along with the increasing numbers of older adults in North Carolina. Yet, it is difficult to determine, without actually making it available, whether Special Assistance for in-home living arrangements and Medicaid for in-home services would, in fact, result in less reliance on adult care homes or whether it would simply result in creating more demand for in-home care.

After listening to the report by DHHS , the Commission believes that a time-limited demonstration project in a limited number of counties should be undertaken. It could be learned first-hand what the effects would be and it would allow a test of the feasibility and cost of giving aged and disabled adults a choice of staying at home or entering an adult care home.

The Commission believes that the following key issues should be tested:

1. What cost savings could occur for the Special Assistance Program and the Medicaid programs by allowing a choice of in-home living arrangements;
2. Which ADL or other need criteria are reliable indicators for identifying individuals with the greatest need for Special Assistance payments for in-home living arrangements;
3. How much case management is needed and which types of clients are most in need of case management.

A demonstration of this nature would provide experience with actually giving a choice to aged and disabled adults and provide valuable information that could be used in making decisions about the practicality and cost of doing this on a statewide basis. After the first year of the demonstration and at the completion of the project, DHHS should provide a report to the Commission and to the General Assembly showing the results and any recommendations for potential statewide use.

RECOMMENDATION 3

The Commission recommends that the 1999 General Assembly establish a study commission to investigate the issue of Medicaid estate recovery and additional issues of Medicaid abuse. (See Appendix D)

At the recommendation of the Commission, the 1997 General Assembly (1998 Session) raised Medicaid benefits to the aged and disabled to 100% of the poverty level. This was in response to the crisis many older adults with low incomes face in paying for prescription medicines. The Commission stated in its Report to the 1997 General Assembly (1998 Regular Session) that each Medicaid recipient should bear as much of the costs as possible from the individual's private assets to help insure that those most in need receive the limited Medicaid benefits.

The Commission believes that the State must be a wise steward and insure that assets remaining in the recipient's estate be used to reimburse the State for its support, when practical, without causing undue hardship on the recipient's family. Federal law required the General Assembly to consider the issue and the 1993 General Assembly (1994 Regular Session) enacted the Medicaid Estate Recovery Act. Also the Department of Health and Human Services, Office of Long-Term Care, at the instigation of the Commission, recently prepared a report entitled "Comparing State Medicaid

Recovery Efforts". (See Appendix E) The Commission believes that now is the appropriate time to again review all options open to the State. The study commission that will review this topic should pay particular attention to the options listed in the attached document prepared by DHHS.

RECOMMENDATION 4

The Commission recommends that the 1999 General Assembly continue its support of community-based long-term care services by providing additional funds to the Department of Health and Human Services, Division of Aging, for adult day care and adult day health care programs. The Commission further recommends that the General Assembly include in the appropriation funds for technical support for the service providers to ensure success of individual adult day care and adult day health centers beyond the start-up phase of operation. This should include support to hire outside consultants to provide specialized technical assistance, on-site review of applications and sessions for groups before they submit any requests for funding. (See Appendix F)

Adult day care and adult day health care are two of the services in the long-term care continuum that prevents or delays placement of the elderly or disabled in institutions. These services are directed toward individuals who are physically and/or mentally impaired to the extent of interfering significantly with their capability for self-care, who live in their own homes, or in homes of relatives.

The Commission recommended in its last report to the General Assembly that it increase funding for the expansion of adult day care and day health services. Upon this recommendation, the 1997 General Assembly did increase this funding and

appropriated $1,665,750 for FY 1997-98 and $2,181,750 for 1998-99. These total appropriations amounts include the expansion request made by the Commission.

In its meeting on December 10, 1998, the Commission reviewed the progress of these new start-up grants. The following points were presented to the Committee:

- There are currently 106 certified adult day centers in North Carolina.
- Sixty of 100 counties now have adult day centers.
- Upon the opening of all grant-funded centers, at least 120 centers will be certified with 72 counties having adult day centers.
- All six conversion grant recipients have converted from social model programs to combination models that provide health services.
- Forty-nine of the 106 certified centers (46%) are certified to provide health services either by combination or health-only model.

Although the program is making progress, there is still considerable need for continued State funding to offer start-up grants and conversion grants. The programs are still unevenly distributed and are unavailable in many areas, particularly in rural counties in the far east and far west. Therefore the recommended legislation will:

1. Provide funds for start-up grants to establish 10 new programs in each year of the biennium.
2. Provide funds to support conversion of five adult care programs each year of the biennium.

To effectively meet the need of local communities, those centers that are funded by State funds must be sound and continue to operate for the long term. Given the nature of the business, the industry often attracts persons and organizations driven by compassionate feelings, but often lacking adequate financial resources to ensure the success of the business beyond the start-up phase of operation -- two or three years. In

the future, it would be in the best interest of the proposed centers and the industry, in general, to scrutinize the business expertise and assurance of financial support more closely. For these reasons the Commission recommends $80,000 for each year of the biennium to hire outside consultants to provide specialized technical assistance, on-site review of applications, and sessions for groups before they submit any requests for funding.

RECOMMENDATION 5

The Commission recommends that the 1999 General Assembly increase its appropriation to the Alzheimer's chapters in North Carolina so that each chapter receives $67,000. (See Appendix G)

Once thought to be a mental illness affecting only the elderly, Alzheimer's Disease is now considered a physical ailment and is not considered part of the natural aging process. There are approximately 110,000 men and women in North Carolina who are victims. The 24-hour care which victims require often strains family relationships as well as life savings. The three North Carolina chapters of the Alzheimer's Association are among the few resources available to provide assistance, information and support for these victims, their families and caregivers.

The Commission believes that it is imperative that the General Assembly increase funding for the three chapters so that this much needed help can continue outside of the governmental arena. The 1997 General Assembly was generous in its appropriation of $100,000 for each year of the biennium for these chapters, but the Commission believes that this funding ought to be increased.

RECOMMENDATION 6

The Commission recommends that the 1999 General Assembly place the Housing Trust Fund in the Continuation Budget so that local housing sponsors may plan ahead and improve their effectiveness in delivering housing for working families and the elderly. (See Appendix H)

Older adults consistently tell those who will listen that they wish to live independently in their own homes. In North Carolina, that home may be a family farm, a single-family dwelling, a mobile home, a garden apartment or a high-rise. It may be a modest home in need of major repairs or a new home in a retirement community offering a variety of amenities. No matter the location or condition, home is where everyone wants to be.

Safe, decent affordable housing continues to be a critical issue for far too many older North Carolinians. Nearly a third of all elderly households pay disproportionately high percentages of their income for rent or home maintenance. The challenge before us is to develop financing strategies that will enable us to increase the availability of affordable options to meet the housing preferences of our older adults.

