NORTH CAROLINA

STUDY COMMISSION ON AGING

REPORT TO THE
GOVERNOR AND THE 2005 REGULAR SESSION OF THE
2005 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

January 20, 2005

To: Governor Michael Easley
President of the North Carolina Senate
President Pro Tempore of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2005 Regular Session of the 2005 General Assembly

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-187. The North Carolina Study Commission on Aging presents to you findings and recommendations based on study conducted after the adjournment of the 2004 Regular Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator A.B. Swindell, IV
Co-Chair

Representative Debbie A. Clary
Co-Chair

Representative Edd Nye
Co-Chair

North Carolina Study Commission On Aging

2004-2005 Membership List

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2005-SWz-4: AN ACT TO APPROPRIATE FUNDS FOR NORTH CAROLINA SENIOR GAMES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2005-SHz-1: AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2005-SHz-6: AN ACT TO RE-ENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2005-SWz-8: AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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PREFACE

As outlined in Chapter 120, Article 21, of the North Carolina General Statutes, the North Carolina Study Commission on Aging is charged with studying and evaluating the existing system of delivery of State services to older adults and recommending an improved system of delivery to meet the present and future needs of older adults. The Commission consists of 17 members. Of these members, eight are appointed by the Speaker of the House of Representatives, eight are appointed by the President Pro Tempore of the Senate, and the Secretary of the Department of Health and Human Services or the Secretary's designee serves as an ex officio, non-voting member.

This report represents the work performed by the North Carolina Study Commission on Aging from the conclusion of the 2004 Session until the convening of the 2005 Session. The Study Commission on Aging met on six occasions to study a variety of topics including: an audit of the Community Alternatives Program for Disabled Adults, issues related to home care agencies, adult care home licensure, adult protective services, and other issues concerning older adults. During the course of its study, the Commission also conducted public hearings in Cherryville and Wilson.

EXECUTIVE SUMMARY

Leaders across the nation are working to identify programs and services to meet the current and future needs of older adults. The White House Conference on Aging takes place once a decade with a goal of making aging policy recommendations to the President and to Congress. The White House Conference on Aging will be held October 23-26, 2005.

North Carolina's leaders are also working to ensure that current needs for older adults are met efficiently and effectively and that identification and planning takes place to ensure that needs of future generations of older adults are met as well. The North Carolina Study Commission on Aging plays a vital role in this effort. The Commission's statutory responsibility is to study and evaluate the delivery of services designed to meet present and future needs of older adults. North Carolina is currently composed of and serves a vital and significant older adult population. Obviously, this population segment shares a common age category, but perhaps unlike some age categories, there is a diverse range of needs for this segment. From those individuals that are active NC Senior Games participates to those frail elderly needing skilled nursing care, from urban to rural, and from residents who have family and caregivers nearby to those whose informal support systems live far away. The range of programs and services serving older adults is diverse.

During the 2004-2005 interim, the North Carolina Study Commission on Aging met four times and conducted two public hearings in an effort to evaluate the system of services to older adults and to recommend improvements. In response to this study, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2005 Session of the 2005 General Assembly:

Recommendation 1
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program for Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Recommendation 2
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Recommendation 3
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Recommendation 4
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Recommendation 5
The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

Recommendation 6
The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Recommendation 7
The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly appropriate an additional $150,000 for Senior Games.

Recommendation 8
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.

Recommendation 9
The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

Recommendation 10
The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

Recommendation 11
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Recommendation 12

The North Carolina Study Commission on Aging recommends that the General Assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce geriatricians, geriatric-social workers, geriatric pharmacists, geriatric allied health workers, and graduates specialized in geriatric nursing and geriatric dentistry; and study how to improve the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program to increase the number of graduates specializing in geriatric care and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

Recommendation 13

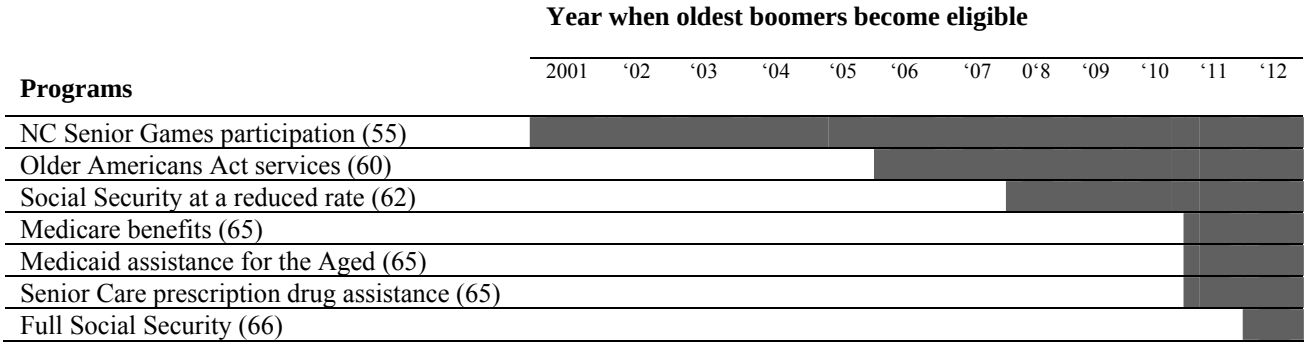
The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

OLDER ADULTS IN NORTH CAROLINA: A PROFILE

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

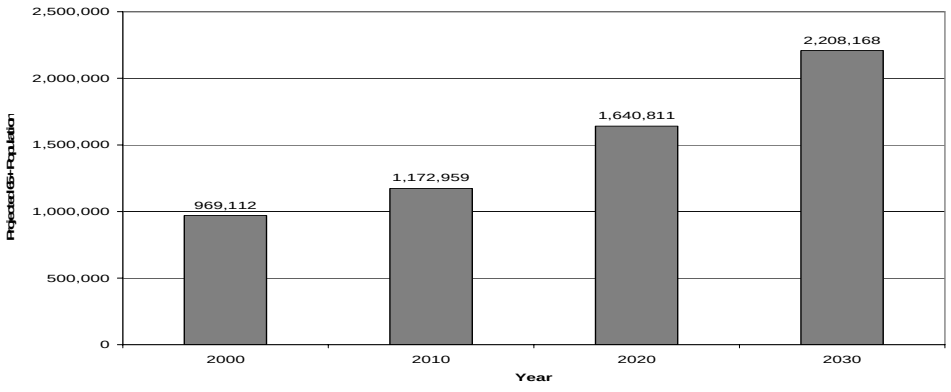
North Carolina's Demographic Shift: North Carolina is only a few years away from a significant demographic change as the state's 2.3 million baby boomers (those born between 1946 and 1964) enter retirement age in this decade. Today, the proportion of the seniors is roughly 12% of the State's total population. By 2030, when the youngest baby boomers are 65, the proportion should reach almost 18% or 2.2 million older North Carolinians age 65+ including the baby boomers that will be between ages 65 and 83. The figure below show the milestones of the baby boomers expressed in terms of some major federal and state age-related programs (eligibility age in parenthesis). For example, in 2006, the oldest baby boomers (i.e., born in 1946) will become eligible to receive services under the Older Americans Act.

Baby Boomer Milestones



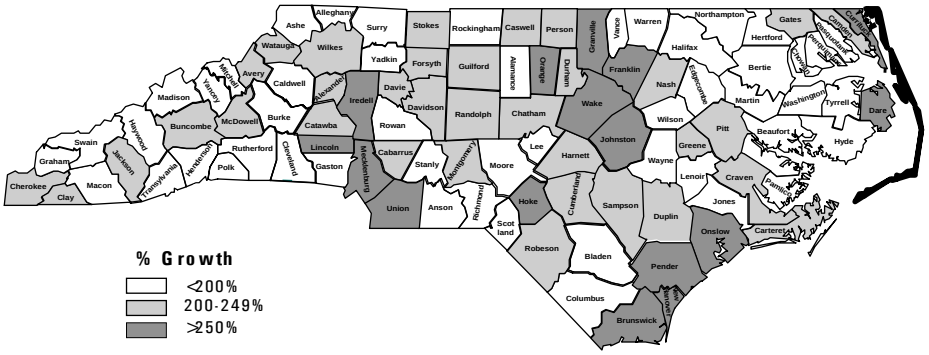
The impact of the aging baby boomers is clearly indicated in the projected growth of North Carolinians age 65+ between 2000 and 2030. [1]

Growth of Older North Carolinians Age 65+ (2000-2030)



The figure below shows the projected growth of the older population by county between 2000 and 2030. The counties with rapidly increasing numbers of older adults are clustered along the coast and in two major metropolitan areas (i.e., Charlotte and Triangle). The projected growth rate for the state's total population is 227.9%.

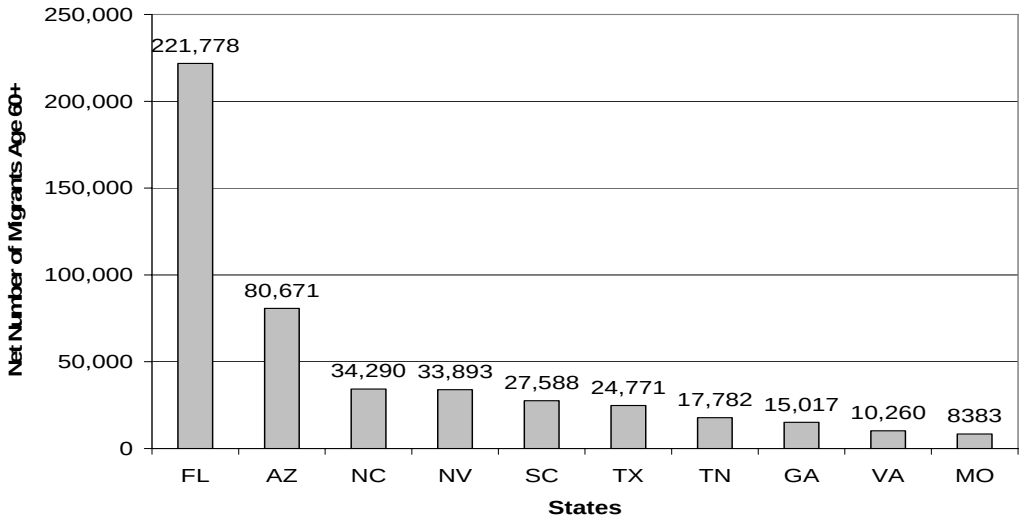
Projected Growth* of Older Population Age 65+ by County (2000-2030)



*Population projection data available from the NC State Data Center

Another major factor in the State's aging population trend is migration. North Carolina ranked third nationally with a net migration number of 34,290 among older adults (60+) in the five-year period between 1995 and 2000. Along with other Sunbelt states (Florida, South Carolina, Texas, Tennessee, Georgia, and Virginia) North Carolina remains a popular destination for people of all ages, including seniors. [2]

Top Ten States with Net Number of Migrants Age 60+ (1995-2000)



The increasing life expectancy in later years also contributes to the growth of the older population. According to the latest estimate from the NC State Center for Health Statistics, babies born today in North Carolina are expected to live, on average, to the age of 75.6 years. The North Carolinians who are age 60 today are expected to live, on average, an additional 20.8 years to almost 81 years old. Generally, women live longer than men and whites live longer than persons of minority race. However, at the oldest ages, minorities have a life expectancy that is the same or slightly greater than that of whites. This is known as the "crossover effect." [3]

Life Expectancies (Years) by Age Group, Gender, and Race

Age Groups	NC Combined	White		Minority	
		Male	Female	Male	Female
(At Birth)	75.6	73.8	79.6	68.0	75.8
60-65	20.8	19.0	22.9	16.8	21.5
65-69	17.1	15.4	18.9	13.8	17.8
70-74	13.7	12.2	15.1	11.1	14.5
75-79	10.6	9.3	11.6	8.8	11.4
80-84	7.9	6.8	8.5	6.7	8.6
85+	5.4	4.5	5.7	4.8	6.0

Source: NC Center for Health Statistics (2002). *Healthy Life Expectancy in North Carolina, 1996-2000*

There are other important factors influencing the diverse experiences in demographic shifts among the State's 100 counties including [4]:

- Rural-to-urban migration of young adults continues to age rural counties.
- Large metropolitan counties attract large numbers of persons from outside the State as well as from rural counties.
- The large metropolitan counties are experiencing greater growth among younger adults than they are among older adults.
- A large number of older adults with higher incomes are retiring in some western and coastal counties.

What Are the Implications of This Shift? The aging of the population is a national and international trend, and North Carolina, like the rest of the world, must be prepared to reap the benefits and face the challenges of an older population. Government faces decisions about the allocation of public resources from a tax base that may experience slowed growth, especially in many aging rural counties. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, employment, and education systems must adapt to the changing needs and interests of the seniors of today and tomorrow. The business, faith communities, and others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Plan, the NC Division of Aging and Adult Services introduced a new initiative–Senior-Friendly Communities–to raise awareness of the aging of our population and to promote the North Carolina communities becoming senior-friendly through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. A senior-friendly community in North Carolina will draw on the talents and resources of active seniors while enhancing services for those who are vulnerable because of their health, economic hardships, social isolation, or other conditions. A senior-friendly community will work to address a wide range of issues and concerns (e.g., air quality, housing, long-term care services, employment, enrichment opportunities) that, as a whole, affect the quality of life of seniors and

others in the community. Also, a senior-friendly community will assure stewardship of its resources to meet the needs of today's seniors, while helping baby boomers and younger generations prepare for the future.

Demographic Highlights

***Population*:** North Carolina ranks tenth among states in the number of persons age 65 and older and eleventh in the size of the entire population. [1] The fast pace of growth of the State's older population is evident in a US Census Bureau's release in which North Carolina was ranked fourth nationally in the increase of the number of older persons age 65+ (47,198 in NC) between April 2000 to July 2003. Only three other states (California, Texas, and Florida) reported a greater increase among their older populations. Even so, when combined with the equally strong growth in other age groups, North Carolina continues to maintain an overall healthy demographic balance among the generations.

- Estimated NC population age 65+ in 2005: 1,035,543 (12.1% of total population)
- Estimated NC population age 85+ in 2005: 125,093 (1.4% of the total population)

Diversity and Disparity: North Carolina is rich in diversity, but its citizens face challenges because of the disparity that exists among all populations, including older adults. Some important differences among NC's older adults relate to gender, marital status, race/ethnicity, residence, rurality, disability, health status, and veteran status.

- Gender: Older women represent 59.8% of the 65+ age group and 74.0% of the 85+ age group. [1] The higher rate of poverty among older women remains a primary issue today. For example, women age 75+ are twice as likely to be poor as men the same age. [5]

- Marital Status: At age 65 and older, women are more than twice as likely to be unmarried as men in their age group. [6] Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. According to the Social Security Administration, 50% of unmarried women rely on Social Security for 80% of their income and 25% rely on Social Security as their sole source of income. [7]

Marital Status by Age Group

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	45.4%	65.8%	76.5%
Unmarried Men in NC	18.7%	25.2%	39.4%

Source: NC Division of Aging and Adult Services (2003). *The 2003-2007 North Carolina Aging Services Plan.*

- Ethnicity/Race: Altogether 18.1% of persons age 65+ are members of ethnic minority groups in North Carolina. [8] Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.3% in NC to 8.3% nationally) and a smaller proportion of Latinos (0.6% in NC to 4.7% nationally). American Indians, Asian Americans, and other ethnic groups each account for 1% or less of the age group 65+. The statistics for African American and other older adults who are minority group members, in North Carolina as well as nationally, show both a higher poverty rate and a lower life expectancy when compared with the white population. [Note:

See the Demographic Shift section for the information on life expectancy.]

Poverty Status by Gender and Race

	65+	White		Minority	
	Total	Male	Female	Male	Female
Below Poverty	13.2%	6.5%	12.9%	21.7%	30.3%
"Near Poor"(101-200% Poverty)	23.2%	–*	–*	–*	–*

*Information currently not available.