In 1987, the General Assembly created the North Carolina Housing Trust Fund as a flexible tool to finance the production and rehabilitation of affordable housing. Since the initial Housing Trust Fund appropriation in 1987, the General Assembly has appropriated $21.4 million to the Trust Fund. In 9 of the past 11 years, there has been an appropriation in the State's Capital or Non-recurring Budget.

The Housing Trust Fund is a significant resource in leveraging other sources of public and private financing. Five dollars of total investment is leveraged for each $1 of State investment. Producing affordable housing requires planning and forward investments. However, the Housing Trust Fund operates in year-to-year uncertainty. A

place in the Continuation Budget and a dedicated revenue source would allow local housing sponsors to plan ahead and improve their effectiveness in delivering housing for working families and the elderly.

APPENDIX A

How North Carolina Compares to the Nation

While North Carolina was the 11th most populous state in 1995, it was 10th in terms of the older population. By 2025, projections still show North Carolina 11th overall but 8th among older populations. Our percentage of older adults in 1995 (12.5%) was slightly less than what it was nationally (12.8%), ranking North Carolina 31st among states. Our projected increase to 21.4% in 2025 will rank us 11th. In contrast, North Carolina's proportion of youth (under age 20) ranked 38th in 1995; this ranking will dip to 44th in 2025 (when youth will represent 23.2% of the state's population).

Variable	U.S.	N.C.	State Ranking
Population Growth 85+ (1983-1993)	33.8%	51.4%	8
Age 65+ Severely Disabled Per 100 (1992)	71.4%	81.1%	8
%65+ Poverty (1990)	12.8%	19.5%	9
% 65+ Minority (1990)	13.6%	18.4%	11

And How We Compare within the State

Counties, cities and regions are aging at varying rates. The table that follows gives the number and proportion of persons age 65 and older by county for 1997. This ranges from 25.5% in Polk County, where there is a steady influx of retirees, to 5.5% in Onslow County, the location of the Camp Lejeune Marine Base. Many of our western and coastal communities, as well as some in the piedmont, have larger proportions of seniors. Nearly 59% of Pinehurst's population in 1990 were persons age 60 and older. Canton and Hendersonville each had about 35%.

OLDER ADULTS IN NORTH CAROLINA IN 1997
State Total: 946,305 State Percent: 12.7%

County	Age 65+	%		County	Age 65+	%
Alamance	18,624	15.7		Johnston	12,699	12.5
Alexander	3,880	12.3		Jones	1,434	15.0
Alleghany	1,957	20.6		Lee	6,855	14.3
Anson	3,827	16.0		Lenoir	8,848	14.8
Ashe	4,389	18.8		Lincoln	7,105	12.3
Avery	2,444	16.0		Macon	6,456	23.7
Beaufort	6,876	15.7		Madison	3,178	17.5
Bertie	3,125	15.0		Martin	3,947	15.2
Bladen	4,623	15.3		McDowell	5,947	15.6
Brunswick	10,887	16.8		Mecklenburg	57,703	9.5
Buncombe	32,532	16.7		Mitchell	2,890	19.3
Burke	11,978	14.2		Montgomery	3,264	13.5
Cabarrus	15,074	13.1		Moore	15,989	22.7
Caldwell	10,088	13.5		Nash	11,045	12.7
Camden	936	14.3		New Hanover	19,724	13.3
Carteret	9,367	15.8		Northampton	3,722	18.0
Caswell	3,395	15.8		Onslow	8,365	5.5
Catawba	16,608	12.8		Orange	9,711	8.8
Chatham	6,906	15.5		Pamlico	2,288	18.9
Cherokee	4,572	20.2		Pasquotank	4,830	14.3
Chowan	2,641	18.6		Pender	5,481	14.8
Clay	1,733	21.6		Perquimans	2,059	19.1
Cleveland	13,163	14.5		Person	4,825	14.6
Columbus	7,502	14.5		Pitt	12,020	9.9
Craven	11,071	12.7		Polk	4,112	25.5
Cumberland	22,938	7.6		Randolph	15,248	12.8
Currituck	2,164	13.0		Richmond	6,600	14.4
Dare	3,362	12.3		Robeson	12,312	10.9
Davidson	18,073	12.9		Rockingham	13,605	15.1
Davie	4,655	15.2		Rowan	18,973	15.4
Duplin	6,326	14.4		Rutherford	9,546	15.9
Durham	19,825	10.1		Sampson	7,728	14.9
Edgecombe	7,233	12.7		Scotland	3,987	11.4
Forsyth	37,673	13.1		Stanly	8,110	14.8
Franklin	5,527	12.7		Stokes	5,216	12.1
Gaston	22,714	12.7		Surry	10,644	15.9
Gates	1,429	14.4		Swain	1,919	16.3
Graham	1,325	17.4		Transylvania	5,926	21.3
Granville	5,208	12.4		Tyrrell	677	18.2
Greene	2,352	13.5		Union	10,191	9.8
Guilford	49,036	12.8		Vance	5,296	13.1
Halifax	8,596	14.8		Wake	44,461	8.0
Harnett	9,741	12.0		Warren	3,603	19.5
Haywood	10,421	20.5		Washington	2,068	15.2
Henderson	18,193	23.1		Watauga	4,775	11.6
Hertford	3,436	15.4		Wayne	12,648	11.2
Hoke	2,903	9.8		Wilkes	9,101	14.5
Hyde	851	16.9		Wilson	9,263	13.4
Iredell	14,765	13.7		Yadkin	5,496	15.7
Jackson	4,462	15.1		Yancey	3,029	18.5

APPENDIX B

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-002
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Emer. Shelter/Health Facil.Immunity. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR CERTAIN LICENSED HEALTH CARE FACILITIES THAT PROVIDE SHELTER OR SERVICES DURING DISASTERS AND EMERGENCIES.

The General Assembly of North Carolina enacts:

Section 1. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-112. Limitation on liability for health care facilities that provide shelter or services during a disaster or emergency; waiver of rules.**

(a) Any health care facility or home care agency licensed under this Article that provides, with or without compensation, temporary shelter or services to handicapped individuals during a disaster or emergency, declared under federal law or in accordance with Article 1 of Chapter 166A of the General Statutes or Article 36A of Chapter 14 of the General Statutes, at the request of an emergency management agency implementing an emergency management plan or program approved by the governmental entity having authority over the emergency management agency is not liable for any personal injury, wrongful death, property damage, or other loss caused by the facility or home care agency's acts or omissions in the provision of shelter or services.

(b) The immunity provided in subsection (a) of this section applies only to shelter or services:

(1) The facility or home care agency is licensed to provide during its ordinary course of business.

(2) Provided in accordance with an agreement between the health care facility or home care agency and the emergency management agency.

(3) Provided for not more than 45 days after the declaration of the emergency or disaster, unless the 45-day immunity period is extended by an executive order issued by the Governor under the Governor's emergency executive powers.