Source: NC Division of Aging and Adult Services (2003). *The 2003-2007 North Carolina Aging Services Plan.*

- Residence: In North Carolina, 23.8% of all homeowners are age 65+, yet among older homeowners, over 61,000 reported incomes for 1999 that were below poverty. [9] This figure represented 38% of the homeowners of all ages with income below poverty and exceeded the national average of 32.7%. Among renters age 65+ who provided information, 53%, or almost 48,000, spent more than 30% of their household income on rent. Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked complete plumbing facilities in their homes. [10]

- Rurality: Although the Bureau of the Census has not yet released figures specifically for the older population residing in rural areas, it is expected to easily exceed 39.8%, the rate for the total population. [11] In 2000, North Carolina's rural population (3,199,831) was almost as large as the one in Texas (3,647,539), the state with the largest number of rural residents in the nation. Not only was North Carolina's rural population among the largest in terms of numbers, but the state also reported the highest proportion (39.8%) of rural population among the 20 most populous states in the nation. While 11 other states reported higher proportions of rural population, ranging from 40.7% to 61.8%, all of these states are much smaller in total population than North Carolina. Thus, North Carolina is unique among more populous states in having so large a rural contingency. A 2002 report highlights a long list of challenges the rural residents and their communities face—isolation by distance, lagging infrastructure, sparse resources that cannot adequately support education and other public services, and weak economic competitiveness. [12]

- Disability: In North Carolina, 45.7% of the non-institutionalized civilian population age 65+ reported having one or more disablities—47.5% of women and 43.2% of men, according to the 2000 Census. [13] The Census defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business."

- Health Status: Heart disease is the leading cause of death among older adults both nationwide and in North Carolina with cancer and stroke, second and third on the list. [14] In particular, the coastal plains region of North Carolina has the fourth highest stroke death rate in the nation and is labeled by some as the Buckle of the Stroke Belt. African Americans and other racial minorities are at substantially higher risk for certain chronic conditions such as heart disease, stroke, and diabetes (a major contributor to heart disease,

stroke and other conditions). [4]

Five Leading Causes of Death among North Carolinians Age 65+

Rank	Cause
1	Heart diseases
2	Cancer
3	Cerebrovascular diseases including stroke
4	Chronic lower respiratory diseases
5	Alzheimer's disease

Source: NC Center for Health Statistics (2003). *Leading Causes of Death – 2002.*

Physical inactivity is known to increase a person's risk of heart disease, diabetes, and other chronic conditions. North Carolinians age 65+ are ranked third from the bottom at 40% in terms of the proportion of older population that participate in physical activities. [15]

In a statewide survey, over one third of people age 65+ say that their general health status is fair or poor, ranging from 34.1% for white women to 49.3% for minority women. In the same survey, 18.4% (highest) of minority women and 4.4% (lowest) of White men age 65+ said that there was a time they could not see a doctor due to medical cost. [16]

- Veteran Status: Of the 779,393 veterans living in NC, 263,102, or 34%, were age 65 and older in 2000. Another 34% were Vietnam-era veterans (between 43 and 57 years old in 2000). The population of veterans of the Vietnam-era contains proportionally more disabled members than the veterans' populations of earlier wars. [17] The Veterans Administration cites the aging of the veterans as a major challenge to its health care system in coming years. [18]

Sources of Information

[1]NC State Data Center (2005). *County/State Population Estimates.*
[2] Charles Longino (2003). *States Ranked by the Net Number of Migrants Age 60+, 1985-1990 and 1995-2000.*
[3]NC Center for Health Statistics (2002). *Healthy Life Expectancy in North Carolina, 1996-2000.*
[4]NC Division of Aging and Adult Services (2003). *The Aging of North Carolina: The 2003-2007 North Carolina Aging Services Plan.*
[5] Institute for Research on Women & Gender (2002). *Difficult Dialogues Program Consensus Report: Aging in the Twenty-first Century.*
[6]US Census Bureau (2002). *Census 2000 PCT 7 (Summary File 3).*
[7]US Social Security Administration (1998). *Fast Facts & Figures about Social Security*.
[8]US Census Bureau (2003*). Census 2000 P12 (Summary File 1).*
[9]US Census Bureau (2002). *Census 2000 HCT 8 (Summary File 2).*
[10]NC State Library (2003). Special tabulation from the Census 2000 data as requested by the NC Division of Aging and Adult Services.
[11]US Census Bureau (2003). *Census 2000 P2 (Summary File 1).*
[12]MDC (2002). *State of the South 2002*.
[13]US Census Bureau (2003). *Census 2000 PCT 26 (Summary File 3).*
[14]NC Center for Health Statistics (2003). *Leading Causes of Death-2002.*
[15]NGA Center for Best Practices (2004). *Measuring the Years: State Aging Trends & Indicators.*
[16] NC Department of Health and Human Services (2003). *A Health Profile of Older North Carolinians*
[17]US Department of Veterans' Affairs (2002). *VA History in Brief.*
[18]US Department of Veterans' Affairs (2002). *Data on the Socioeconomic Status of Veterans and on VA Program Usage.*

Pertinent Web Sites for Related Information

- NC Division of Aging and Adult Services (http://www.dhhs.state.nc.us/aging/demo.htm)
- NC State Data Center (http://demog.state.nc.us/)
- NC State Center for Health Statistics (http://www.schs.state.nc.us/SCHS/)
- US Census Bureau (http://www.census.gov)

COMMISSION PROCEEDINGS

October 21, 2004

The North Carolina Study Commission on Aging conducted the first of two public hearings on October 21, 2004 at 10:30 a.m. at the First Baptist Church in Cherryville. Representative Clary was the presiding Co-Chair. At this hearing, 14 people spoke on a variety of issues of concern to seniors, including home and community-based services, Senior Games, CAP/DA, mental health patients in nursing homes and adult care homes, and staffing ratios in nursing homes, Appendix A. Volunteers were present to provide information and enroll participants in the NC Senior Care program for prescription drugs.

October 26, 2004

The North Carolina Study Commission on Aging conducted its second public hearing on October 26, 2004 at 1:00 p.m. at the Wilson County Agricultural Center in Wilson. Senator Swindell was the presiding Co-Chair. Thirty-three people spoke to Commission members about a number of concerns, including Senior Center funding, the long-term care insurance tax credit, transportation, funding for home and community based services, and lack of affordable housing for seniors, Appendix A. NC Senior Care volunteers were again present to provide information and enroll participants in the program.

October 27, 2004

The North Carolina Study Commission on Aging met on Wednesday, October 27, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Nye was the presiding Co-Chair. At this meeting, the Commission heard several reports and updates concerning ongoing programs.

After approving its budget for 2004-2005, the Commission heard presentations from Dianna Jessup, Commission Staff, on 2004-2005 legislation of interest to seniors and the status of the Commission's recommendations in 2004, Appendix B. Ms. Jessup reported that 9 of the 10 recommendations of the Commission were acted upon during the 2004 Session. The only recommendation that was not acted upon was the Commission's recommendation that the General Assembly repeal the sunset on the long-term care insurance tax credit.

Following the legislative update, the Commission heard from Janet Hayes of the Office of the State Auditor, Appendix D, on the results of a CAP/DA audit, PER-2004-0208, that was originally recommended by the Commission. The audit focused on Department of Health and Human Services guidelines and goals used to implement and administer the program and assessment measures used to determine compliance with the State's CAP/DA waiver. The audit did not assess the quality and adequacy of actions from a medical or clinical perspective. The audit concluded that generally, the Department was in compliance with the guidelines under which the program is authorized. However, a few operational changes were suggested to improve administration of the program. Suggested changes include updating the CAP-DA manual, providing more training for locals, adding computer edits for payment approval, performing annual on-site reviews and improving the use of technology by locals. The audit also concluded that to improve the assessment of the program, the General Assembly should provide funds to complete an audit of the clinical aspects of the program.

Next, Michael Keough from the Department of Health and Human Services (DHHS) updated the Commission on NC Senior Care, the State's prescription drug program. Specifically, Mr. Keough focused on the implications of the new Medicare discount card and recent changes to the program. Pursuant to a provision in last year's budget, Senior Care is authorized to autoenroll seniors in the Medicare discount drug card program. Current and future participants in Senior Care whose income is not more than 135% of the federal poverty level are eligible for automatic enrollment in the Medicare discount drug card program; however, those individuals must have an opportunity to decline automatic enrollment if they choose. Other changes to the Senior Care program have expanded benefits and persons covered by the program, including elimination of the restrictions on eligibility or covered drugs based on diagnosis and increasing the upper income threshold for eligibility from 200% to 250% of the federal poverty level. There is now a Senior Care Community Care Rx program that allows members with both benefits to have one card instead of two and ensures that no State money is spent until the federal transitional assistance program money is spent. NC Senior Care and Medicare drug program benefits have been communicated to North Carolina residents through community-based meetings, news articles, and a statewide NC Senior Care sign-up day on October 26, 2004.

The final topic for this meeting was the pilot project for long term care community service coordination. The objective of this initiative is to give counties the structure and technical assistance needed to develop and implement a local long term care planning process. Several persons spoke on the status of the pilot. First, Julie Bell of the Division of Aging and Adult Services, DHHS, spoke on pilot site selection and pilot site activities to date. Two volunteer pilot communities were chosen to participate in evaluating their long term care services and in identifying and implementing strategies to strengthen long term care services for older and disabled adults. The Long Term Care Cabinet chose New Hanover and Mecklenburg counties to participate based on their capacity and willingness to undertake the project. John Highfill, Adult Services Section, Mecklenburg County Department of Social Services, updated the Commission on Mecklenburg's activities. Mecklenburg developed a Steering Committee and an Executive Advisory Board to lead their efforts. Work groups met to evaluate the county's long term care services and determine the major barriers and gaps in services. Recommendations generated by the work groups were referred to the Steering Team. A Planning Report was generated, which details the leading concerns realized during the planning process and recommendations. Gayla Woody from the Centralina Council of Governments Area Agency of Aging, spoke about Rowan County's efforts at long term care planning. Finally, Steve Friedman from the Division of Aging and Adult Services, DHHS, noted that funding for local long term care planning and more State consultation and technical assistance are needed.

November 10, 2004

The North Carolina Study Commission on Aging met on November 10, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator Swindell was the presiding co-chair. Presentation topics for this meeting included: restructuring personal care services, adult care home licensing, consumer-directed care and a report on care for the mentally ill in long-term care facilities. The Commission also received a summary of comments from the public hearings.

The presentation on the Medicaid In-Home Personal Care Services Program Appendix C was given by Lynne Perrin, Chief, Facility and Community Care Clinical Policy and Programs, Division of Medical Assistance (DMA), Department of Health and Human Services; and Sherry Thomas, Senior Vice President, Association for Home and Hospice Care of North Carolina (AHHC). Ms. Perrin gave the Commission members background information on the program including: types of Personal Care Services (PCS), reimbursement amounts, providers, and

benefit limitations. She informed the Commission that in 2004, Medicaid PCS expenditures were $220,933,622 and there were 41,222 recipients. For SFY 2004, the average annual expenditure per recipient was $5,360 and the average monthly expenditure per recipient was $446. Ms. Perrin pointed out that the PCS program is important to the State's long-term care system and has been operating since 1985 with little change in administrative structure or State-level oversight. Reasons to restructure include: growth in program expenditures and recipients; growth in the number of providers and appropriate targeting of services; quality issues; the need to refine and clarify medical criteria; the need for improved assessment tools; the need for provider standards, training, and best practices; and the need to improve State-level oversight and monitoring functions. As a result, a PCS restructuring initiative was undertaken by AHHC and DMA in January 2004. Ms. Thomas presented recommendations for improvement and a comparison of the current PCS structure to a restructured PCS program. Among the recommendations for improvement are: a new Registered Nurse (RN) assessment that serves as a certification that assessment is accurate and also as the physician's authorization for services; a new patient assessment tool; revised RN supervision standards; and quality assurance/utilization reviews. The desired outcome of the program improvements is, "To assure PCS continues to be an important service in the State's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure service quality and fiscal accountability." It is anticipated that the implementation process will take from 6-10 months, and the target date for implementation is July 1, 2005.

Bob Fitzgerald, Director, Division of Facility Services, DHHS, and Melissa Trippe, Attorney, Office of the Attorney General, addressed the Commission on the topic of adult care home licensing. Current law requires DHHS to conduct a compliance history review of a facility, and its principals and affiliates, prior to renewing a license or issuing a new license. The Department has the authority to refuse to license a facility when the compliance history review reveals a pattern of noncompliance. (Rules adopted by the Medical Care Commission define the terms: "affiliate," "owner," and "principal.") Mr. Fitzgerald briefly mentioned a series of newspaper articles that may have indicated the need for an overhaul of the licensing application process. He and Ms. Trippe indicated that an overhaul of the system was not necessary, but do believe that the State would benefit by granting DHHS the authority to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Next the Commission heard from Ann Eller and Lynne Perrin on North Carolina's consumer-directed care initiatives. Ms. Eller's presentation began with a definition of consumer-directed support that was supplied by Sue Flanagan, National Institute on Consumer-Directed Long-Term Services. Ms. Flanagan defined consumer-directed support as, "A philosophy and orientation to the delivery of home and community based service delivery whereby informed individuals assess their service needs, determine how and by whom these needs should be met and monitor the quality of services received." Ms. Eller told the Commission that this concept supports individuals in need of assistance with activities of daily living; allows individuals to plan, budget, and make choices that work best for them; and allows participants control in managing their support services (i.e. attendant/aide, medical equipment and supplies, and mobility aides). There are three main steps for participants: Participant-Centered Plan, Participant Budget, and Participant Direction of Services. The team members include the following: participant, representative (optional), support advisor, attendant/aide, financial manager, and State and local government. In closing, Ms. Eller noted that consumer-directed support fulfills the intent of the *Olmstead* decision to support individuals through cost-effective community based systems, and promotes full community participation of individuals with disabilities as encouraged by the

federal New Freedom initiative.

Lynne Perrin presented information on the Community Alternatives Program (CAP) Choice waiver that targets elderly and disabled adults who require nursing facility level of care. Ms. Perrin told the Commission that the CAP Choice waiver is an alternative to Community Alternatives Program for Disabled Adults (CAP/DA). CAP Choice provides elderly and disabled adults the flexibility to manage their own care plans. The CAP Choice waiver allows recipients to hire, train, supervise, evaluate, and release a personal assistant; negotiate the assistant's pay and other benefits; and select providers and direct reimbursement. The Division of Medical Assistance received approval from the federal Centers for Medicare and Medicaid Services to implement the Independence-Plus 1915(c) waiver (CAP Choice) in January 2004. The CAP Choice pilot will be held in Duplin County and Cabarrus County. Currently, these pilot counties serve approximately 400 CAP/DA clients. Ms. Perrin reported that the target date for implementation is January 2005.

Dr. Bonnie Morrell, Division of Mental Health, Developmental Disabilities, and Substance Abuse, Department of Health and Human Services (DHHS) made an interim report on the provisions contained in S.L. 2004-144 (SB 1148). S.L. 2004-144, based on a recommendation made by the Commission, requires DHHS to study the mission of the Geriatric Mental Health Specialty Teams, to standardize five criteria across the Teams, to immediately begin tracking expenditure and use data, and to submit an interim report by October 30, 2004. Dr. Morrell reported that DHHS has defined the team purpose and the eligibility for services, which are two of the five criteria to standardize. Dr. Morrell also told the Commission that a committee has been formed to study the mission of the teams and the first meeting was held on October 28, 2004. The Department is continuing to work on developing and implementing a screening and referral process, developing an operations manual, and implementing the tracking system. S.L. 2004-144 requires DHHS to submit their final report on its standardization and tracking efforts, and the results of its study, by October 30, 2005.

For the final presentation of the meeting, Staff member, Shawn Parker, presented a summary of public hearing comments. The Commission held a public hearing on October 21, 2004 in Cherryville, NC and a public hearing in Wilson NC on October 26, 2004. Mr. Parker provided the Commission with a handout Appendix A portraying the frequency of issues expressed by the speakers during the hearings. The issues mentioned with the greatest frequency were as follows:

- Preserve/Expand Support for Senior Games;
- Preserve/Expand Senior Centers Including Certified Senior Centers;
- Preserve/Expand Support for In-Home and Community-Based Services;
- Lower/Provide Assistance with Prescription Drug Costs; and
- Concerns About Combining Mentally Ill and Elderly Populations.