(c) The immunity provided in subsection (a) of this section does not apply if it is determined that the personal injury, wrongful death, property damage, or other loss was caused by the gross negligence, wanton conduct, or intentional wrongdoing of the health care facility or home care agency.

(d) Commission rules including but not limited to those pertaining to admission, capacity, staffing, services, and census of the licensed facility or home care agency shall be waived to the extent necessary to allow the facility or home care agency to provide the temporary shelter and services requested by the emergency management agency as authorized by this section, unless the Division determines that the placement or services would pose an unreasonable risk to the health, safety, or welfare of any of the persons occupying the facility. In the event the Division determines that placement or services would pose an unreasonable risk, then the Division shall work with the emergency management agency to assist in identifying ways of removing or reducing the risk or in securing alternative temporary shelter or services during the disaster or emergency. The emergency management agency requesting temporary shelter or services under this section shall notify the Division within 72 hours of placement of one or more individuals in a facility.

(e) As used in this section:

(1) 'Emergency management agency' means a State or local governmental agency charged with coordination of all emergency management activities for its jurisdiction.

(2) 'Handicapped individual means an individual who has a physical or mental disability or an infirmity."

Section 2. Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-7. Limitation on liability for certain adult care homes providing shelter or services during disaster or emergency; waiver of rules.**

(a) An adult care home licensed under this Article that provides, with or without compensation, temporary shelter or services to handicapped individuals during a disaster or emergency, declared under federal law or in accordance with Article 1 of Chapter 166A of the General Statutes or Article 36A of Chapter 14 of the General Statutes, at the request of an emergency management agency implementing an emergency management plan or program approved by the governmental entity having authority over the emergency management agency is not liable for any personal injury, wrongful death, property damage, or other loss caused by the adult care home's acts or omissions in the provision of shelter or services.

(b) The immunity provided in subsection (a) of this section applies only to shelter or services:

(1) The adult care home is licensed to provide during its ordinary course of business.

(2) Provided in accordance with an agreement between the adult care home and the emergency management agency.

(3) Provided for not more than 45 days after the declaration of the emergency or disaster, unless the 45-day immunity period is extended by an executive order issued by the Governor under the Governor's emergency executive powers.

(c) The immunity provided in subsection (a) of this section does not apply if it is determined that the personal injury, wrongful death, property damage, or other loss was caused by the gross negligence, wanton conduct, or intentional wrongdoing of the adult care home.

(d) Commission rules including but not limited to those pertaining to admission, capacity, staffing, services, and census of the adult care home shall be waived to the extent necessary to allow the adult care home to provide the temporary shelter and services requested by the emergency management agency as authorized by this section, unless the Division determines that the placement or services would pose an unreasonable risk to the health, safety, or welfare of any of the persons occupying the adult care home. In the event the Division determines that placement or services would pose an unreasonable risk, then the Division shall work with the emergency management agency to assist in identifying ways of removing or reducing the risk or in

securing alternative temporary shelter or services during the disaster or emergency. The emergency management agency requesting temporary shelter or services under this section shall notify the Division within 72 hours of placement of one or more individuals in an adult care home.

(e) As used in this section:

(1) 'Emergency management agency' means a State or local governmental agency charged with coordination of all emergency management activities for its jurisdiction.

(2) 'Handicapped individual means an individual who has a physical or mental disability or an infirmity."

Section 3. This act becomes effective July 1, 1999 and applies to shelter or services provided on and after that date.

SUMMARY
BILL DRAFT - 99-LNZ-002
December 10, 1998

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR CERTAIN LICENSED HEALTH CARE FACILITIES THAT PROVIDE SHELTER OR SERVICES DURING DISASTERS AND EMERGENCIES.

This bill draft amends the Chapters of the General Statutes pertaining to licensure of certain health care facilities. Article 6 of Chapter 131E provides for licensure of nursing homes and home health agencies. Article 1 of Chapter 131D provides for licensure of adult care homes.

Page 1, lines 9-24. Provides that any health care facility or home care agency that is licensed and that provides temporary shelter or services to handicapped individuals during a disaster or emergency is not liable for personal injury, wrongful death, property damage, or other loss caused by the acts or omissions of the facility or agency that occur while providing shelter or services. The shelter or services must have been requested by an emergency management agency that is implementing an approved emergency management plan, and the disaster or emergency must be one that has been declared under federal law or under Article 1 of Chapter 166A (by the Governor or by local ordinance) or Article 36A of Chapter 14 (riots and civil disorders) of the General Statutes.

Page 2, lines 1-12. Immunity from liability provided under subsection (a) applies only to shelter or services:

(1) The facility or agency is licensed to provide during its ordinary course of business;
(2) Provided in accordance with an agreement between the facility or home care agency and the emergency management agency; and
(3) Provided for not more than 45 days after the declaration of the emergency, unless the Governor extends the 45-day immunity period by executive order.

Page 2, lines 13-17. The immunity does not apply if it is determined that the personal injury, wrongful death, property damage, or other loss was caused by the facility or home care agency's gross negligence, wanton conduct, or intentional wrongdoing.

Page 2, lines 18-33. Rules adopted by the Social Services Commission pertaining to the admission, capacity, staffing, services, or census of the licensed facility or agency that would be a barrier to the provision of emergency shelter or services are waived unless the Division of Facility Services determines that placement or services would pose an unreasonable risk to the health, safety, or welfare of any of the persons occupying the facility. In such event, DFS must work with the emergency management agency to assist in finding ways in removing or reducing the risk, or in securing alternative temporary placement. The emergency management agency must notify DFS within 72 hours of placing one or more individuals in a facility.

Page 2, lines 34-40. This subsection defines the terms "emergency management agency" and "handicapped individual".

Section 2 of the bill, provides the same immunity from liability for adult care homes (other than group homes for developmentally disabled persons and family care homes).

Section 3 of the bill provides that the act becomes effective July 1, 1999 and the immunity applies to shelter or services provided on and after that date.

Additional relevant information:

Chapter 166A of the General Statutes, the North Carolina Emergency Management Act, provides that the Governor shall have general direction and control of the State emergency management program. The Secretary of Crime Control and Public Safety is responsible to the Governor for State emergency management activities. G.S. 166A-5.

The Act also provides that the government body of each county is responsible for emergency management within the geographical limits of the county and that all emergency management efforts within the county will be coordinated by the county, including activities of municipalities within the county. The governing body of each county is authorized to establish and maintain an emergency management agency. All incorporated municipalities are authorized to establish and maintain emergency management agencies subject to coordination by the county. Each political subdivision (counties and incorporated cities, towns and villages(is also authorized to direct and coordinate the development of emergency management plans and programs in accordance with the policies and standards set by the State. G.S. 166A-8.