December 1, 2004

The North Carolina Study Commission on Aging met on December 1, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Clary was the presiding co-chair. At this meeting, the Commission heard presentations on adult care home licensing, elder mistreatment and abuse, and an adult day service reimbursement methodology study. The Commission also reviewed and approved recommendations to be presented to the Governor and the 2005 Session of the 2005 General Assembly.

Lieutenant Governor Beverly Perdue addressed the Commission on the topic of adult care home licensing. In her introduction, Lieutenant Governor Perdue described to the Commission her

past efforts in spearheading an initiative to update the statutes on adult care homes in North Carolina that resulted in the 1999 passage of Senate Bill 10 (a component of the bill limited the expansion of adult care homes facing compliance complaints). Lt. Governor Perdue stated that according to an investigative series published in the Raleigh News and Observer last spring, operators of multiple homes appear to have circumvented the law by registering each individual home as a separate corporate entity. Referring to her discussions with Bob Fitzgerald, Director of the Division of Facility Services, the Attorney General's office, and staff attorneys with the North Carolina General Assembly, Lt. Governor Perdue explained that G.S. 131D-4.5(6) satisfies legislative intent, so substantive changes are not needed. She did, however, believe that the intent could be more closely adhered to if punitive authority for the Division of Facility Services is created. Lt. Governor Perdue then requested the following: 1. Clarification of the language on the renewal license application for the provider so that it is simple, clear and concise and is consistent with rules and regulations. 2. Determination by DHHS of what is considered a pattern of non-compliance that demonstrates disregard for health, safety and welfare of residents in current facilities and past facilities. 3. Adoption of rules by the Medical Care Commission to define the length of compliance history information from the applicant licensee and what constitutes compliance history information. 4. Establishment of a plan of action by DHHS when there is a licensee identified that disregards health, safety and welfare of residents. In addition, she suggested that the Department should have a plan ready to inspect all associated or affiliate facilities. An analysis of cost reports for each facility should be conducted to determine how the licensee, in meeting requirements of the home and financial stability of each home across the whole organization, has utilized reimbursement money. Based on the inspection results and reimbursement analysis, a determination for each facility should be made based on the established pattern of non-compliance history and reimbursement. Lt. Governor Perdue also strongly encouraged the Commission to re-enact the long term care insurance tax credit that expired on January 1, 2004. Lt. Governor Perdue concluded her presentation by reiterating the importance of the Commission's work. She thanked everyone for past efforts and noted that she looks forward to working with the Commission during the 2005 Session.

A status report on the North Carolina Adult Day Services Reimbursement Study was presented by Nancy J. Cox, Director, Partners in Caregiving: The Adult Day Services Program from the Department of Psychiatric and Behavioral Medicine, Wake Forest University School of Medicine. Ms. Cox began by identifying Section 10.21(a) of S.L. 2004-124 as the impetus for this study. After a brief history of adult day services in North Carolina, Ms. Cox explained the service definitions for Adult Day Care and Adult Day Health Care. Gary Cyrus from the Division of Aging and Adult Services, DHHS, continued the presentation with a budget analysis of the three funding streams for adult day services. Services are funded through the Home and Community Health Care Block Grant (HCCBG), the State Adult Care Fund (SADCF) and Community Alternatives Program for Disabled Adults (CAP/DA). Mr. Cyrus then presented a program comparison with South Carolina, Virginia, Georgia, and Florida. Mr. Cyrus explained that one difference is that North Carolina reimburses by days of enrollment, but the four other states reimburse by attendance. Mr. Cyrus provided the methodology of the survey. He explained the study was conducted by use of key informant interviews including staff from DHHS (Division of Aging and Adult Services and Division of Medical Assistance), the North Carolina Adult Day Services Association, and adult day services providers in the 17 Area Agency on Aging regions. Ms. Cox completed the presentation by offering three key issues for consideration: the current system does not allow for negotiated rates; no formal system is in place to determine and report unit cost and a reasonable reimbursement rate; and there are differences among the funding streams that could possibly be made uniform to ease administration and promote clarity and fairness in the application of rules. She pointed out that

this would not require legislative action, but could be handled by the administrative process. Representative Clary suggested consulting with staff and co-chairs to determine if any of the recommendations would require legislation.

Next the Commission heard from Dr. Margaret Hudson on elder mistreatment. Dr. Hudson's presentation included a historical perspective on the topic based on research that has been completed over the last twenty-five years. She defined the differences between elder mistreatment, elder abuse, elder neglect and self-neglect in the context of North Carolina adult protective services, and recommended a change of wording in G.S. 108A-101 to more accurately reflect these differences. She reiterated elder abuse and elder neglect are different and must be studied separately. Dr. Hudson concluded her presentation by advocating for a place that healthy elders can go for help. Dr. Hudson also suggested a coalition to help with the formal training, circumventing the tendency to focus on ruling out mistreatment instead of ruling in mistreatment.

Dianna Jessup and Theresa Matula, Committee Staff, then presented draft recommendations for the Commission's consideration. After review and discussion, those recommendations were adopted, and staff was directed to prepare a report for adoption at the next meeting. Representative Weiss raised two additional recommendations. The Commission asked her to have more definitive recommendations drafted for consideration at the next meeting.

January 20, 2005

The North Carolina Study Commission on Aging met on Thursday, January 20, 2005 at 10:00 a.m. in Room 544 of the Legislative Office Building. The Commission heard a presentation from Nancy Cox on the Adult Day Service Training and Reimbursement Methodology Report as authorized by S.L. 2004-124, Section 10.21. Appendix E. Commission staff reviewed the Commission's draft report and three additional recommendations submitted by Representative Weiss. The Commission discussed and approved the North Carolina Study Commission on Aging's Report to the Governor and the 2005 Regular Session of the 2005 General Assembly.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this section to the Governor and the 2005 Session of the 2005 General Assembly. Each recommendation is followed by background information, and corresponding legislative proposals appear in Appendix F of this report.

Recommendation 1

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program for Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Background

The North Carolina Study Commission on Aging recommended that the 2003 General Assembly direct the Office of the State Auditor to conduct a full audit of the Community Alternatives Program for Disabled Adults (CAP/DA). In response to the Commission's recommendation, S.L. 2003-284, Section 10.29B(a) provided that the State Auditor should perform an audit of the CAP/DA program if State funds were appropriated. The provision directed the Auditor to build upon the results of the study conducted by the North Carolina Institute of Medicine in accordance with S.L. 2002-126, Section 10.16(c). The purpose of the audit was to determine whether CAP/DA is operating within waiver guidelines and program goals. During the course of its study, the Commission heard a number of presentations on CAP/DA, and 33% of those who spoke during the March and April 2002 public hearings expressed support for the program. Much of the concern regarding the CAP/DA program stemmed from fact that the Division of Medical Assistance had directed that effective October 1, 2001, no individuals could be added to CAP/DA. However, by August 2002, new enrollees were allowed to replace people leaving CAP/DA.

Although the General Assembly did not provide funding, the Office of the State Auditor did conduct a performance audit, PER-2004-0208, on the Community Alternatives Program for Disabled Adults. The presentation made during the meeting on October 27, 2004 meeting, specified that the objectives of the audit were: 1. To determine guidelines and goals used to implement and administer CAP/DA; and 2. To identify program assessments used by CAP/DA. The findings and recommendations for each of the two objectives were outlined and an issue for further study was identified, Appendix D.

The audit report specifies that, "to provide complete information to the General Assembly, the Auditor would require assistance from outside subject matter specialists to fully assess the medical and clinical quality and/or adequacy of actions taken by DMA." The report further states that, "the Auditor strongly recommends that the General Assembly provide funds to fully determine the CAP/DA program's compliance with waiver guidelines and goals. Those funds would allow the State Auditor's Office to obtain assistance from health care professionals to assess the following areas: Review of case files to assure compliance with the requirement for medical necessity, plans of care, and provision of needed services; Review of service provider standards and monitoring of same; Review of safeguards to protect health and welfare of clients; Determination that clients are institutionalized when necessary; and Review of the independent assessment function for the program."

The Office of the State Auditor indicated that it would cost $150,000 to secure the services of experts who could evaluate the quality and adequacy of the medical and social services provided to CAP/DA clients. This would be accomplished by:

1. Conducting a qualifications review of-
   - local lead agency case managers (licenses, qualifications, educational levels, etc.),
   - local provider organizations (licensed or certified), and
   - provider's employees who actually see clients (licenses, qualifications, educational levels).
2. Conducting a "desk review" of documents to determine-
   - the medical justification supplied by the attending physicians on the FL2 forms,
   - adequacy and completeness of the plans of care prepared by local case managers, and a
   - comparison of services provided per case notes to services needed per physicians.
3. Conducting in-home visits with a sample of clients, discussing care with clients, and confirming that case notes document services received.

The Study Commission on Aging believes that CAP/DA is a vital offering in the State's array of care options and therefore the program should run efficiently and effectively. As such, the Commission recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor for the purpose of conducting an assessment of CAP/DA to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Recommendation 2

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Background

On November 10, 2004, the Commission heard presentations on the Medicaid In-Home Personal Care Services (PCS) Program, Appendix C. This presentation pointed out a number of recommendations for program improvement with the desired outcome being, "To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure service quality and fiscal accountability. During the presentation, the Commission was told that the Association of Home and Hospice Care supported legislation granting the Medical Care Commission the authority to define geographical service areas for home care licensed agencies as a way to assure adequate access to Registered Nurse supervision.

Home care agencies, licensed by the Division of Facility Services, DHHS, and enrolled in the Medicaid program provide PCS in North Carolina. As of October 2004, there were a total of 1,284 licensed home care agencies – 1055 were licensed-only home care agencies, and 219 were Medicare-certified home health agencies. Certified agencies have geographical service areas defined by the federal Centers for Medicaid and Medicare Services (CMS). Licensed-only agencies providing in-home aide services do not have a defined service area. Both the Department of Health and Human Services, and the Association of Home and Hospice Care (AHHC), have concerns about home care agencies serving clients in areas that are too far from the licensed site. Current State statutes and rules provide that any agency licensed by DHHS is subject to inspections as a condition of holding the license. Further, G.S. 131E-138(g) provides that DHHS, at its discretion,

determine the frequency and extent of the review and inspection of home health agencies already certified as meeting federal requirements, but not more frequently than on an annual basis for routine reviews. According to DHHS, Medicare-certified home health agencies currently receive inspections not less than every 3 years. However, there is currently not a mandatory inspection cycle for licensed-only home health agencies. This recommendation seeks to establish a survey cycle of every two years.

In order to establish a two-year survey cycle, additional employees would be needed. According to DHHS, there are currently 27 employees in the Acute and Home Care Branch of the Licensure and Certification Section, of these employees; seven are involved in the regulation of Medicare-certified home health agencies, home care agencies and hospices. The employees spend the majority of their time regulating Medicare-certified home health agencies, since federal money provides most of the position funding. However, only one and a half of the seven positions are devoted to the regulation of licensed-only home care agencies and this regulation primarily involves conducting initial surveys and investigating complaints. The Department estimates that they will need to establish 8 positions, at a cost of $550,000, to implement the two-year survey cycle. The $550,000 includes salary, benefits, and other costs related to establishing the positions. Therefore, the Commission recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Recommendation 3

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Background

Pursuant to the North Carolina General Statutes (Article 15, Chapter 131E) and the North Carolina Administrative Code (10 NCAC 3B-1000 to 1002), the North Carolina Health Care Personnel Registry is a comprehensive listing of personnel who have been subject to findings, or where an investigation is required based on an accusation, in situations involving abuse; neglect; misappropriation of property; diversion of drugs belonging to a health care facility, patient or client; and fraud against a health care facility, patient, or client. Home Care Agencies, as defined in G.S. 131E-136, are among the entities that are considered "health care facilities" under G.S. 131E-256(b). Therefore, a home care agency must access the Health Care Personnel Registry before hiring health care personnel and must notify the Department of all allegations against health care personnel.

The NCAC contains rules that prohibit adult care homes from hiring individuals with substantiated findings on the Health Care Personnel Registry (10A NCAC 13F .0407(5)), and that prohibit nursing homes from hiring individuals who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property (10 NCAC 3H .2210 and 42 CAR Section 483.13(c)(ii)(B)). The rules for home care agencies do not prohibit hiring individuals with substantiated findings on the Health Care Personnel Registry.

The Commission supports long-term care consumer protection and recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry.

The entities and individuals subject to the provisions of the Health Care Personnel Registry are defined by statute. G.S. 131E-256(b) defines entities that are considered "health care facilities" and G.S. 131E-256(c) defines individuals that are considered "health care personnel." Concerns were expressed regarding whether these statutory definitions contain a comprehensive listing of all entities and personnel currently providing similar hands-on care. In response to this concern, the Commission recommends that the General Assembly direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Recommendation 4

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Background

The Home Care Agency Licensure Act establishes licensing requirements for home care agencies and is contained in Part 3, Article 6, Chapter 131E of the General Statutes. The Department of Health and Human Services (DHHS) is charged with the application process under G.S. 131E-138. This section also requires that each application filed with DHHS contain all information requested. The Department charges a nonrefundable annual license fee of one hundred seventy-five dollars ($175.00). A license granted to an applicant upon a determination by DHHS that the applicant has complied with the provisions of statute and the rules adopted by the Medical Care Commission.

According to the Association of Home and Hospice Care (AHHC), the current licensure process primarily consists of potential agencies going through a review of policies and procedures required by the home care licensure rules with Division of Facility Services (DFS) staff. The AHHC reports that the staff spends considerable time educating potential applicants one-on-one regarding the licensure process. A set schedule of mandatory, group training would create more efficient use of DFS staff time and also allow applicants a more in-depth training session that would also cover agency responsibilities in rule compliance and patient care. Such training would assure DFS that the applicant has enough knowledge to comply with the provisions of the statute and rules before granting the license. Therefore, the Commission recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Recommendation 5

The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

Background

The Nursing Home Patients' Bill of Rights is contained in Part 2, Article 6 of Chapter 131E of the NC General Statutes. The Adult Care Home Residents' Bill of Rights is contained in Article 3 of Chapter 131D of the General Statutes. The North Carolina Administrative Code (10 NCAC 3L .1007) provides the home care Client Rights and Responsibilities, but there is no provision similar to the Adult Care Home and Nursing Home Patients' Bill of Rights set out in the statutes for home care clients. Therefore, the Commission recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules to model them after the Adult Care Home and Nursing Home Patients' Bill of Rights.

Recommendation 6

The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Background

Prior to issuing a new license or renewing an existing license for an adult care home, the Department of Health and Human Services is required to conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its "principals or affiliates". The Department must refuse to issue a new license to an applicant who:

- Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date or revocation; or
- Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with a correction plan and substantial compliance has been certified by the Department; or
- Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provision status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license; or
- Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provision status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

"Affiliate", "owner", and "principal" are defined by rules adopted by the Medical Care Commission.

The application for an adult care home license requires disclosure of information concerning owners, affiliates, and principals of the applicant. Failure to disclose or providing false information on an application may subject the licensee, after the fact, to revocation of the

license.

On November 10, 2004, the Commission heard presentations on adult care home licensing. Specifically, recent media attention had been focused on perceived "loopholes" in the law that would permit an adult care home licensee with a history of noncompliance to open another facility under a different name. Bob Fitzgerald, Director, Division of Facility Services, Department of Health and Human Services, and Melissa Trippe, Attorney, Office of the Attorney General, addressed the Commission on this issue. Mr. Fitzgerald briefly mentioned the newspaper articles that may have indicated the need for an overhaul of the licensing application process. He and Ms. Trippe indicated that an overhaul of the system was not necessary, but do believe that the State would benefit by granting the Department the authority to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

During her presentation to the Commission on December 1, 2004, Lieutenant Governor Perdue said that her conversations with staff and with the Department has led her to conclude substantive changes are not needed to the law in order to prevent operators who have a history from noncompliance from opening new homes. She did, however, believe that the intent could be more closely adhered to if punitive authority for the Division of Facility Services is created.

The Commission agrees with the Department and the Lieutenant Governor that while substantive changes to the current law are not needed at this time, permitting the Department to impose a civil penalty may deter applicants from providing false or omitting material information. Therefore, the Commission recommends that the General Assembly authorize the Department to impose a civil penalty against applicants who supply false information or omit material information from the licensure application.

Recommendation 7

The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly appropriate an additional $150,000 for Senior Games.

Background

The Centers for Disease Control and Prevention and the Merck Institute of Aging & Health recently released, *The State of Aging and Health in America 2004*. The study indicated that in 2002, 39.9% of older adults in North Carolina participated in no leisure-time physical activity; North Carolina ranked 49 out of 50. The study indicates that the benefits of physical activity may include: reduction in a person's risk for cardiovascular disease; prevention of the development of diabetes, high blood pressure, and colon cancer; prevention of falls by helping to maintain and improve balance; and maintenance of healthy bones and muscles, increased joint mobility, and improved functional capacity of people with osteoarthritis.

The State Senior Games program provides year-round health promotion and education for North Carolinians 55 years of age and older. The program has 50,000 participants and serves all 100 counties.

In both public hearings, the continued support for the program was the most frequently mentioned issue. The Commission recognizes the benefits of supporting the North Carolina Senior Games

program and recommends increasing the $175,000 provided by the General Assembly in the continuation budget by an additional $150,000.

Recommendation 8

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.

Background

In its report to the Governor and the 2004 General Assembly, the Commission recommended that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant (HCCBG) for the 2004-2005 fiscal year. This recommendation was an effort by the Commission to restore a one million dollar ($1,000,000) reduction that had been made in State funds for the HCCBG. In formulating this proposal the Commission considered presentations made on March 23, 2004, which gave an overview of the program; eligibility criteria; and information on program utilization, availability, and needs. They also considered that support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina. S.L. 2004-124 restored eight hundred thousand dollars ($800,000) in funding for the HCCBG.

The HCCBG, established by G.S. 143B-181.1(a)(11), consolidates several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations)—some of which traditionally went to separate organizations. The HCCBG is composed of federal funds, State funds, local funds, and a client cost sharing component. Any person age 60 and older is eligible for services under the HCCBG. Although no income restrictions apply, special consideration is given to older adults with the greatest economic and social need. Of the 18 services, 14 are "core" services and 92% of the funds, over which counties have discretion, support these core services. Counties have discretion to determine services, levels, and providers. The 18 eligible services are: Adult Day Care, Adult Day Health Care, Care Management, Congregate Nutrition, Group Respite, Health Promotion and Disease Prevention, Health Screening, Home Delivered Meals, Housing and Home Improvement, Information and Assistance, In-Home Aide (levels I-IV), Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior Companion, Skilled Home (Health) Care, Transportation (General and Medical) and Volunteer Program Development. The SFY 2003-04 HCCBG service profile indicates that: 71% of participants are women (compared to 58% of the NC 60+ population), 33% are minority, (compared to 18% of the NC 60+ population), 63% are age 75 or older (compared to 34% of the NC 60+ population), 46% live alone (compared to 28% of the NC 60+ population); 71% are unable to mange on their own (compared to 12% of the NC 60+ population), 48% are reportedly low-income (compared to 13% of the NC 60+ population), and 66% are at risk of malnutrition.

During its study this interim, the Commission again heard how important the HCCBG is to North Carolinians. Preserving/expanding support for in-home and community-based services was the third most frequently mentioned item during the public hearings conducted in October 2004. The Division of Aging and Adult Services reports that 55% of the roughly 450 service providers indicate having 7,430 individuals on waiting lists for HCCBG services. The Commission recognizes the need for services provided through the Home and Community Care Block Grant and recommends that the General Assembly appropriate an additional $4,000,000 in State funds.

Recommendation 9

The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

Background

In 1997, the North Carolina Study Commission on Aging recommended that the 1997 General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. According to the 1997 Commission report, the Office of State Budget and Management estimated that a 15% tax credit up to a maximum of $350 may result in a revenue loss of $17 million. The report further stated that, the average premium was $1,600, thus a 15% credit would be equal to $240. The report acknowledged that it was difficult to estimate the offsetting benefits of the tax credit in terms of reduced Medicaid payments, but that the cost of a year's stay in a North Carolina nursing home was $40,000. The Commission recommended this tax credit again in 1998, and the credit became G.S. 105-151.28:

§ 105-151.28. Credit for premiums paid on long-term care insurance.

(a) Credit. – An individual is allowed, as a credit against the tax imposed by this Part, an amount equal to fifteen percent (15%) of the premium costs the individual paid during the taxable year on a qualified long-term care insurance contract that offers coverage to either the individual, the individual's spouse, or a dependent for whom the individual was allowed to deduct a personal exemption under section 151(c)(1)(A) of the Code for the taxable year. The credit allowed by this section may not exceed three hundred fifty dollars ($350.00) for each qualified long-term care insurance contract for which a credit is claimed. The credit allowed under this section may not exceed the amount of tax imposed by this Part for the taxable year reduced by the sum of all credits allowed, except payments of tax made by or on behalf of the taxpayer. A nonresident or part-year resident who claims the credit allowed by this subsection shall reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate.

(b) No Double Benefit. – No credit is allowed for payments that are deducted from, or not included in, the taxpayer's gross income for the taxable year. If the taxpayer claimed a deduction for health insurance costs of self-employed individuals under section 162(l) of the Code for the taxable year, the amount of credit otherwise allowed the taxpayer under this section is reduced by the applicable percentage provided in section 162(l) of the Code. If the taxpayer claimed a deduction for medical care expenses under section 213 of the Code for the taxable year, the taxpayer is not allowed a credit under this section. A taxpayer who claims the credit allowed by this section must provide any information required by the Secretary to demonstrate that the amount paid for premiums for which the credit is claimed was not excluded from the taxpayer's gross income for the taxable year.

(c) Definition. – For purposes of this section, the term 'qualified long-term care insurance contract' has the same meaning as defined in section 7702B of the Code.[1]

The tax credit was effective for taxable years beginning on or after January 1, 1999, and expired for taxable years beginning on or after January 1, 2004.

On January 16, 2003, the Department of Revenue prepared a memorandum for the Revenue Laws Study Committee on the status of the tax credit for premiums paid on long-term care insurance. The memorandum outlined the Department's review of some of the returns on which the credit was

[1] A corresponding change was also made to the estates provision to exclude long-term care insurance premiums from an estate or trust. G.S. 105-160.3(b)(7).

claimed. During this review, auditors found that some taxpayers, who were not eligible for the tax credits, claimed the tax credits; and that some taxpayers claimed long-term care credits greater than the cap of $350. The Department found that, "Of the 2,155 returns reviewed, only 192 contained allowable long-term care credits. Taxpayers were not eligible for the credits claimed on the remaining 1,963 returns in this group. As a group, therefore, over 90% of the returns incorrectly claimed the credit." Because this represented a sample, the Department indicated that they did not know the error rate for all returns claiming the credit. They attributed the high error rate to two possible factors: "One factor is the complicated nature of the credit and the other is confusion of this credit with the repealed child health insurance credit." Additionally, the memorandum indicated that, for tax year 2001, the credit reduced tax revenue by $10,367,883.

The 2003 North Carolina Study Commission on Aging recommended repealing the sunset on the long-term care insurance tax credit. In its 2003 report, the Commission expressed agreement with a statement from a Division of Aging's report, *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance*. The Division's report stated that, "In addition to the public benefit of having a much larger segment of the adult population positioned to pay privately for long-term care in terms of the state's economic health, consumers and families benefit from the ability to pay privately through increased choice and flexibility in terms of the range of services and settings of care available." The Commission's bills repealing the sunset were introduced during the 2003 Session, but were not successful.

According to information received by the Commission staff, on June 5, 2003, the Department of Revenue reported that they had audited 2,372 returns for the tax year 2002, and adjusted 650 to disallow the credit, representing a 27% error rate. This error rate was down considerably from the 90% error rate on the 2001 returns reported earlier by the Department. The Department attributed the decrease to: 1) informing tax preparers of the appropriate use of the credit; 2) clarifying instructions about eligibility for the credit; 3) improving the verbiage in software developers' tax packages; and 4) communicating with taxpayers whose credit was disallowed in 2001, to inform them of the eligibility criteria for the tax credit. An additional $279,628 was assessed on the 650 returns adjusted, and returns continue to be audited as resources permit. On November 3, 2003, the Department reported that they had processed 3,574,530 returns: 2,158,850 paper and 1,415,680 efiled. Of the total, there were 35,936 on which a credit for long-term care insurance was claimed for a total of $19,110,623.

During the February 10, 2004 meeting, the Commission heard a presentation on long-term care insurance from Carla Obiol with the Seniors' Health Insurance Information Program (SHIIP), and presentations on issues related to the tax credit from Department of Revenue employees Karl Knapp, Tax Research Division, and Nancy Pomeranz, Personal Taxes Division. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. The Department indicated that they had made progress in reducing the error rate on the long-term care insurance tax credit.

Restoration of the long-term care insurance tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing older adults in North Carolina. At the Commission's request, legislation was introduced during the 2004 Session to remove the sunset on the long-term care tax credit. The legislation did not pass, and the credit has sunset effective for the 2004 tax year.

During the Commission's public hearings following the 2004 Session, persons expressed support for re-enactment of the tax credit. Lieutenant Governor Purdue also expressed her support of re-

enactment of the tax credit during her presentation to the Commission on December 1, 2004.

The North Carolina Study Commission on Aging has supported the long-term care insurance tax credit since before its inception and continues to support it. Therefore, the North Carolina Study Commission on Aging recommends re-enactment of the long-term care insurance tax credit.

Recommendation 10

The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

Background

On December 1, 2004, the Commission heard a presentation from Dr. Margaret Hudson on issues related to the adult protective services system. Dr. Hudson's presentation included a historical perspective on the topic based on research that has been completed over the last twenty-five years. Her presentation defined the differences between elder mistreatment, elder abuse, elder neglect and self-neglect in the context of North Carolina adult protective services, and she recommended a change of wording in G.S. 108A-101 to more accurately reflect these differences. She reiterated elder abuse and elder neglect are different and must be studied separately. Dr. Hudson also suggested a coalition to help with the formal training, circumventing the tendency to focus on ruling out mistreatment instead of ruling in mistreatment.

The Department of Health and Human Services, in conjunction with the County Department of Social Services Directors' Association, has convened the Adult Protective Services (APS) Task Force. The Task Force has been working on ways to strengthen the adult protective services program and to improve quality, performance, and improved outcomes for county Departments of Social Services, and for the State, in an effort to carry out the statutory mandate to protect vulnerable adults. The Task Force has taken a multi-pronged approach by looking at any needed statutory changes; administrative rule changes; workload, administration, and required training needs; policies and procedures; assessment tools, and community inter/intra relations i.e., how the community views our delivery of APS. The task force has 28 members, including county DSS agencies and DHHS staff. Task Force members representing the county DSS agencies include: agency directors, program managers, supervisors, and line social workers, all of whom have responsibility for the delivery of APS at the local level. Short-term goals of the task force are to recommend technical and clarifying changes to the law. Long-term goals include: the potential for recommendations involving more in-depth statutory changes, improved caseload management, and additional training.

The General Assembly, in S.L. 2004-161, Part 45, established a Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State law. Among the items the Commission is required to consider is a review of the State's adult protective services law. The Legislative Study Commission on State Guardianship Laws is required to make a final report to the 2006 Regular Session of the 2005 General Assembly upon its convening.

The National Center on Elder Abuse, the National Committee for the Prevention of Elder Abuse (NCPEA), and the National Adult Protective Services Association are partnering to conduct a

national study of elder abuse. Part of the study includes, "The 2004 Survey of Adult Protective Services Data," that intends to capture data from all 50 states. The initial survey deadline for the end of September has been extended to allow additional state response time. The purposes of the survey are to: establish a national data set for Adult Protective Services (APS); compare APS programs nationwide; measure APS interventions; demonstrate trends in the field of APS; and to bring national attention to the field. The University of Kentucky is conducting the research for NCPEA.

The Commission finds that review of and changes to the adult protective services system are likely to be necessary to ensure that older adults are protected from abuse and neglect. The Commission also recognizes that several groups are already reviewing the adult protective services system, and that collaboration would be helpful in determining what improvements could be made to the system. Therefore, the Commission recommends that the Adult Protective Services Task Force collaborate with stakeholders and other persons interested in improving the adult protective services and report its findings and recommendations to the Commission and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

Recommendation 11

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Background

Wage comparisons presented on December 10, 2002, highlighted that direct care workers make lower median hourly and annualized wages than any of the following: dental assistants, manicurists, school bus drivers, file clerks or hairdressers. For 2000, direct care workers had a median hourly wage rate of $7.86 per hour and an annualized wage of $16,349. By 2002, the median hourly wage rate improved to $8.36. The Commission recommends that the General Assembly appropriate funds to enhance the wages for nurse aides employed by non-institutional Medicaid providers and that counties be held harmless for their share of the rate increase.

According to the Division of Medical Assistance, the NCHCFA conducts annual wage surveys of nursing homes to determine wages that nursing facilities expect to pay during the coming year. DMA uses the survey information to estimate the inflation rate that is used to determine the reimbursement rates for nursing facilities. The 2001 wage survey (survey was not conducted during 2002) identified an hourly pay rate of $9.67 for nurse aides in an institutional setting and $7.51 for nurse aides in a non-institutional setting. (Note that DMA review of PCS and CAP-DA cost reports submitted by providers primarily for SFY2001 identified an average hourly pay rate of $7.77 for nurse aides.) The NCHCFA survey was the basis for Medicaid rate increases to nursing facilities that became effective October 1, 2000. While these rate increases were not a targeted wage pass-through, the increases resulting from the wage survey were included as a component in the direct care cost rates. Because direct care costs are settled to actual through DMA audit of nursing facility cost reports, the rate increases would not be paid by DMA unless they were given to nurse aides by the providers. Similar rate increases were not made for non-institutional care Medicaid providers (most notably those who provide personal care services to patients at home, in community alternative programs [CAP], and in adult care homes). These types of providers face increasing difficulty in the recruitment and retention of nurse aides. The purpose of this recommendation is to provide funds necessary to support increased aide wage rates for those employed by this group of providers.

The Commission recommends that the General Assembly appropriate these funds to improve the wage rates of these workers, who are so vitally important to the long-term care system.

Recommendation 12

The North Carolina Study Commission on Aging recommends that the General Assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce geriatricians, geriatric-social workers, geriatric pharmacists, geriatric allied health workers, and graduates specialized in geriatric nursing and geriatric dentistry; and study how to improve the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program to increase the number of graduates specializing in geriatric care and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

Background

By 2020, North Carolina will be home to over 2 million Baby Boomers. By 2025, North Carolina will rank 8th in the nation in the number of people aged 65 years and older. Our current nursing, geriatrician, geriatric-social worker and geriatric allied health workforce is incapable of absorbing the impact of this emerging trend.

In 1991, North Carolina became the first state to fund an agency dedicated to assuring that there would be adequate nursing resources to meet the health care needs of its citizens. The creation of the North Carolina Center for Nursing was the culmination of three years of work by the General Assembly and the Legislative Study Commission on Nursing. The Nursing Shortage Act of 1991 (S.L. 1991-550) outlined the mission and strategies defined by the General Assembly to address the nursing shortage that had plagued North Carolina in the late 1980's. That act established the North Carolina Center for Nursing to address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse manpower resources. The Center was charged with providing an ongoing strategy for the allocation of the State's resources directed towards nursing. The Center is pivotal for providing information regarding the entire nursing workforce, but does not specifically address the needs of our growing elder population.

A Nursing Workforce Taskforce, convened by the North Carolina Institute of Medicine (IOM), began meeting in February 2002 to look at ways to respond to the growing nursing shortage in the State. The 55-member task force included representatives from the NC Nursing Association, the NC Center for Nursing, the NC Board of Nursing, the NC Hospital Association, and the NC Area Health Education Centers (AHECs). There were also representatives from the NC Community College System, the University of North Carolina and NC Independent Colleges and Universities on the task force. The IOM task force developed recommendations directed at each agency involved in either educating or hiring nurses; 23 of them specifically affect community colleges.