APPENDIX C

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-013
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Spec.Assist/Alt.Living. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE USE OF FUNDS FOR ADULT SPECIAL ASSISTANCE FOR DEMONSTRATION PROJECT ON ALTERNATIVE LIVING ARRANGEMENTS.

The General Assembly of North Carolina enacts:

Section 1. The Department of Health and Human Services shall implement a demonstration project to test the feasibility and cost of giving elderly and disabled adults who are eligible for State/County Special Assistance a choice of staying at home or entering an adult care facility. The Department shall use funds available for State/County Special Assistance for the 1999-2000 and 2000-2001 fiscal years to make payments to eligible individuals in in-home living arrangements. Payments may be made for not more than two hundred (200)individuals for the fiscal period beginning July 1, 1999 and ending June 30, 2001. The Department shall make an interim progress report to members of the House and Senate Appropriations Subcommittees on Health and Human Services and to the North Carolina Study Commission on Aging no later than June 30, 2000 and shall make a final report no later than October 1, 2001. The final report shall include but is not limited to the following information:

(1) Cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option to remain in the home.

(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.

(3) How much case management is needed and which types of individuals are most in need of case management.

(4) Findings and recommendations as to the feasibility of continuing or expanding the demonstration project.

Section 2. This act becomes effective July 1, 1999 and expires June 30, 2000.

APPENDIX D

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S/H **D**

SENATE JOINT RESOLUTION 97-LNZ-006
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Sponsors:

Referred to:

A JOINT RESOLUTION AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY STATE MEDICAID RECOVERY POLICY AND LAW.

Be it resolved by the Senate, the House of Representatives concurring:

Section 1. The Legislative Research Commission may conduct a comprehensive study of the State's current Medicaid recovery policies and law to determine the feasibility and desirability of enhancing recovery efforts beyond minimum federal requirements. The study may include but is not limited to all of the following:

(1) Federal requirements for Medicaid recovery efforts, whether current State efforts exceed federal requirements, and if not, the reasons therefor.

(2) State recovery collections as a percent of total Medicaid expenditures.

(3) Review of Medicaid recovery policy and laws enacted or being considered by other states.

(4) Findings of the study conducted by DHHS, Division of Medical Assistance comparing State Medicaid recovery efforts, and policy options contained in the study.

Section 2. The Legislative Research Commission may make an interim report to the 1999 General Assembly, 2000 Regular Session, and shall make a final report to the 2001 General Assembly.

Section 3. This resolution is effective upon ratification.

Comparing State Medicaid Recovery Efforts

Published by the
Long-Term Care Policy Office
in collaboration with the
Division of Medical Assistance

Department of Health and Human Services
October 1998

Background Information

Federal Law Requires That All States Implement Polices To:

1) Prevent persons who could otherwise pay for at least some of their care from giving away/divesting their assets to meet Medicaid financial eligibility criteria. *(Referred to as "Transfer of Asset" policies – imposed in 1988.)*

2) Recoup, from estates of deceased Medicaid beneficiaries age 55+ (and permanently institutionalized adults under 55), Medicaid payments for long-term care services as well as any related hospital, prescription drug and Medicare cost-sharing costs. *(Referred to as Estate Recovery policies– imposed in 1993)*

While states must meet minimum federal requirements, they have considerable latitude with regard to implementing policies that go beyond minimum federal requirements, within certain limits.

A Quick Overview of Transfer of Asset Requirements

- States must apply policies to Medicaid funded nursing home care (includes ICF-MR) and all home and community based waiver programs.
- States must determine whether an applicant has transferred any assets within 36 months of applying for Medicaid or established, within the past 60 months, a Trust from which the applicant cannot benefit. *(These time frames are commonly referred to as the "look back" period.)*
- States must impose penalties on Medicaid long-term care applicants that violate the look back criteria above.
- States may opt to apply their policies to other long-term care related services.
- States may not lengthen the 36 month "look-back" period.

A Quick Overview of Estate Recovery Requirements

- Recovery efforts must apply to persons 55 and older (and permanently institutionalized adults under age 55) receiving Medicaid funded nursing home care or care through home and community based waivers, including related hospital, prescription drug and Medicare cost-sharing costs.
- States must establish "hardship" criteria to exempt persons in certain situations (prescribed by the state) from recovery efforts.
- States may expand recovery efforts to other Medicaid services.
- States may place liens on real property of Medicaid long-term care recipients not expected to return home (within certain parameters).
- When a spouse or dependent child remains in the home after the beneficiary dies, states may seek judgments to collect Medicaid costs when the house is sold or from the estate once the spouse or dependent child dies.

Currently, North Carolina's Transfer of Asset and Estate Recovery policies meet, but do not exceed, minimum federal requirements.

Purpose

The Purpose of this Report is to:

1) Assess nationwide trends regarding state policies governing the scope and administration of Transfer of Asset and Estate Recovery policies.

2) Identify common policy trends among states having the best collection rates.

3) Determine how North Carolina compares with nationwide trends pertaining to Medicaid recovery efforts.

4) Assess implications of national trends for North Carolina and potential ramifications of various policy changes that might be considered.

Key Items To Be Examined:

- Identification of states with the highest percentage of recovery collections as a percent of total Medicaid spending and any common policy trends
- Identification of states with the lowest percentage of recovery collections as a percent of total Medicaid spending and any common policy trends
- Prevalence of current use of TEFRA (pre-death) liens placed on real property of Medicaid long-term care recipients not expected to return home
- Prevalence of states that exceed minimum federal requirements regarding Transfer of Asset and Estate Recovery policies
- Use of private contractors for recovery collections and associated impact
- States considering/implementing further efforts to tighten identified loopholes to:
  - increase private payment for care (through either changes to state Transfer of Asset or Estate Recovery policies)
  - address inequities that result in incentives or disincentives for seeking institutional long-term care as opposed to home/community care
- Prevalence of use of "undue hardship" criteria
- Recovery efforts in situations where a surviving spouse/eligible dependent remains in the home of the deceased Medicaid long-term care recipient
- How states define "estate" -- (i.e. more broadly than probate definition?)

In spite of the federal mandate, Alaska, Georgia, Texas, and Michigan indicated that they do not yet have an operational estate recovery program.

Methodology for Determining National Trends

The Long-Term Care Policy Office, with the assistance of staff in the Recipient and Providers Services Section of the Division of Medical Assistance, developed a survey to collect information from all 50 states regarding the items outlined above. The survey was conducted in July and August of 1998. As necessary, follow-up contacts were made with states in an attempt to clarify their responses or solicit missing information. Some states indicated that information for some survey items was not readily available. Based on the responses provided by states, survey data for key items was then compiled and analyzed. The Division of Medical Assistance reviewed the findings compiled by the Long-Term Care Policy Office to help ensure the accurate interpretation of the responses as well as the accuracy of terminology and descriptions used in this report.

48 states responded, at least in part, to the survey. No information was received from the states of Virginia or Oklahoma.

Survey Findings

Overall Recovery Collection Information:

1.) As a percent of total Medicaid expenditures reported, state recovery collections for 1997 ranged from a low of less than one-one hundredth of one percent to a high of .83%. (NC's percentage was .01%)

- ♦ based on findings from this survey compared with 1994 data, (published in a 1996 report on Medicaid recovery efforts among states by the AARP Public Policy Institute), collection rates as a percentage of total Medicaid spending have increased somewhat (at least among states for which prior data was available).

This earlier AARP report showed:

- Oregon had the highest percentage of collections versus total Medicaid expenditures (.54%) based on 24 states reporting.
- California had the highest dollar volume of collections ($28 million or .19%)

State recovery collections as a percent of total Medicaid expenditures ranged from less than .01% to a high of .83%.

Total Medicaid expenditures for all states reporting was $87.6 billion with collections totaling $209.4 million.

2.) The national average collection percentage, based on states reporting information for this item was .26%.

- It is important to note that collection amounts reported are inclusive of both estate recoveries as well as collections from liens (for states that use liens).

(See Attachment #1 for state-by-state summary of above items.)

While not included in the 16 states using TEFRA liens, Wyoming & Nevada both have state authority to use these liens but are not doing so.

Overall Recovery Policy Findings

1.) 48% (21) of states responding (44) indicated that they applied Estate Recovery policies to services beyond those required by federal law. (NC does not apply policies to services beyond those required.)

- Of these 21 states, 15 apply Estate Recovery policies to all Medicaid services provided. (See Attachment #2 for a state-by-state summary.)

The State of Washington reports that they require long-term care facilities to remit all funds remaining in the personal account of a deceased Medicaid covered resident.

2.) 28% (13) of states responding (46) indicated that they applied Transfer of Asset policies to individuals receiving services in addition to the services required by federal law. (NC is not one of these states.)

(See Attachment #2 for a state-by-state summary.)

3.) 91% (40) of states responding (44) have established "undue hardship" criteria to exempt certain beneficiaries from recovery collection efforts. (NC has such criteria)

- Ohio, New Hampshire, and Connecticut are all working on developing undue hardship criteria.
- In Minnesota, counties determine undue hardship on a case-by-case basis within allowable federal parameters.

(See Attachment #3 for a state-by-state summary.)

About a third of states responding had, or were considering, actions to strengthen recovery efforts through better enforcement of existing policies and/or through policy changes.

4.) 35% (16) of the states responding (46) indicated they are using or will implement in near future TEFRA (pre-death) liens as a way to increase potential repayment of Medicaid expenditures. (NC does not use TEFRA liens)

(See Attachment #2 for a state-by-state summary.)

About a third of states responding reported that recovery efforts go beyond the state's definition of the "probate estate."

5.) **33% (14) of states responding (43) indicate that they seek to recover assets beyond those limited to the state's probate definition of estate.** (NC is not one of these states)

(See Attachment #4 for a state-by-state summary and descriptions of other types of recoverable assets pursued.)

About a third of states responding have established an estate value below which no recovery is sought. About a third of states also reported having claim levels below which no recovery is sought.

6.) **35% (16) of states have established thresholds for which recovery is not pursued when the estate value is less than the threshold level.** (NC has a $5,000 threshold on estate values for pursuing recovery.)

- Another 5 states indicate that they consider the cost/benefit of recovery efforts for small estates. (See Attachment #4 for a state-by-state summary)

7.) **32% (14) of states indicate they do not seek recovery for claim amounts below certain state established levels.** (NC does not pursue claims less than $3,000.)

- Another 4 states report that they consider the cost/benefit of seeking recovery depending upon the claim amount.

(See Attachment #4 for a state-by-state summary.)

Eight states reported using private contractors for estate and/or lien recovery efforts. When considering collections as a percentage of total Medicaid spending, average collection rates among states that contract were almost identical to states that do not contract out this function.

8.) **In cases where a spouse or a minor/disabled adult child is living in the home after the Medicaid beneficiary dies:** (some use more than 1 approach)

- 84% (37) of states responding (44) indicate they can waive recovery
- 27% (12) of states responding (44) indicate they can defer recovery
- 34% (15) of states responding (44) indicate they can negotiate recovery

(See Attachment # 2 for a state-by-state summary.)

Collection Method Findings

- **19% (8) of states responding (42) contract out all or a portion of their recovery collections to private entities.** (NC does not contract out recovery efforts.)
  - collection rates for these states, as a percent of total Medicaid spending, is not significantly different from average collection rates overall (.27% compared with .26% overall)
  - fees charged by contractors range from 10% to 19.4% of collections (averages 14.5%)

(See Attachment #3 for state-by-state summary.)

Collections as a percent of total Medicaid spending among the top ten collecting states ranged from .39% to .83%- with an average rate of .60% compared to .26% overall.

Consistent with the 1996 AARP report, California had the highest dollar volume of recovery collections $32.5 million or .20% of total Medicaid spending.

States with the Highest and Lowest Collection Rates as a Percent of Total Medicaid Spending

- **The 10 states with the highest collections as a percent of total Medicaid spending ('97) are:**

1. Minnesota *	(.83%)	6. Wisconsin	(.52%)
2. New Hampshire	(.78%)	7. Iowa	(.52%)
3. Connecticut	(.74%)	8. North Dakota	(.49%)
4. Oregon	(.74%)	9. Maine	(.45%)
5. Idaho	(.54%)	10. Massachusetts	(.39%)

* *Note: Collections reported for MN for 1997 included some recoveries made in 1996 which could not be extracted from the total reported. As such, their percentage of collections and possibly also their rank order may be skewed.*

Survey Findings - Continued

- **Average collections as a percent of total Medicaid spending for these states is 0.60% compared to 0.26% overall.**

- It is also worth noting that, consistent with the findings published in 1996 by the AARP Public Policy Office, California continues to have the highest collections in terms of total dollars collected.
  - Collections reported for 1997 totaled $32.5 million or 0.20% of total Medicaid spending. (Also has highest reported expenditures)

States with higher collection rates are more likely to seek recovery for, and apply Transfer of Asset policies to, services in addition to those required by federal law. They are also more likely to use TEFRA liens and not to limit recovery efforts to the state's probate definition of estate.

Common Policy Trends Among Top 10 Collection States:

1.) **More of these states (60%) apply Estate Recovery policies to services in addition to those mandated by federal law** (compares to 48% overall).

2.) **More of these states (50%) use TEFRA liens** (compares to 35% overall).

4.) **Slightly more of these states apply transfer of asset penalties to services in addition to those federally mandated** (30% compared to 28% overall).