The Board of Governors has a Committee on the Future of Nursing. The Committee was charged to review the IOM Nursing Workforce Report and other information to address issues of nursing and make recommendations to the Board regarding the steps UNC nursing programs need to take to help North Carolina avoid a nursing shortage. The State Board of Community Colleges also has a similar committee.

Currently, three North Carolina based institutions of higher education receive grants to improve the

ability of health professionals to provide medical care for elderly Americans. The University of North Carolina at Greensboro, The University of North Carolina at Chapel Hill, and Duke University have received either federal funding from The Health Resources and Services Administration (HRSA), and/or funds from such private foundations as The John A. Hartford Foundation or The Donald W. Reynolds Foundation.

The Donald W. Reynolds Foundation recently awarded a grant to The Duke Center for the Study of Aging totaling $3 million over six years for geriatric training. Duke University will become part of a Consortium to strengthen faculty expertise in geriatrics, in cooperation with Johns Hopkins University, Mount Sinai Medical School and the University of California, Los Angeles. The Consortium members will provide fellowships to train clinical educators in geriatrics and continue the training and career development of their own junior faculty members.

Presently the Nursing Scholars Program, a merit based scholarship loan program, and the Nurse Educational Scholarship Loan Program, a need based scholarship loan program for nursing students provide funds for students in nursing programs offered by community colleges and The University of North Carolina, and by private colleges that offer licensed practical nursing or registered nursing programs. The Commission would like these programs to be studied to determine if they can be improved to increase the number of graduates specializing in geriatric care.

The Commission finds that review of these programs is necessary to ensure that there will be enough qualified workers to care for older adults in the future. The Commission is supportive of all the research based on general nursing workforce needs currently being conducted; however population predictions require the State to focus intensively on meeting the needs of the elder population through geriatric care providers. Therefore, the Commission recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is geriatric care.

Recommendation 13

The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

Background

State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area mental health authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in

nursing homes and home care agencies other than those involving direct patient care and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

On March 23, 2004, the Commission heard a presentation from John Aldridge of the North Carolina Attorney General's office on this issue. He reiterated that unless federal law provides otherwise, the results of a national criminal history record check can only be released to a governmental agency. Currently, federal law only permits these results to be released to nursing homes and home care agencies on applicants for positions that involve direct patient care. Therefore, in order to be able to conduct national criminal history record checks on applicants for positions in nursing homes and home care agencies that do not involve patient care and on applicants for positions in adult care homes, current State law would have to be changed to direct that the results be sent to a governmental agency.

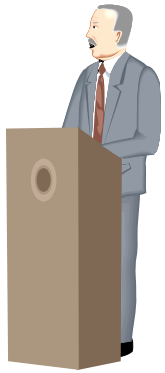
During the 2004 Session, the General Assembly enacted a provision (S.L. 2004-124, Sec. 10.19D) that attempted to facilitate the conducting of the national criminal records checks. That provision directed the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". The Department would provide notice to the provider that an applicant has a criminal record elsewhere. The Department would not reveal the contents of that record. It would be the employer's responsibility to follow up on the information to obtain the public record of that crime.

Since enactment of the provision, the federal government has informed the Department that further changes to the statutes are needed to ensure that only public information is revealed. Otherwise, the FBI will be unable to provide the national criminal records checks under the long-term care statutes. The Commission has long supported the need for these checks. Therefore, the Commission recommends that the General Assembly enact legislation to make the changes required by the federal government in order to be able to conduct the national criminal history records checks.

APPENDICES

APPENDIX A

Public Hearing Comments
Summary



Prepared for the
North Carolina Study Commission on Aging

November 10, 2004

Background Information

The North Carolina Study Commission on Aging is created to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. This study shall be a continuing one and the evaluation ongoing, as the population of older citizens grows and as old problems faced by older citizens magnify and are augmented by new problems. (G.S. 120-180)

The Commission may hold public meetings across the State to solicit public input with respect to the issues of aging in North Carolina. (G.S. 120-185)

2004 Public Hearings

Date	Location	Number of Speakers
October 21, 2004	**Cherryville, NC**	**14**
October 26, 2004	**Wilson, NC**	**33**

Issue Frequency

On the following pages, issues mentioned by speakers at the public hearings are listed, grouped, and totaled based on the frequency with which they were mentioned.

The issues mentioned with the greatest frequency were:

- **Preserve/Expand Support for Senior Games** ***(17 responses)***
- **Preserve/Expand Senior Centers Including Certified Senior Centers** ***(10 responses)***
- **Preserve/Expand Support for In-Home and Community-Based Services,** ***(9 responses)***
- **Lower/Provide Assistance with Prescription Drug Costs,** ***(6 responses)***
- **Concerns About Combining Mentally Ill and Elderly Populations,** ***(5 responses)***

Frequency of Issues Expressed by Speakers
2004 Public Hearings

	CHERRYVILLE	WILSON	TOTAL
PROGRAM FUNDING			
Preserve/Expand Support for Senior Games	5	12	17
Preserve/Expand Senior Centers Including Certified Senior Centers	1	9	10
Preserve/Expand Support for In-Home and Community-Based Services	3	6	9
Preserve/Expand Home and Community Care Block Grant (HCCBG) Funding	2	2	4
Preserve/Expand Community Alternatives Program for Disabled Adults (CAP/DA)	3		3
Increase Adult Day Services Reimbursement Rate		3	3
Institutional Bias vs. Community Based Services		2	2
Preserve/Expand the State/County Special Assistance (SA) In-Home Project	2		2
Remove the Off-Set for SA In-Home Participants Receiving Food Stamps	1		1
Preserve/Expand Ombudsman Program	1		1
Preserve/Expand Family Caregiver Support Program		1	1
Increase Reimbursement Rates for Nursing Facilities		1	1
Restore Cut to AAA Professional Staff Funding		1	1
TOTAL			55
WORKFORCE ISSUES			
Lower Staff to Resident Ratios in Nursing Homes and Adult Care Homes	1	2	3
Offer Incentives to Attract Workers to Nurse Aide Positions	1		1
Expand Community College System's Capacity for Training More Direct Care Workers	1		1
TOTAL			5

	CHERRYVILLE	WILSON	TOTAL
OTHER			
Lower/Provide Assistance With Prescription Drug Costs		6	6
Concerns About Combining Mentally Ill and Elderly Populations	2	3	5
Preserve/Expand Senior-Friendly Communities	1	3	4
Transportation		4	4
Long Term Care Insurance Tax Credit		3	3
Safe/Affordable Housing for Seniors		2	2
Public Awareness of Available Services		2	2
Monitoring/Enforcement of Laws Related to Nursing Homes and Adult Care Homes		2	2
Improve Air and Water Quality	1	1	2
Job-Training for Older Workers	1		1
Expression of Support for the Study Commission on Aging and its Members	1		1
Raise Medically Needy Income Limit – Medicaid		1	1
Expand Grandparents' Rights		1	1
Seniors With Low Wage Jobs Caring For Children		1	1
Veterans Care		1	1
Volunteer Training and Retention		1	1
Adult Protective Services		1	1
Guardianship		1	1
Long Term Care Internet Project		1	1
TOTAL			40

APPENDIX B

2004 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2004 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

October 27, 2004

2004 *Recommendation Status Report*

RECOMMENDATION	RESULT
Recommendation 1 **The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.**	There were a number of bills that addressed this issue, including HB 1489 and SB 1146 introduced on behalf of the Commission. However, none of the bills were enacted and the tax credit expired for taxable years beginning on or after January 1, 2004.
Recommendation 2 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.**	S.L. 2004-144 (SB 1148) requires DHHS to study the mission of the Geriatric Mental Health Specialty Teams. Representatives from Area Authorities, Local Management Entities, adult care home and nursing home industries, and other appropriate stakeholders, must be included in the process. As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission. The act requires the Department to standardize the following criteria across all mental health specialty teams: team purpose; eligibility for services; Screening processes; referral processes; and forms, training manuals, service orders, and authorizations. Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report. Additionally, the act requires the Department to proceed immediately with implementation of the following: Tracking expenditure data for each Team and each Area Program/Local Management Entity; Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams. DHHS is required to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The final report on its standardization and tracking efforts, and the results of its study, shall be submitted to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

RECOMMENDATION	RESULT
Recommendation 3 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.**	S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires DHHS to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study: • Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities; • Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served; • Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living; • Determining the most effective way to identify mentally ill individuals that have mental health treatment needs; • Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded; • Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and • Identifying specific problems that exist due to mixing aging and mentally ill populations. DHHS is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

RECOMMENDATION	RESULT
Recommendation 4 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.**	S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005. This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime. This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime. The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004.

RECOMMENDATION	RESULT
Recommendation 5 **The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.**	S.L. 2004-124 provides $281,000 in recurring funds and $1,550,000 in non-recurring funds for 2004-05 for Senior Centers.
Recommendation 6 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.**	S.L. 2004-124, appropriates $3 M to the Housing Trust Fund (HTF) for FY 2004-05, however, none of the appropriation was specifically set aside for independent housing with services. The General Assembly appropriated a total of $4,750,945 for each FY of the 2003-05 biennium, of which $3 M was intended for the HTF and $1.75 M for the HOME match. (The HOME program is a Federal block grant that provides formula grants to States and localities that communities use (often in partnership with local nonprofit groups) to fund a wide range of activities that build, buy, and/or rehabilitate affordable housing for rent or homeownership for low-income households.)
Recommendation 7 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.**	S.L. 2004-124 restored $800,000 (of the previous $1 million reduction) for the Home and Community Care Block Grant.
Recommendation 8 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.**	S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires DHHS to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

RECOMMENDATION	RESULT
Recommendation 9 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**	S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.
Recommendation 10 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.**	S.L. 2004-124 provides funding to increase the daily rate by $5.00 for Adult Day Care and Adult Day Health Care Additionally, S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2004 Session

Prepared by Staff for the:
North Carolina Study Commission on Aging

October 27, 2004

Enacted Legislation

Downtown Adult Residential Facility

S.L. 2004-2 (SB 623) provides a one-year extension of deadlines to meet conditions set forth in Section 3 of S.L. 2001-234 entitling certain "specially impacted" adult care homes that qualified for an exemption from the moratorium on new adult day care homes established in S.L. 1997-443 to continue to develop the beds authorized by the exemption. The specific deadline changes are from June 1, 2004 to June 1, 2005 and from December 1, 2004 to December 1, 2005. A specially impacted adult care home is defined as an adult care home that qualified for an exemption under S.L. 2000-67, Section 11.9 (a) and is 10 stories or more in height, located within a municipal service district created under Article 23 of Chapter 160A of the General Statutes, located within 100 yards of a mixed use building more than 10 stories tall that will be opened for occupancy after May 26, 2004, located within 100 yards of an office building that is more than 20 stories tall, and some of the residents of which are to be relocated to a facility in the same county but not on a college campus. One facility where the occupants of the building are relocated is to continue to have the same status under S.L. 2000-67, Sec. 11.9 (a) as the facility from where the occupants came.

This section became effective May 26, 2004. (BR)

Centralize Criminal Record Check Functions

S.L. 2004-124, Sec. 10.1 (HB 1414, Sec. 10.1) requires the Department of Health and Human Services to consolidate all activities within the Department related to coordinating and processing criminal record checks required by law beginning January 1, 2005. The Department is to report the details of the implementation plan to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before January 1, 2005.

This section became effective July 1, 2004. (EC)

Automatic Enrollment Medicare Prescription Drug Discount Card

S.L. 2004-124, Sec. 10.2B (HB 1414, Sec. 10.2B) gives the Department of Health and Human Services authority to enroll senior citizens in the federal Medicare Prescription Drug Discount Program. Current and future participants in the State's Senior Care Prescription Drug Assistance Program whose income is not more than 135% of the federal poverty level are eligible for automatic enrollment in the Medicare Drug Program; however, those individuals must have an opportunity to decline automatic enrollment if they choose. This section also provides that the State's Senior Care Prescription Drug Assistance Program will be the payor of last resort.

This section became effective July 1, 2004. (TM)

Community Alternatives Programs

S.L. 2004-124, Sec. 10.9 (HB 1414, Sec. 10.9) directs the Department of Health and Human Services to ensure the following:

- Expenditures for Community Alternatives Programs (CAP) do not exceed the budget for these programs;
- CAP slots are fully allocated and filled in a timely manner; and
- Budgeted expenditures are not limited by the non-allocation of or delays in filling CAP slots.

Additionally, the section specifies that services provided by the Community Alternatives Program for Disabled Adults shall be provided for the 2004-2005 fiscal year to any eligible person who entered a nursing facility on or before June 1, 2004, within the existing availability of the county allocation, or within the existing availability of services.
This section became effective July 1, 2004. (SP)

PACE Pilot Program Funds

S.L. 2004-124, Sec. 10.12 (HB 1414, Sec. 10.12) requires the Department of Health and Human Services, Division of Medical Assistance, to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE). One pilot site shall be planned for the southeastern area of the State and the other for the western area of the State. The Division is required to design the pilot program to access federal Medicaid and Medicare dollars to provide acute and long-term care services for older patients through the use of interdisciplinary teams. Upon implementation, the PACE pilot program may include the following: physician visits, drugs, rehabilitation services, personal care services, hospitalization, and nursing home care. The PACE program may also offer social services intervention, case management, respite care, or extended home care nursing. This section authorizes the Division to use $123,156 of the funds appropriated for the 2004-2005 fiscal year, to support two positions in the Division of Medical Assistance to develop the pilot programs and to contract for actuarial analysis as part of the development of the pilot programs.

On March 1, 2005, the Department must report on the development of PACE pilot program to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services. The report will include services proposed to be offered under the pilot program, administrative structure of the pilot program, number of Medicare and Medicaid eligible recipients anticipated to receive services from the PACE pilot sites, and the projected savings to the State from PACE pilot program implementation.

Finally, this section clarifies that nothing obligates the General Assembly to appropriate funds to implement the PACE program statewide.

This section became effective July 1, 2004. (TM)

Long-Term Care Facility Criminal Record Checks

S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State

criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required.

Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime.

This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime.

The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004. (DJ)

State/County Special Assistance

S.L. 2004-124, Sec. 10.21A (HB 1414, Sec. 10.21A) establishes the maximum monthly rate for residents in adult care home facilities as $1,084 per month per resident unless adjusted by the Department in accordance with Section 10.52(f) of S.L. 2003-284. This rate is effective October 1, 2004.

This section became effective July 1, 2004. (TM)

Health Care Personnel Registry Changes

S.L. 2004-203, Sec. 52 (HB 281, Sec. 52) makes changes to conform the Health Care Personnel Registry to federal law governing the Nurse Aide I Registry program. During the 2000 Regular Session legislation was enacted that standardized the reporting requirements of both these registry programs, conforming them to the federal reporting requirements. All covered facilities and agencies will report using the current standardized reporting requirements that apply to nursing homes (federal law). In 2000, the federal requirement to allow a nurse aide to submit a rebuttal statement that would be included on the Nurse Aide Registry was not included in the legislative change. In addition, the federal statute changed after the passage of this 2000 law to include a process to allow nurse aides to petition the state to have a single finding of neglect removed from the Nurse Aide Registry when certain requirements were met.

This section became effective August 17, 2004. (EC)

Studies

Legislative Research Commission

Care and Safety of Residents of Residential Facilities Study

S.L. 2004-161, Sec. 2.1(8)b (SB 1152, Sec. 2.1(8)b) provides that the Legislative Research Commission may study the care and safety of residents of residential care facilities. If the Commission elects to study this issue, they may report findings, together with any recommended legislation, to the 2005 General Assembly upon its convening.

This section became effective August 2, 2004. (TM)

New / Independent Studies / Commissions

Legislative Study Commission on State Guardianship Laws

S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.