5.) **Similar to overall findings, the vast majority of these states do not contract out collections to private companies (estate and/or liens).** (80% vs. 81% overall)

Although North Carolina is in the bottom 10 collecting states, recoveries have increased by 200% between 1996 and 1997 from about $279,000 to more than $840,000. It is likely that our low Medicaid eligibility level impacts beneficiary estate values and subsequently, the likelihood of there being significant recoverable assets. Another factor likely to impact collections is the ability of beneficiaries to convert real property to income producing property which can then be transferred without penalty.

States with the Lowest Collection Rates

- **The 10 states with the lowest collections as a percent of total Medicaid spending ('97) are:**

1.) Louisiana	(<0.01%)	6. Delaware	(0.02%)
2.) Alabama	(<0.01%)	7. Arkansas	(0.02%)
3.) Tennessee	(<0.01%)	8. Mississippi	(0.03%)
4.) Hawaii	(0.01%)	9. Ohio	(0.04%)
5.) North Carolina	(0.01%)	10. New Jersey	(0.05%)

Note: These states average collections of .03 % as a percentage of total Medicaid spending (compares with .26% overall).

Compared to other states, states having the lowest collections as a percent of total Medicaid spending are less likely to apply Estate Recovery and/or Transfer of Asset policies to services that go beyond those required by federal law. These states are also less likely to pursue assets that go beyond the state's definition of "probate estate."

Common Policy Trends Among Lowest Collecting States:

1.) **Fewer (30%) of these states apply estate recovery policies to additional services beyond those required by federal law** (compares to 48% overall).

2.) **30% of these states apply Transfer of Asset policies to services in addition to those required by federal law** (same percentage overall).

3.) **Fewer (20%) of these states use TEFRA liens** (compares to 34% overall).

4.) **More of these states (80%) limit recovery efforts to their state's probate definition of estate** (compares with 67% overall).

Some Policy Options NC Could Consider

North Carolina has flexibility to exercise options with regard to recovery collection policies. Some key policy changes that could be considered include:

1.) **Applying Estate Recovery policies to additional services.**
- Estate Recovery efforts could be applied to additional long-term care related services such as Personal Care Services (regardless of setting), home health care, private duty nursing, etc. or encompass all Medicaid state plan services provided to Medicaid beneficiaries 55 and older.

2.) **Applying Transfer of Asset sanctions to persons seeking services in addition to those required by federal law.**
- could be applied to same long-term care related services listed above

3.) **Placing TEFRA (pre-death) and/or post death liens on real property owned by Medicaid beneficiaries to whom recovery efforts apply to ensure that the property is not transferred or sold without the state having the opportunity seek repayment of Medicaid costs from any property equity that has accumulated.**

4.) **Applying Transfer of Asset sanctions to income producing property.**
- This would help stem the tide of persons who convert real property to income producing property to become Medicaid eligible and then subsequently transfer the property without penalty-- eliminating the opportunity for the state to recoup all, or a portion of Medicaid costs from the equity that exists in the property which was transferred.

5.) **Broadening the definition of "estate" for recovery collection purposes.**
- Federal law allows additional types of assets to be recovered.

Major options available to the state to potentially increase recovery collections include applying Estate Recovery and Transfer of Asset policies to additional services, using liens, and/or expanding the types of assets subject to recovery.

Conclusion

This report identifies several options allowable under federal law and/or regulation that North Carolina could pursue. Some states have adopted one or more of these options in an effort to enhance their recovery efforts and reduce the likelihood of persons transferring their assets in order to access Medicaid covered long-term care services and/or to avoid repayment of long-term care costs incurred by Medicaid. North Carolina policymakers should give consideration to enacting these options.

The Long-Term Care Policy Office would like to thank participating states for taking the time to respond to the survey upon which this report is based. While our purpose in conducting this survey was to provide an overview of state efforts in this area for North Carolina policymakers, advocacy groups, etc., we hope this information will be useful to other states as well.

Comments or questions regarding this document should be directed to the Long-Term Care Policy Office at 919-733-4534:

Bonnie Cramer - Director

Susan Harmuth - Health Systems Analyst

Recovery Collection Data

Attachment # 1

State	Total Medicaid Exp. 1997	Tot. Medicaid LTC Exp. 1997	Total Amt. Billed for Recovery 1997	Total Amount Collected 1997	Collections as Percent of Invoiced Amt.	Collections as % of total Medicaid Expenditures 1997
Alabama	$ 2,251,530,170	$ 687,069,824	$ 2,849,307	$ 2,849,307	100.00%	0.13%
Alaska	N/A	N/A	No program	No Program	N/A	N/A
Arizona	N/A	N/A	N/A	$ 1,123,227	N/A	N/A
Arkansas	$ 1,347,130,797	$ 410,609,807	N/A	$ 335,890	N/A	0.02%
California	$ 16,000,000,000	$ 2,340,000,000	$ 66,000,000	$ 32,500,000	49.24%	0.20%
Colorado	$ 1,322,000,000	$ 376,640,000	$ 13,883,926	$ 2,559,513	18.44%	0.19%
Connecticut	$ 2,389,940,806	$ 1,352,127,573	N/A	$ 17,800,000	N/A	0.74%
Delaware	$ 402,657,227	$ 80,916,020	$ 609,505	$ 83,302	13.67%	0.02%
Florida	$ 6,561,890,645	$ 1,808,030,992	$ 85,975,013	$ 6,026,453	7.01%	0.09%
Georgia	N/A	N/A	N/A	N/A	N/A	N/A
Hawaii	$ 350,580,000	$ 147,514,000	N/A	$ 38,978	N/A	0.01%
Idaho	$ 409,886,411	$ 134,547,779	N/A	$ 2,200,000	N/A	0.54%
Illinois	$ 5,656,000,000	$ 1,688,200,000	N/A	$ 19,217,121	N/A	0.34%
Indiana	$ 2,359,000,000	$ 1,013,054,000	N/A	N/A	N/A	N/A
Iowa	$ 349,844,587	$ 166,526,290	$ 2,777,620	$ 1,819,673	65.51%	0.52%
Kansas	$ 891,900,000	$ 398,400,000	$ 4,020,000	$ 2,330,000	57.96%	0.26%
Kentucky	N/A	N/A	N/A	N/A	N/A	N/A
Louisiana	$ 3,261,212,093	$ 808,740,440	$ 13,469	$ 13,469	100.00%	0.00%
Maine	$ 975,000,000	$ 212,000,000	$ 16,750,498	$ 4,408,026	26.32%	0.45%
Maryland	N/A	N/A	N/A	N/A	N/A	N/A
Massachusetts	$ 4,500,000,000	$ 1,400,000,000	$ 54,204,929	$ 17,331,065	N/A	0.39%
Michigan	N/A	N/A	No Program	No Program	N/A	N/A
Minnesota *	$ 2,842,506,229	$ 1,394,827,376	N/A	$ 23,527,968	N/A	0.83%
Mississippi	$ 1,790,882,196	$ 423,318,601	$ 1,547,030	$ 515,361	33.31%	0.03%
Missouri	$ 2,160,222,548	$ 849,786,828	$ 14,128,633	$ 2,366,444	16.75%	0.11%
Montana	$ 343,093,868	$ 117,708,677	$ 1,401,371	$ 1,032,384	73.67%	0.30%
Nebraska	$ 749,753,865	$ 314,792,467	N/A	$ 703,494	N/A	0.09%
Nevada	$ 387,600,000	$ 65,700,000	$ 51,000,000	$ 531,974	1.04%	0.14%
New Hampshire	$ 709,302,805	$ 186,937,840	N/A	$ 5,501,179	N/A	0.78%
New Jersey	$ 5,625,078,532		N/A	$ 2,662,949	N/A	0.05%
New Mexico	$ 954,687,700	$ 253,799,500	N/A	N/A	N/A	N/A
New York	N/A	N/A	N/A	N/A	N/A	N/A
North Carolina	$ 4,640,421,917	$ 1,466,752,241	$ 21,011,685	$ 279,596	1.33%	0.01%
North Dakota	$ 328,362,994	$ 108,020,980	N/A	$ 1,595,811	N/A	0.49%
Ohio	$ 6,414,431,952	$ 2,233,466,672	$ 845,340,836	$ 2,802,514	0.33%	0.04%
Oklahoma	N/A	N/A	N/A	N/A	N/A	N/A
Oregon	$ 1,601,606,160	$ 363,394,346	N/A	$ 11,803,644	N/A	0.74%
Pennsylvania	N/A	N/A	N/A	$ 18,100,894	N/A	N/A
Rhode Island	$ 835,098,889	$ 339,154,939	N/A	$ 427,949	N/A	0.05%
South Carolina	$ 2,242,716,798	300,919,984 *	$ 24,638,175	$ 2,643,267	10.73%	0.12%
South Dakota	$ 338,000,000	$ 98,000,000	N/A	$ 665,370	N/A	0.20%
Tennessee	$ 3,405,389,300	$ 938,970,548	$ 1,094,010	$ 152,418	13.93%	0.00%
Texas	N/A	N/A	N/A	N/A	N/A	N/A
Utah	$ 636,527,596	$ 203,768,768	$ 3,315,858	$ 2,284,673	68.90%	0.36%
Vermont	N/A	N/A	N/A	N/A	N/A	N/A
Virginia	N/A	N/A	N/A	N/A	N/A	N/A
Washington	N/A	$ 663,000,000	N/A	$ 6,991,574	N/A	N/A
West Virginia	N/A	N/A	$ 2,008,180	$ 1,116,992	55.62%	N/A
Wisconsin	$ 2,454,416,000	N/A	N/A	$ 12,651,048	N/A	0.52%
Wyoming	$ 185,607,617	$ 131,344,953	N/A	$ 421,968	N/A	0.23%

Long-Term Care Policy Office

State	Apply estate recovery policies to services beyond those federally required	How handle estate rec. when surviving spouse/dependent in home 1=waive 2=defer 3=negotiate 4=other				Apply Transfer of Asset Policies to persons seeking services in addition to those federally required	Use Tefra (pre-death) Liens
		1	2	3	4		
Alabama	No		X			No	Yes
Alaska	*No estate rec. program*					N/A	N/A
Arizona	No	X				Yes	No
Arkansas	No	X				Yes	No
California	Yes - all Medicaid svcs.				X	No	Yes
Colorado	No	X				Yes	Yes
Connecticut	Yes	X				Yes	Yes
Delaware	Yes				X	No	Yes
Florida	Yes - all Med. services	X				No	No
Georgia	*No estate rec. program*					No	No
Hawaii	No	X				No	Yes
Idaho	Yes		X			No	Yes
Illinois	No		X			No	Yes
Indiana	Yes -all Med. services	X				No	No
Iowa	Yes - all Med.services				X	No	No
Kansas	No				X	No	No
Kentucky	Yes	X				No	No
Louisiana	No		X			No	No
Maine	No	X				No	No
Maryland	Yes -all Med. services	X*	X	X		No	Yes
Massachusetts	No		X			No	Yes
Michigan	*No estate rec. program*					No	No
Minnesota	Yes- all Med. services	X				No	Yes
Mississippi	No	X				Yes	No
Missouri	Yes - all Med. services	X	X			No	to implement
Montana	Yes - all Med. services	X				No	Yes
Nebraska	Yes -all Med. services	X				Yes	No
Nevada	No		X			Yes	No
New Hampshire	No		X			Yes	No
New Jersey	Yes -all Med. services	X*				Yes	No
New Mexico	No		X			No	No
New York	Yes -all Med. services	X				No	Yes
North Carolina	No	X				No	No
North Dakota	Yes - all Med. services				X	No	No
Ohio	Yes -all Med. services	X				No	No
Oklahoma	*No survey response*					N/A	N/A
Oregon	No				X	Yes	No
Pennsylvania	No	X			X	No	No
Rhode Island	No	X				No	No
South Carolina	No	X				No	No
South Dakota	No				X	Yes	No
Tennessee	No	X				No	No
Texas	*No estate rec. program*					No	N/A
Utah	Yes -all Med. services	X				Yes	No
Vermont	No				X	No	No
Virginia	*No survey response*					N/A	N/A
Washington	Yes				X	No	No
West Virginia	No		X	X	X	No	begin- FY'99
Wisconsin	Yes		X*			No	Yes
Wyoming	Yes - all Med. services		X*			Yes	No