This part became effective August 2, 2004. (DJ)

Referrals to Existing Commissions / Committees

Long-Term Care Remediation

S.L. 2004-161, Sec. 23.2 (SB 1152, Sec. 23.2) provides that the North Carolina Study Commission on Aging may study the feasibility of implementing a remediation program for long-term care facilities in North Carolina, similar to the Collaborative Remediation Project in

Michigan. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.
This section became effective August 2, 2004. (SP)

Mentally Ill Long-Term Care Residents

S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3) provides that the North Carolina Study Commission on Aging may study issues related to mentally ill residents in long-term care facilities. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.
This section became effective August 2, 2004. However, **Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities** was also referred to the Department of Health and Human Services in S.L. 2004-124, Sec. 10.2. (HB 1414, Sec. 10.2). (See *Referrals to Departments, Agencies, Etc.*, under the *Studies* Heading.) S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in S.L. 2004-124, Sec. 10.2 will be implemented instead of the study authorized by this section. (SP)

Referrals to Departments, Agencies, Etc.

Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities

S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study:

- Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities;
- Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served;
- Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living;
- Determining the most effective way to identify mentally ill individuals that have mental health treatment needs;
- Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded;
- Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and
- Identifying specific problems that exist due to mixing aging and mentally ill populations.

The Department is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

This section became effective July 1, 2004.

Note: A study on **Mentally Ill Long-Term Care Residents** was also referred to the North Carolina Study Commission on Aging in S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3). See *Referrals to Existing Commissions/Committees* under the *Studies* Heading. However, S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in this section will be implemented instead of the study authorized by S.L. 2004-124, Sec. 10.2. (TM)

DHHS Study Medicaid Institutional Bias

S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires the Department of Health and Human Services to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

This section became effective July 1, 2004. (DJ)

Adult Day Service Training and Reimbursement Methodology

S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

This section became effective July 1, 2004. (TM)

Care for the Mentally Ill in Long Term Care Facilities

S.L. 2004-144 (SB 1148) requires the Department of Health and Human Services to study the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. The Department must include representatives from Area Authorities, Local Management Entities, the adult care home and the nursing home industries, and other appropriate stakeholders in the process.

As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in

long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

The act requires the Department to standardize the following criteria across all mental health specialty teams:

- Team purpose;
- Eligibility for services;
- Screening processes;
- Referral processes; and
- Forms, Training Manuals, Service Orders, and Authorizations.

Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report.

Additionally, the act requires the Department to proceed immediately with implementation of the following:

- Tracking expenditure data for each Team and each Area Program/Local Management Entity;
- Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and
- Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams.

The act also requires the Department to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department is required to submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

This act became effective July 29, 2004. (TM)

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
Report on standardization and tracking efforts and the study of the mission of Geriatric Mental Health Specialty Teams	DHHS to Aging Study Commission and Joint Legislative Oversight Committee on MH/DD/SA	Interim report 10/30/04 Final report 10/30/05	S.L. 2004-144 (SB 1148), Sec. 4
Report findings on issues related to mentally ill residents of long-term care facilities	DHHS to Aging Study Commission	10/1/05	S.L. 2004-124 (HB 1414), Sec. 10.2
Report on independent study of institutional bias in the Medicaid program	DHHS to Aging Study Commission	January, 2005	S.L. 2004-124 (HB 1414), Sec. 10.13
Report on reimbursement methodology for adult day services	DHHS (contracting with consultant) to Aging Study Commission	1/1/05	S.L. 2004-124 (HB 1414), Sec. 10.21

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services
MH/DD/SA: Mental Health, Developmental Disabilities, and Substance Abuse Services

APPENDIX C

Medicaid In-Home Personal Care Services Program

Presented by Lynne Perrin
Chief, Facility and Community Care
Clinical Policy and Programs
NC Division of Medical Assistance
November 10, 2004

In-Home Personal Care Services

- Optional Medicaid Benefit
- Provided to persons living in a private residence and who have medical conditions that require assistance from a personal care aide
- Must be authorized by a physician in accordance with a plan of treatment or otherwise approved by the state

Medicaid Reimbursement

- Medicaid reimburses $14.20 (effective Aug. 2004) per hour for personal care tasks performed by in-home aides.
- The tasks may include
  - Helping patients with bathing, toileting, moving about, keeping track of vital signs; and,
  - Help with housekeeping and home management tasks as a secondary support to maintain one's health.

Amount of Services and Medicaid Benefit Limitations

- Hours of PCS are determined through an assessment performed by the home care agency's RN and authorized by the physician.
- PCS is limited to a maximum of 60 hours per month per patient.
- If prior approved by DMA, one may receive up to 80 hours per month under the *PCS Plus* program based on documented need for additional services.

Who Provides PCS Services?

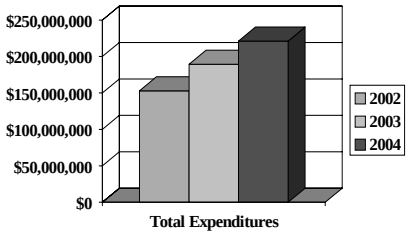
- Home care agencies in North Carolina
  - Licensed by the Division of Facility Services to provide in-home aide services
  - Enrolled in the Medicaid program
- In-home aides must meet the requirements in the Home Care Licensure Rules

Providers Enrolled in Medicaid

- There are currently 685 home care providers* enrolled in the Medicaid Program.

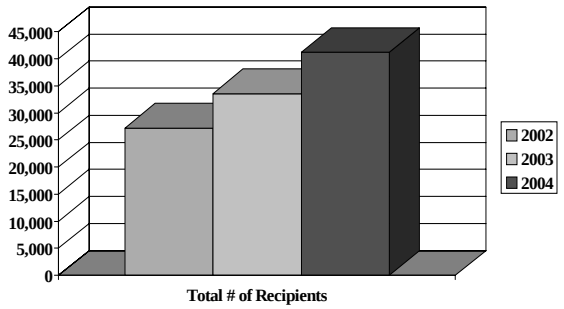
* An agency may have several site locations and each site is treated as a separate provider and not all providers enrolled may actively be billing Medicaid.

Medicaid Expenditures for PCS



2004 Expenditures:
$220,933,622

Recipients of PCS



2004 Recipients:
41,222

Growth in PCS

- Growth in Expenditures
  - 2002 to 2003 was 24%
  - 2003 to 2004 was 17%
- Increase in Recipients
  - 2002 to 2003 was 23%
  - 2003 to 2004 was 23%

Average Expenditures Per Recipient

- Average Annual Per Recipient
  - SFY 2004 $5,360
- Average Monthly Per Recipient
  - SFY 2004 $446

Need for PCS Program Improvements

- PCS is an important program in the NC's long term care system as it supports recipients in their own homes.
- Service has been operating since 1985 with little change in administrative structure or state level oversight.

Key Reasons to Restructure

- Growth in program expenditures and recipients
- Growth in numbers of providers and appropriate targeting of services
- Quality issues
- Need to refine and clarify medical criteria
- Need for newer improved assessment tools
- Need for provider standards, training and best practices
- Need to improve state level oversight and monitoring functions

PCS Restructuring Initiative

- Restructuring initiated by AHHC and DMA in January 2004
- Partnership among PCS providers, DMA staff, and DFS staff
- Established PCS Restructuring Advisory Committee to guide the work of four work groups
  - Criteria/Documentation
  - Policy/Process
  - Utilization Review
  - Rules Subcommittee

PCS Restructuring Initiative

- Restructuring Advisory Committee met on a monthly basis
- First PCS Kickoff meeting held March 18, 2004
- More than 40 people have participated in the process to date
- Over 30 meetings took place between January, 2004 and October, 2004
- Final PCS Wrap-Up meeting of work groups held October 27, 2004

PCS Restructuring Goals

- Restructure the PCS program
- Refine the PCS policy
- Streamline the PCS service delivery process
- Develop a quality assurance and utilization management component
- Strengthen provider compliance with policies
- Establish provider training requirements
- Build strong partnerships with shared goals

PCS Restructuring Advisory Committee

Tom Harmelink, *Provider-Health Force*
Jeff Horton, *DFS*
Azzie Conley, *DFS*
Robyn Reasor, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Carol Putnam, *DMA-Program Integrity*
Tim Rogers, *AHHC*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Dr. Nancy Henley, *DMA-Medical Policy*
Pamela Horrell, *DMA-Provider Enrollment*
Frank Dziepak, *DMA-Financial Operations*
Lynne Perrin, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*

Criteria/Documentation Work Group

- Donna Turlington, *Provider-Liberty HC*
- Phyllis Nealey, *Provider-Interim HC*
- Tina Glenn, *Provider-Hearthside HC*
- Roget Berendes, *Provider-Hearthside Home Care*
- Sandra Bridges, *Provider-First Choice HC*
- Betty Nance, *Provider-Guardian Angel HC*
- Carol Putnam, *DMA-Program Integrity*
- Sherry Thomas, *AHHC*
- Robyn Reasor, *DMA-Program Integrity*
- Donna Steele, *DMA-Medical Policy*
- Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Policy/Process Workgroup

Beverly Stewart, *DMA-Program Integrity*
Phyllis Burwell, *DMA-Medical Policy*
Jim Arp, *Provider-Advantage Home & Hospice*
Heather Blank, *Provider-Assisted Care*
Sherry Thomas, *AHHC*
Sandi Massey, *Provider-Good Health Services*
Karen Rowe, *Provider-Carolinas Home Care*
Bonnie McBride, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Pamela Horrell, *DMA-Provider Enrollment*
Sandi Massey, *Provider-Good Health Services*
Tom Harmelink, *Provider-Health Force*
Nena Reaves, *Provider-Health Services Personnel*
Lloyd Pattison, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Utilization Review Workgroup

Bill Craig, *Provider-Quality Patient Care*
Peggy Mallard, *Provider-Guardian Health Services*
Larry Nason, *DMA-Medical Policy*
Lynne Perrin, *DMA-Medical Policy*
Ginger Parrish, *Provider-Albemarle Home Care*
Robyn Slate, *DMA-Rate Setting*
Pat Jeter, *DMA-Rate Setting*
Frank Dziepak, *DMA-Financial Operations*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Sheila Alford, *Provider-Home Health & Hospice of Halifax*
Tim Brooks, *Provider-Healthkeeperz Home Health*
Pam Wells, *DMA-Program Integrity*
Peggy Davis, *DMA-Program Integrity*
Robyn Reasor, *DMA-Program Integrity*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

Outcomes of the Work Groups

- Key Recommendations for Program Improvements presented by Sherry Thomas

Comparisons & Recommendations for Statewide Improvements In the Medicaid Personal Care Services Program

Sherry Thomas, BSN, MPH
Senior Vice President, AHHC

AHHC

- Established in 1972 by Registered Nurse directors and supervisors, the Association for Home & Hospice Care of North Carolina (AHHC) is a nonprofit trade association made up of professionals from a wide variety of disciplines, all with an active interest or involvement in North Carolina's in-home health, hospice, and community-based care industry. Today, the Association represents nearly 500 agencies including the largest ones in the State.

Comparisons & Recommendations

- **Current PCS**
  - *Limited to 3 1/2 hours per day - 60 hours per month
  - *Physician authorization based on Registered Nurse assessment
- **Restructured PCS**
  - *Same
  - *Physician authorization based on Registered Nurse assessment with recommendation for physician's PA and/or NP to authorize as delegated by physician

Comparisons & Recommendations

- **Current PCS Relationship to PCS Plus**
  - *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria
- **Restructured PCS Relationship to PCS Plus**
  - *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria

Comparisons & Recommendations

- **Current PCS**

  *Assessment tools: two page RN assessment with required elements of assessment but optional form. Time and tasks assigned by RN with physician authorization. Home management tasks incidental to personal care.

Comparisons & Recommendations

- **Restructured PCS**

  *New four page RN assessment. The tool also serves as the RN certification that the assessment is accurate and as the physician's authorization for the services.

  - PCS Physician Authorization for Certification and Treatment (PACT) Form *(also known as the revised DMA-3000 Form)*
  - Annual Renewal/Recertification
  - DMA intends to eventually automate both the new PACT Form and the PCS-Plus Form.

Comparisons & Recommendations

- **Restructured PCS**

  A major committee focus was developing a new patient assessment tool that will capture more complete information on the patient's functional limitations/medical condition and the related need for personal care and home management assistance.

Comparisons & Recommendations

- **Restructured PCS**

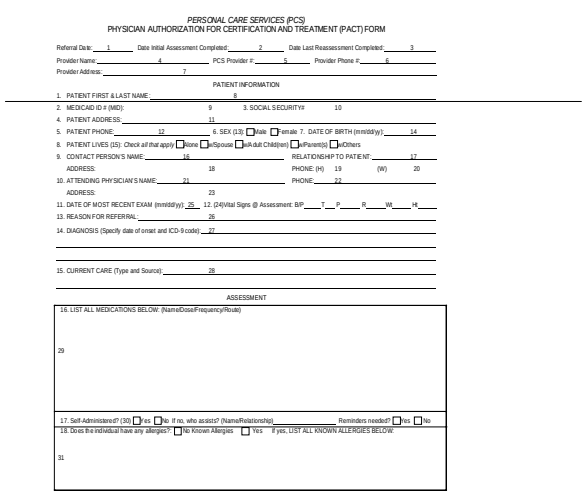
*The new draft tool is a "scored" assessment and incorporates elements and definitions from the nursing home MDS while also addressing the specific home environment and PCS program requirements. The new draft tool paints a clearer picture of the patient to the physician.

Comparisons & Recommendations

- **Restructured PCS**

*The new tool will be mandatory. Along with the tool, there will be a guideline detailing the time allotment available based on how the patient scores on the assessment.

*Home management tasks will be directly linked to ADL limitations (bathing, feeding, dressing, ambulation, toileting, etc) on the new tool.



PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

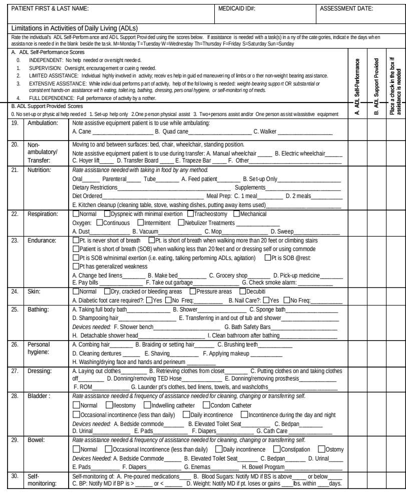
Referral Date: 1 Date Initial Assessment Completed: 2 Date Last Reassessment Completed: 3
Provider Name: 4 PCS Provider #: 5 Provider Phone #: 6
Provider Address: 7

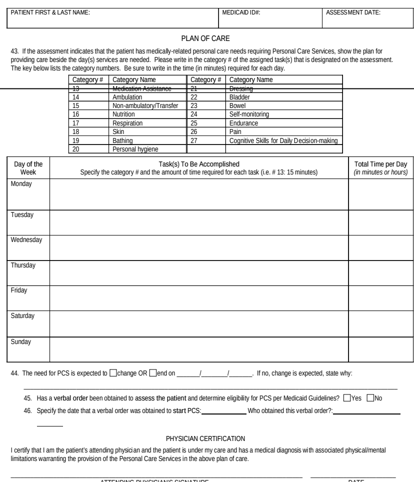
PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME: 8
2. MEDICAID ID # (MID): 9 3. SOCIAL SECURITY# 10
4. PATIENT ADDRESS: 11
5. PATIENT PHONE: 12 6. SEX (13): ☐Male ☐Female 7. DATE OF BIRTH (mm/dd/yy): 14
8. PATIENT LIVES (15): *Check all that apply* ☐Alone ☐wSpouse ☐wAdult Child(ren) ☐wParent(s) ☐wOthers
9. CONTACT PERSON'S NAME: 16 RELATIONSHIP TO PATIENT: 17
ADDRESS: 18 PHONE: (H) 19 (W) 20
10. ATTENDING PHYSICIAN'S NAME: 21 PHONE: 22
ADDRESS: 23
11. DATE OF MOST RECENT EXAM (mm/dd/yy): 25 12. (24)Vital Signs @ Assessment: B/P ___ T ___ P ___ R ___ Wt ___ Ht ___
13. REASON FOR REFERRAL: 26
14. DIAGNOSIS (Specify date of onset and ICD-9 code): 27
15. CURRENT CARE (Type and Source): 28

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (NameDoseFrequency/Route)
29
17. Self-Administered? (30) ☐Yes ☐No If no, who assists? (Name/Relationship) _____ Reminders needed? ☐Yes ☐No
18. Does the individual have any allergies? ☐No Known Allergies ☐Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:
31





Piloted Form with RNs and Patients

- Positive feedback and time wise
- Tool longer, yet more concise in measuring ADLs/needs
- Tool's language is consistent with PCS Plus/Transitions to PCS-Plus DMA-3000A
- Strengthened Nurses' Certification Statement

Comparisons & Recommendations

- **PCS Current Criteria**

  * PCS available based on one ADL limitation or more

- **Restructured PCS Criteria**

  *Restricted now to <u>two</u> ADL limitations or more. Also recommended standardized ADL definitions and standardized task definitions

Comparisons & Recommendations

- **Current PCS**

  *RN supervision - although no federal requirement, NC PCS required every 60 days by a registered nurse.