Recovery Policy Information - Continued

Attachment #3

State	Undue Hardship Criteria	1 = waive 2 = defer 3 = negotiate 4 = other				Contract out to collect	If yes, percent currently paid to contractor	Year Begun
Alabama	Y	X	X	X		No		
Alaska	N/A					N/A		
Arizona	Y	X			X	Yes (estate)	15%	1994
Arkansas	Y	X				No		
California	Y				X	No		
Colorado	Y	X				Yes (est. & liens)	13.5%-16%	1992
Connecticut	N					No		
Delaware	Y				X	No		
Florida	Y	X		X		Yes (estate)	12.50%	1994
Georgia	N/A					N/A		
Hawaii	Y	X				Yes (liens only)	17%	1997
Idaho	Y	X	X	X		Yes (liens only)	13%	1996
Illinois	Y					No		
Indiana	Y	X	X	X		No		
Iowa	Y	X				Yes (est. & liens)	10%	E-'95 L-'90
Kansas	Y	X				No		
Kentucky	Y	X				N/A		
Louisiana	Y	X				No		
Maine	Y	X			X	No		
Maryland	Y	X*				No		
Massachusetts	Y	X				No		
Michigan	N/A					N/A		
Minnesota	N	X	X	X		No		
Mississippi	Y	X				No		
Missouri	Y	X				No		
Montana	Y	X	X	X		Yes (est. & liens)	19.40%	1996
Nebraska	Y	X		X		No		
Nevada	Y		X	X	X	No		
New Hampshire	N	X				No		
New Jersey	Y	X				No		
New Mexico	Y	X		X		No		
New York	Y					No		
North Carolina	Y	X				No		
North Dakota	Y	X	X	X	X	No		
Ohio	N	X				No		
Oklahoma	N/A					N/A		
Oregon	Y	X	X	X		No		
Pennsylvania	Y	X	X	X		No		
Rhode Island	Y		X			No		
South Carolina	Y	X				No		
South Dakota	Y	X				No		
Tennessee	Y	X				No		
Texas	N/A					N/A		
Utah	Y	X	X	X		No		
Vermont	Y	X				No		
Virginia	N/A					N/A		
Washington	Y	X		X		No		
West Virginia	Y	X	X	X		N/A		
Wisconsin	Y	X				No		
Wyoming	Y	X				combined state/cont.	paid hourly fee	1995

Long-Term Care Policy Office

Recovery Policy Information - Continued

Attachment #4

State	Estate Recovery Limited to Probate Estate	If No, other recoverable assets: 1=cash (below Med. asset level); 2=other personal prop. owned by benef; 3=Personal/real property jointly owned 4=Personal/real prop. for which benefic. had life estate prior to death; 5=Other					Estate Value below which no recovery sought	Claim Value below which no recovery sought
		1	2	3	4	5		
Alabama	Yes						No	No
Alaska	*No recovery program*						N/A	N/A
Arizona	Yes						No-but consider litg.cost	No-consd.litg.cst.
Arkansas	Yes						No	No
California	No	X	X	X		TRUSTS, ANN.	Yes ($500)	Yes ($500)
Colorado	Yes						No-but consider cst/ben.	Yes ($500)
Connecticut	No				X		Yes ($100)	Yes ($100)
Delaware	Yes						No	No
Florida	Yes						Yes (generally, $1,000)	Yes ($100)
Georgia	*No recovery program*						*No recovery program*	N/A
Hawaii	Yes						No	No
Idaho	Yes						No	Yes ($500)
Illinois	Yes						No	No
Indiana	Yes						Yes (consider cst/ben.)	No
Iowa	No	X	X	X	X		No	No
Kansas	Yes						No-but consider cst/ben.	No-consider cst/ben
Kentucky	No						Yes ($5,000)	No
Louisiana	Yes						Yes ($500)	No
Maine	Yes						Yes ($4,000)	Yes ($200)
Maryland	No	X	X				No	No
Massachusetts	Yes						No	No
Michigan	*No recovery program*						*No recovery program*	N/A
Minnesota	No						No	No
Mississippi	Yes						Yes ($5,000)	No
Missouri	Yes						Yes ($500)	Yes ($500)
Montana	No	X	X	X	X		No	No
Nebraska	Yes						No	No
Nevada	No	X	X	X	X		Yes ($100)	Yes ($100)
New Hampshire	Yes						Yes ($100)	Yes ($100)
New Jersey	No					all allowed by OBRA	No-but consider cst/ben.	No-consider cst/ben
New Mexico	Yes						No	No
New York	*No response to question*						based on cst/ben	based on cst/ben
North Carolina	Yes						Yes ($5,000)	Yes ($3,000)
North Dakota	Yes						No	No
Ohio	Yes						No	No
Oklahoma	*No survey response*						*No survey response*	N/A
Oregon	No	X				revocable trusts	No	Yes ($500)
Pennsylvania	Yes						No	No
Rhode Island	No	X	X				No	No
South Carolina	Yes						Yes ($10,000)	Yes (<$500)
South Dakota	No	X	X	X			No	No
Tennessee	Yes						No	No
Texas	*No recovery program*						No recovery program	N/A
Utah	Yes						No	Yes-based on cst/ben
Vermont	Yes						No	No
Virginia	*No survey response*						N/A	N/A
Washington	No	X	X	X			Yes (cst/ben <$3,000)	Yes ($100) *
West Virginia	Yes						Yes ($5,000)	Yes-based on cst/ben
Wisconsin	No	X				X	Yes ($50)	Yes ($50 & $100)
Wyoming	Yes						No	No

APPENDIX F

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-005
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Funds for Adult Day Care. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE ADULT DAY CARE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of three hundred fifty-six thousand two hundred fifty dollars ($356,250) for the 1999-2000 fiscal year and the sum of three hundred fifty-six thousand two hundred fifty dollars ($356,250) for the 2000-2001 fiscal year for the State Adult Day Care Program. These funds shall be allocated for the following purposes:

(1) To provide funds for start-up grants to establish 10 new adult day care programs in the 1999-2000 fiscal year and ten new adult day care programs in the 2000-2001 fiscal year in the 49 counties currently without adult day care programs; and

(2) To provide funds to support the conversion of five adult day care programs into adult day health programs in the 1999-2000 fiscal year and the conversion of five adult day care programs into adult day health programs in the 2000-2001 fiscal year.

(3) Of the funds appropriated in this section, the sum of eighty thousand dollars ($80,000) in each fiscal

year shall be used hire independent consultants to provide specialized technical assistance to adult day care programs.

Section 2. This act becomes effective July 1, 1999.

APPENDIX G

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-003
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Alzheimers Funds Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR ALZHEIMER'S ASSOCIATION CHAPTERS IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of two hundred one thousand dollars ($201,000) for the 1999-2000 fiscal year and the sum of two hundred one thousand dollars ($201,000) for the 2000-2001 fiscal year. These funds shall be allocated among the chapters of the Alzheimer's Association, as follows:

(1) $67,000 in each fiscal year for the Western Alzheimer's Chapter;

(2) $67,000 in each fiscal year for the Southern Piedmont Alzheimer's Chapter; and

(3) $67,000 in each fiscal year for the Eastern Alzheimer's Chapter.

Before funds may be allocated to any Chapter under this section, the Chapter shall submit to the Division of Aging, for its approval, a plan for the use of these funds.

Section 2. This act becomes effective July 1, 1999.

APPENDIX H

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-004
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Housing Funds for Elderly. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR HOUSING FOR ELDERLY PERSONS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Housing Finance Agency the sum of two million dollars ($2,000,000) for the 1999-2000 fiscal year and the sum of two million dollars ($2,000,000) for the 2000-2001 fiscal year. These funds shall be used to provide affordable housing for elderly persons. Beginning with the 2001-2002 fiscal year, funding for housing for the elderly shall be included in the Housing Finance Agency's continuation budget request.

Section 2. This act becomes effective July 1, 1999.