- **Restructured PCS**

  *RN supervision – lines up now with DFS home care licensure rules – every 90 days, with new requirements for mandated elements of supervision and allowance for technology such as telephony to enhance supervision.

RN Supervision Restructured PCS

- Supervision is provided by an RN with training and/or program competency in Personal Care Services/policy.
- To reassess a client after a hospitalization/reported functional health change in the client for review and update of the plan of care **or**
- To reassess a client after an unplanned lapse in service, greater than 7 service days.
- Joint supervisory visits with the aide recommended as mandatory

Supervision Standards for PCS Services

- Nursing evaluation during the visit:
  - Client: condition, specific to primary diagnosis and diagnosis pertinent to ADL deficits qualifying for PCS services, changes in client (including hospitalizations, other services, others who participate in home environment)
  - Plan of Care: tasks and time in the POC meet identified needs, plan is revised based on the evaluation. Client continues to need the service. If hours are increased, additional needs and tasks to meet needs are identified on the plan/note.
  - Evaluation of the employee implementing the plan of care and interacting with the client.
  - Client/family perception of care is evaluated and input is addressed.

Other Supervision Standards

- Aide Flow sheet review by RN to monitor and review the implementation of the plan of care. The follow-up of activities may include phone management, a visit, a case conference based on identified needs and changes in client.
  - Phone contact: evaluates attendance, activities, satisfaction, investigation of problems, questions.
  - Case references: with one/all employee, family and staff.
- LPN can record, report and observe, but doesn't meet supervisory qualifications. Can't do minimal required supervisory visits.
- LPN can not collect data for RN to review and sign.

Other Oversight Enhancements

- AHHC supporting legislation for Medical Care Commission being granted authority to define geographical service area for home care licensed agencies providing in-home aide services as a means to assure adequate access to RN supervision.
- AHHC would support legislation increasing the survey cycle for licensed only agencies providing in-home aide services

Comparisons & Recommendations

- **Current PCS**

*Predominantly paper based

- **Restructured PCS**

*The new assessment tool will lend itself to the eventual development of web-based data entry and a much more accurate data bank of patient and program information.

Comparisons & Recommendations

- **Current PCS**

*RN program training largely handled by agencies

- **Restructured PCS**

*State approved curriculum for mandatory web based RN program training with testing and certificate. Partnering with AHEC. Development grant by AHHC. State will have administrative access to data bank of participants, pass rate, etc.

Comparisons & Recommendations

- **Current PCS**

*Staffing qualifications for licensed only agencies limited to that required by individual licensure/certification Boards or payer requirements

- **Restructured PCS**

*PCS Advisory Committee and AHHC supporting legislation for Medical Care Commission being granted authority to set staffing qualifications through rules.

MR/DD and PCS

- The Workgroup noted the increase in MRDD requests for PCS services.
- Noted that the client/agency should seek programs developed for specifically for these recipients (for example, CAP-MRDD).
- Clients admitted/served in PCS with the diagnosis of MRDD should have ADL deficits clearly identified.
- Should not be targeted for the primary diagnosis of "psychiatric patient".

Pediatrics and PCS

- PCS services do not include "skill training" services.
- PCS services do not replace parental responsibility.
- Must document medically-based tasks to be done under RN supervision
- For example:
  - Therapeutic exercises/activity deficits
  - Special feeding
  - Special handling of body fluid/waste
  - Special skin care
  - NA II Tasks
  - Special monitoring tasks: (FCBG) which occur during care

Comparisons & Recommendations Quality Assurance/Utilization Review

- **QA/UR Current PCS**

*Post pay review through program integrity

- **QA/UR Restructured PCS**

*DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies

- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

PCS QA/UR

- DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies
- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

CMS Domains

- Participant access (assessment)
- Participant-centered service planning and delivery
- Provider capacity/capabilities
- Participant safeguards
- Participant rights
- Participant outcomes/satisfaction
- System performance

Agency Self Audit & Audit Strategies

- Evaluation of Client Records (active and closed)
- Telephonic surveys
- Supervisory visits
- Electronic check in systems
- Review of aide service logs
- Incident/Complaint management
- At state-level review, the auditor may request to review agency self audit, findings and plan
- DMA desk review may request agency self audit

Educational Review

New Providers- after 6 months of billed service

- State Review
  - Random Selection
  - Educational /validation visits the first six months
- Does not replace PI audit
  - Egregious findings addressed

State Reviews

- Targeted Review from automated data - Automated sampling based on identified thresholds.
  - Examples:
    - pediatrics
    - More than one PCS recipient in the same home
    - Diagnosis targeted audit
- Desk Review and/or
- On-Site Review

State Review Findings

- If the findings of the review indicate that the client does not meet PCS criteria, a letter will be issued regarding the determination of coverage review.
- Other findings could lead to PI investigations

Provider Operation Impacts

- Administrative Changes - staff qualification requirements; paper/software changes (mandatory forms, mandatory elements on forms and/or costs associated with electronic entry)
- Training Costs
- Geographical service area impacts (volume impacts on costs)
- More in-depth UR role, more oversight

AHHC's Role

- Continue to partner with State on improvements
- Support curriculum and RN program training
- Assist with provider training and communication
- Continue role on PCS Advisory to evaluate program changes
- Continue to monitor provider impacts and costs
- Support legislation that directly and indirectly enhances patient care

Next Steps in the Restructuring Process

- Physician Advisory Group (PAG) input
- DMA development of draft policies
- DMA internal review of draft policies by all sections in DMA
- Fiscal Impact Analysis by DMA
- Formal Review of policies by PAG and recommendations to DMA
- Preparation of "final" policies and posting on DMA web site for 45 day comment period
- Identify and secure resources to implement components (utilization management, automation of assessment tools, provider training, etc.)

Next Steps in the Restructuring Process

- Implementation process will take from 6-10 months
- Looking at a July 1, 2005 target date for the major changes to be implemented
- Information systems changes and contracting for a utilization management program may take longer

Details and Determination

- Participation by stakeholders has made the PCS Restructuring products better than they might have been otherwise.
- There is much left to do and many details to be worked out.
- DMA and AHHC remain committed to the process.

Outcome Focus

- To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure services quality and fiscal accountability.

APPENDIX D

Objectives

1. To determine guidelines and goals used to implement and administer CAP/DA
2. To identify program assessments used by CAP/DA program

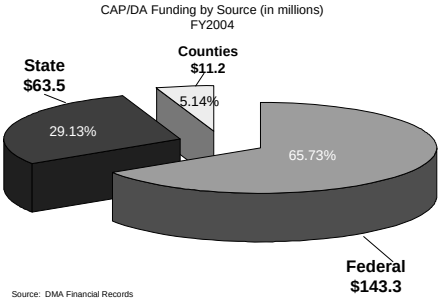
Scope

- DHHS Division of Medical Assistance
  - CAP/DA program
- Visits to 24 local lead agencies
- Limited to actions taken to
  - Implement and
  - Administer program

Program Overview

- CAP/DA began in NC in 1982
- Offered as a county option
- Covers all counties since 1995
- CAP/DA positions now part of unit responsible for
  - CAP/DA
  - Adult Care Homes
  - Personal Care Services

CAP/DA Budget



Clients and Costs

Fiscal Year	# Clients	Avg. Daily Cost *	Total Expenditures (in millions)
2004	11,727	$47.14	$201.8
2003	10,716	$47.22	$184.7
2002	11,137	$52.00	$211.4
2001	12,243	$43.79	$195.7

* Does not include non-CAP/DA waiver services such as durable medical equipment, prescription drugs, etc.
Source: DMA records

Objective 1: Guidelines and Goals

Conclusions:

- Federal waiver outlines guidelines
- DHHS in compliance with guidelines
- Operational changes could improve administration of program

Objective 1: Guidelines and Goals

Findings and Recommendations: State Administration

- CAP/DA Manual not updated; job descriptions not current.
  - Update to reflect recent changes; request OSP classification study.
- Budget cuts curtailed training to locals.
  - Explore ways to offer more cost-effective training.
- Service provider bills paid without approval.
  - Establish electronic approval for claims.

Objective 1: Guidelines and Goals

Findings and Recommendations: Local Administration

- Program policies inconsistent.
  - DMA develop model program policies.
- Client case management notes not uniform.
  - Use electronic format where possible; DMA give more specific guidance.
- Case manager service hours vary.
  - Establish normal parameters for hours; DMA review during monitoring visits.
- Waiting list information not consistent.
  - Continue developing standard waiting list policy.

Objective 2: Program Assessment

Conclusions:

- DMA has made considerable progress in addressing prior recommendations
- Monitoring negatively affected by budget cuts
- AQUIP will improve monitoring and assessments
- Administrative efficiency could by enhanced through use of laptops

Objective 2: Program Assessment

Findings and Recommendations:

- Annual on-site reviews not performed.
  - Establish process to determine which locals should be reviewed first; re-evaluate objectives of reviews.
- Laptops for local case managers could improve efficiency.
  - Encourage locals to employ computer technology where possible.

Issue for Further Study

- HB397-10.29B.(a) directed the State Auditor to supply information to determine
  - Whether CAP/DA was operating within
    - Guidelines
    - Program goals
- No funds provided for outside assistance
  - To assess medical and clinical quality and adequacy

Recommendation: Provide funds to complete audit

Issue for Further Study

- Under direction of OSA, subject matter experts would
  - Conduct qualifications review of local lead agency personnel and providers
  - Conduct documents review to determine
    - Medical justification
    - Adequacy/completeness of plans of care
    - Comparison of services provided to services needed
  - Conduct in-home visits with sample of clients
- Estimated costs = $150,000

Major Issues

1. DHHS operating within federal waiver guidelines
   - Locals need more detailed guidance
2. DHHS developing monitoring and assessment program (AQUIP)
   - Need to perform annual on-site reviews
   - Improve technology use at locals
3. Need outside assessment of medical / clinical quality and adequacy of actions

APPENDIX E

North Carolina
Adult Day Services Reimbursement Methodology Study

Final Report
North Carolina Study Commission on Aging

January 1, 2005

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Partners in Caregiving: The Adult Day Services Program
Department of Psychiatry & Behavioral Medicine
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Winston-Salem, NC

for

North Carolina Department of Health and Human Services

Adult Day Services Training and Reimbursement Methodology
Special Provision – Section 10.21(a) S.L. 2004-124

The following special provision, Section 10.21(a) was included in the budget bill approved in July of 2004 (S.L. 2004-124):

In an effort to support and sustain adult day services in North Carolina, the Department of Health and Human Services shall contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant shall study the current method of reimbursement for adult day services and make recommendations regarding changes to the reimbursement methodology. The final report shall be presented to the Study Commission on Aging by January 1, 2005.

The Department of Health and Human Services (DHHS) assigned responsibility to the Division of Aging and Adult Services (DAAS) for contracting with a national adult day services resource center for activities as specified in the special provision. Partners in Caregiving from the Department of Psychiatry and Behavioral Medicine at Wake Forest University School of Medicine in Winston-Salem was chosen as the consultant.

Partners in Caregiving began contract activities in October of 2004. The contract will extend to June 30, 2005. Contract activities through December 2004 have focused on the reimbursement study and planning training and consultation services that will begin in January of 2005. The focus of this report is on the reimbursement study. Activities to be carried out January through June are summarized at the end of the report.

There are three funding sources for adult day services administered through the DHHS. These are the Home and Community Care Block Grant (HCCBG), the State Adult Day Care Fund (SADCF) and the Community Alternatives Program for Disabled Adults (CAP/DA, which covers adult day health care only). Because of time constraints to prepare recommendations for the legislative Study Commission on Aging, the scope of the study focused primarily on the Home and Community Care Block Grant and State Adult Day Care Fund, which are both administered by the Division of Aging and Adult Services.

Adult Day Services Background

Adult day services have grown in North Carolina from two adult day programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the programs that closed later reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. There has continued to be a steady decrease in certified adult day programs. Approximately one year ago, there were 113 programs in 60 counties. Today there are only 106 programs in 58 counties.

A **National Study of Adult Day Services** (2001 - 2002), funded by The Robert Wood Johnson Foundation, was conducted by Partners in Caregiving. The study revolved around three major

activities: (1) conducting a census of adult day service providers to determine how many adult day programs exist and where they are located; (2) surveying these providers to determine populations served and services offered; and, (3) identifying gaps in the current service delivery system. The assessment of gaps included analysis of utilization gaps (i.e., where programs exist but are underutilized) and availability gaps (i.e., where no programs exist despite a probable need), illustrating counties that are under served or have excess capacity.

The study confirmed 3,407 adult day programs in the United States, of which 107 were located in North Carolina. Nationally, although overall growth in the adult day services industry was evident, it lags behind the need for the service, with 56% of U.S. counties being under served. In North Carolina, 75 out of 100 counties (75%) are under served. With current need not being met, 5,415 new adult day programs are needed nationwide. Of these, 138 are needed in North Carolina, ranging from one new program needed in 43 counties to seven new programs needed in three counties.

The service gap analysis of the national study determined that North Carolina (based on the age 65+ population) could support, overall, a total of 243 adult day programs at an average program size of serving 40 people per day. With 138 new programs needed in the State, only 43% of this need is being met. This could be considered a conservative estimate because adult day services also assist younger persons with disabilities. With the steady decline in certified programs, the percent of need being met will only decrease. Thus, the reason for the special provision: to support and sustain adult day services in North Carolina.

Adult Day Services Overview

Adult day programs are designed to serve adults experiencing a decrease in physical, mental and social functioning. The adult day program environment recognizes and attends to emotional and intellectual needs, as well as physical. Adult day programs serve adults who may need supervision, social interaction, and assistance with more than one activity of daily living (eating, walking, toileting, bathing, dressing).

There are three different models of adult day programs: a social model of care (with no medical component), a medical model of care (with nursing services), or a combination of the two. The majority of adult day programs are open Monday through Friday, eight or more hours a day. These programs provide a vast array of services such as: therapeutic activities, health monitoring, social services, personal care services, meals, transportation, nursing services, medication management, caregiver support services, rehabilitation therapy (such as physical therapy, occupational therapy and speech therapy), medical services (such as podiatry), and emergency respite.

According to the **National Study of Adult Day Services**, individuals being served in adult day programs range in age from 18 to 109, with an average age of 72. The two most prevalent groups of people served are those with dementia (52% which includes people with Alzheimer's disease or related disorders) and 41% frail elderly (age 60+ in need of supervision and/or at-risk of social isolation; no dementia). Twenty-four percent (24%) are diagnosed with mental retardation/developmental disabilities, 23% are physically disabled but cognitively intact (such as stroke, multiple sclerosis, and Parkinson's disease), and 14% have a chronic mental illness. Forty-three percent (43%) of individuals enrolled in an adult day program need assistance with toileting, 37% with walking, and 24% with eating.

The national study showed that most people attending an adult day program live with an adult child (35%) or a spouse (20%). The average length of stay in the program is two years, with the number one reason for discharge from the program being placement in a residential setting (such as a long-term care facility). The number two reason for discharge is death. Consequently, adult day programs either delay or prevent institutionalization. In the long-term care continuum, adult day programs help keep individuals (in need of chronic care) at home, in the community, with family and friends for as long as possible.

The preface of the **North Carolina Adult Day Care and Day Health Services Standards for Certification** defines adult day care and adult day health care as follows:

Adult Day Care

Adult day care is the provision of an organized program of services during the day in a community group setting for the purpose of supporting personal independence, and promoting social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using appropriate community resources. Medical examinations are required for individual participants for admission to a program and periodically thereafter. Services must be provided in a home or center certified to meet state standards for such programs.

Adult Day Health Care

The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured day program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

General Statute 131D-6 defines adult day care as follows:

> Adult day care means the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. The following programs are exempted from the provisions of G.S. 131D-6:
>
> - those that care for three people or less;
> - those that care for two or more persons, all of whom are related by blood or marriage to the operator of the facility;
> - those that are required by other statutes to be licensed by the Department of Health and Human Services.

The North Carolina Administrative Code (NCAC) 06S .0102 further defines adult day health care as follows:

Adult day health services is the provision of an organized program of services during the day in a community group setting for the purpose of supporting an adult's personal independence, and promoting his social, physical, and emotional well-being. Services must include health care services as defined in Rule .0403(a) of this Subchapter and a variety of program activities designed to meet the individual needs and interests of the participants, and referral to and assistance in using appropriate community resources. Also included are food and food services to provide a nutritional meal and snacks as appropriate to the program. Transportation to and from the service facility is an optional service that may be provided by the day health program.

The community group setting is:

(1) a day health center, which is a program operated in a structure other than a single family dwelling; or
(2) a day health home, which is a program operated in a single family dwelling; or
(3) a day health program in a multi-use facility, which is a day health center established in a building which is used at the same time for other activities; or
(4) a combination program, which is a program offering both adult day care and adult day health services.

Adult Day Services Funding

Third party public reimbursements streams for adult day programs in North Carolina include HCCBG, SADCF, and CAP/DA. Appendix A is a chart reflecting the total amount of dollars being expended through each of these funding streams for State FY 03-04 and State FY 04-05.

DAAS administers HCCBG and the SADCF. During SFY 03-04, HCCBG expended 97.67% and SADCF expended 98.87% of budget resources. These programs consistently expend approximately 98% of annual available resources. CAP/DA, administered by the Division of Medical Assistance, does not annually budget funding for specific services.

As is the case with all services funded through the HCCBG, State appropriations are the primary funding source for adult day services. State appropriations account for 59% of SFY 03-04 HCCBG adult day services expenditures, while federal Older Americans Act funds and local match account for 31% and 10% of total expenditures, respectively. A total of 1,173 HCCBG clients were served through 74 adult day programs. HCCBG funding is awarded to counties through Area Agencies on Aging on the basis of an intrastate funding formula. Individual counties determine the mix of services to be provided. Adult Day Care and Adult Day Health Care are two (2) of the seventeen (17) services that can be provided through the HCCBG.

The SADCF is supported through the State Social Services Block Grant (SSBG) Plan. SSBG funding represents 65.25% of SFY 03-04 SADCF expenditures, while state appropriations and local match account for 22.25% and 12.50% of total expenditures, respectively. A total of 1,340 clients were served through 96 adult day programs. State Adult Day Care funding is allocated to counties largely on the basis of prior year expenditures, with consideration given to counties where newly certified centers are located.

SFY 04-05 budgeted funding for the HCCBG and the SADCF takes into account an increase in State appropriations to increase the daily care reimbursement by $5.00 per day as directed by

General Assembly Session Law 2004-124, Section 5.1 (a). Effective, July 1, 2004, daily care reimbursement for Adult Day Care increased from $23.07 to $28.07 and daily care reimbursement for Adult Day Health Care increased from $30.00 to $35.00. In addition to the daily rate, the HCCBG allows for administrative costs based on reasonable expenses. HCCBG service providers are continuing to budget $482,565 in appropriations required for this purpose and State Adult Day Care Fund budget information reflects $520,000 in appropriations for the daily care rate increase. The Division of Aging and Adult Services expects that all available resources for adult day services will be expended at rates comparable to previous years.

Third Party Public Reimbursement Systems

The three adult day services third party public funding streams administered through the Department of Health and Human Services are separate and distinct programs. The following provides a brief overview of each system with an explanation of the respective target population.

Home and Community Care Block Grant (HCCBG)

The Home and Community Care Block Grant Fund provides funding of adult day care and adult day health care for persons who are 60 years of age or older who are in the target population. The target population is identified as "functionally impaired adults whose impairments prohibit them from living independently without supportive services and who are, therefore, at risk of institutionalization or placement in a substitute care setting."

Within this target population, there is a priority order given to individuals, as follows:

1. Older adults for whom the need for adult protective services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan;
2. Older adults who are at risk of abuse, neglect, and/or exploitation;
3. Older adults with extensive impairments in activities of daily living (ADL's), or instrumental activities of daily living (IADL's), who are at risk of placement or substitute care;
4. Older adults with extensive ADL or IADL impairments;
5. Older adults with less extensive (1-2) ADL or IADL impairments;
6. Well older adults

State Adult Day Care Fund (SADCF)

The State Adult Day Care Fund provides payment for service to adults 18 years of age and older who because of age, disability, or handicap need the service to enable them to remain in or return to their own home. Within the target population, eligible clients shall be provided day care services in the following order of priority:

1. Adults who require complete, full-time daytime supervision in order to live in their own home or prevent impending placement in substitute care (e.g. nursing home, adult care home), and adults who need the service as part of a protective services plan.
2. Adults who need help for themselves with activities of daily living or support for their caregivers in order to maintain themselves in their own homes or both.

3. Adults who need intervention in the form of enrichment and opportunities for social activities in order to prevent deterioration that would lead to placement in group care.
4. Individuals who need time-limited support in making the transition from independent living to group care, or individuals who need time-limited support in making the transition from group care to independent living.

Community Alternatives Program for Disabled Adults (CAP/DA)

The Community Alternatives Program for Disabled Adults is for persons 18 years of age and older who are:

1. Eligible for Medicaid for the Aged (MAA), Medicaid for the Blind (MAB) or Medicaid for the Disabled (MAD) according to Section 6 of the CAP/DA Manual;
2. Lives in a private residence and is at risk of being placed in a nursing facility or lives in a nursing facility and desires to return to a private residence;
3. Requires nursing care (intermediate care or skilled nursing) as determined through the Medicaid prior approval process;
4. Needs CAP/DA services to remain safely at home;
5. Can have his or her health, safety, and well-being maintained at home within the Medicaid cost limit; and
6. Desires CAP/DA services instead of institutional care.

The first step in analyzing DHHS adult day services reimbursement methodology is to look at each third party public reimbursement system side-by-side.

Appendix B is a chart comparing HCCBG, SADCF and CAP/DA funding streams in relation to:

- Who establishes the reimbursement rate;
- When the current rates were established;
- The system used for establishing rates;
- Frequency for rate change;
- How days of service are reimbursed;
- Absentee policy;
- The current rate per day (excluding transportation);
- The current rate per month; and,
- What constitutes a unit of service.

Rates are established for each of the third party funding streams by different methods and authorities. DAAS utilizes the Social Services Commission rate setting for HCCBG. The Social Services Commission has the authority to set maximum reimbursement rates for the SADCF. The Division of Medical Assistance (DMA) establishes the reimbursement rate for the CAP/DA

program. The current rates for each of these funding streams were established in July 1, 2004 (HCCBG and SADCF) and November 1, 1999 (CAP/DA). Prior to the recent $5.00 per day rate increase, a result of legislative action, the HCCBG and SADCF rate had not been increased since April, 1999.

There is no clear system for the establishment of the reimbursement rate for HCCBG and SADCF. The reimbursement for all three funding streams is based on a standard fixed rate; however, the Division of Medical Assistance (DMA) calculates the CAP/DA rate. After collecting information on each center's actual cost/day/client, DMA tallies volume by center, from the least to the most, and at the 50% mark identifies and reimburses the cost/day/client. In contrast, the reimbursement amount for HCCBG and the SADCF has no basis on actual program costs per day.

Of particular concern is the lack of any system for automatic rate increases among the three third party public reimbursement streams. General cost-of-living increases are not being addressed by these reimbursement systems. Furthermore, recent findings from North Carolina's Center for Disease Control (CDC) Behavioral Risk Factor Surveillance System indicate that, relative to other states, North Carolina has a high proportion of persons providing informal care for adults over 60. Although the population of those needing the service continues to grow, the funds established to serve them have remained fairly stagnant. At minimum, automatic rate increases would help address a growing need for the service.

Adult day program costs are fairly fixed, regardless of actual attendance in a program. Fortunately, both HCCBG and the SADCF recognize this fact and reimburse programs based on enrollment. Thus, a program receives reimbursement for days a participant is absent. The CAP/DA reimbursement system, however, does not reimburse for these days as the federal waiver guidelines and regulations call for reimbursement based on attendance.

In order to assure there is no abuse of an enrollment-based reimbursement system, the SADCF and HCCBG both have established absentee policies. HCCBG guidelines restrict reimbursement for absent participants to ten consecutive days, after which time units of service can no longer be reported until the client has returned. The SADCF requires adult day programs to notify the county Department of Social Services (DSS) when an enrollee has been absent for five consecutive scheduled days. The case manager then makes a decision as to whether it would be appropriate to terminate the service, hold the slot through the use of a holding fee, or revise the enrollment plan. This difference in policy has created some confusion and is further discussed under system change recommendations.

The current reimbursement per day falls well short of both the national average and of program costs. Although the recent $5.00 per day rate increase raised the reimbursement rate of HCCBG and SADCF from $23.07 per day to $28.07 per day (social model), nationally the typical daily cost of running a social model program is $54.00. In North Carolina, a 2004 pilot project to determine program costs (discussed later in this report) reported an average daily cost of $44.97. When adding the health care component, which requires the employment of a registered nurse (RN) or licensed practical nurse (LPN), the average daily cost for combination adult day care/adult day health programs nationally rose to $57.00, with North Carolina unit costs for combination adult day care/adult day health programs being reported at $52.31. This again falls short of the current reimbursement rate for day health care, recently increased from $30.00 per

day to $35.00 per day. The current reimbursement under CAP/DA is $36.51 per day, which only applies to programs with the health component.

The current rate per month also varies by funding source. For HCCBG, DAAS has an automated service information system that calculates monthly reimbursement on the basis of units reported, multiplied by the provider unit rate recorded in the system. The SADCF has a maximum reimbursement limit set at $608.00 per month (social model) or $758.00 per month (combination or health model). CAP/DA also has a maximum monthly cost limit rate, based on the person's approved level of care (intermediate care or skilled nursing care).

The unit of service also varies by funding source. HCCBG identifies a unit of service as being a 6-hour day. The SADCF and CAP/DA identify a unit of service as "a day." This inconsistency among funding sources can also prove to be problematic and is further discussed under system change recommendations.

Adult Day Services Funding in Other Southern States

An additional step in analyzing the adult day services reimbursement methodology in North Carolina involved a comparison of how other comparable southern states reimburse for adult day services. Appendix C compares South Carolina, Virginia, Georgia, and Florida in relation to:

- Types of adult day services reimbursed;
- Who establishes rates;
- How days of service are reimbursed;
- Absentee policy;
- The current rate per day;
- The current rate per month;
- What constitutes a unit of service;
- Funding source; and,
- Frequency for rate change.

Overall, a comparison of third party public reimbursement among the four southern states clearly demonstrates a higher adult day services reimbursement level. With the exception of Florida, rates are established by the legislature and are based on days of attendance. None of the other four states surveyed have an absentee policy. Reimbursement is based on a per day basis, not per month, except in Florida, where reimbursement is per hour. All programs are reimbursed via a Medicaid waiver with no automatic system for rate changes.

South Carolina reimburses $38.00 per day for social programs (which includes transportation if within 15 miles of the program), and adds an additional $15.00 per day for programs that include the nursing component, raising the total reimbursement rate to $53.00 per day. Virginia only

reimburses programs with the health component, and then sets the limit between $43.05 and $47.25, depending on the area of the State. Georgia has a more complicated system, with two levels of care, further divided into two levels of time. Levels of care are determined by the type and complexity of care needed. For programs providing Level I (less involved care, typically comparable to care received in a social model) programs are reimbursed $30.27 for a 3-hour day or $50.45 for a 5-hour day. Those providing Level II care (indicating a more complex level of care), are reimbursed $37.00 for a 3-hour day or $63.07 for a 5-hour day. Florida reimburses programs $10.00 per hour but will only reimburse at a maximum of eight hours per day. This equates to a maximum reimbursement of $80.00 per day. When compared to North Carolina reimbursement rates, these states seem to be more in line with the program costs as identified by the National Study of Adult Day Services.

Study Methodology

The methodology used to conduct the adult day services reimbursement study consisted primarily of key informant interviews. To obtain information on how the system operates and suggestions regarding changes to improve the system, interviews were conducted with staff from DAAS, the North Carolina Adult Day Services Association, and a representative number of adult day services providers, located in the 17 Area Agency on Aging regions.

Adult day services providers from each of these regions participated in a confidential 30-minute telephone interview. In preparation for the interview, each participating provider received (in advance) the chart similar to that in Appendix B (Adult Day Services Third Party Public Reimbursements through the North Carolina Department of Health & Human Services.)

The 17 providers were selected based on urban/rural mix, adult day services funds being accessed, and level of expertise with the system. They included the programs listed below. Adult Day Care programs, social model only, are referenced as ADC and adult day care/adult day health care combination programs are referenced as ADC/ADH.

Region A (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)
Pruett House Family Center, ADC certified for 32 participants
Franklin, NC (Macon County)

Region B (Buncombe, Henderson, Madison, Transylvania)
Mountain Care, ADC/ADH combination program, certified for 66 participants
Asheville, NC (Buncombe County)

Region C (Cleveland, McDowell, Polk, Rutherford)
Life Enrichment Center, ADC/ADH combination program, certified for 50 participants
Shelby, NC (Cleveland County)

Region D (Alleghany, Ashe, Avery, Mitchell, Watauga, Wilkes, Yancey)
Generations Adult Day Health Care, ADC/ADH combination program, certified for 40 participants
West Jefferson, NC (Ashe County)

Region E (Alexander, Burke, Caldwell, Catawba)

Adult Life Programs, ADC/ADH program, certified for 50 participants
Hickory, NC (Catawba County)

Region F (Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union)
Blessed Assurance Adult Day and Health Care, ADC/ADH program, certified for 40 participants
Matthews, NC (Mecklenburg County)

Region G (Alamance, Caswell, Davidson, Guilford, Montgomery, Randolph, Rockingham)
Adult Center for Enrichment, multiple ADC/ADH program sites, certified for 16-29 participants
Greensboro, NC (Guilford County)

Region I (Davie, Forsyth, Stokes, Surry, Yadkin)
Mount Zion Senior Enrichment Adult Day Care/Day Health Center, ADC/ADH program, certified for 40 participants
Winston-Salem, NC (Forsyth County)

Region J (Chatham, Durham, Johnston, Lee, Moore, Orange, Wake)
Resources for Seniors Total Life Programs, multiple ADC & ADC/ADH sites, certified for 25 to 41 participants each
Raleigh, NC (Wake County)

Region K (Franklin, Granville, Person, Vance, Warren)
Franklin County Adult Day Program, ADC/ADH program, certified for 24 participants
Louisburg, NC (Franklin County)

Region L (Edgecombe, Halifax, Nash, Northampton, Wilson)
Roanoke Valley Adult Day Care Center, ADC/ADH program, certified for 48 participants
Weldon, NC (Halifax County)

Region M (Cumberland, Harnett, Sampson)
Sampson County ADC/ADH Center, ADC/ADH program, certified for 20 participants
Clinton, NC (Sampson County)

Region N (Bladen, Hoke, Richmond, Robeson, Scotland)
Bladen County Adult Day Care Center, ADC program certified for 10 participants
Elizabethtown, NC (Bladen County)

Region O (Brunswick, Columbus, New Hanover, Pender)
Elderhaus at the Lake, ADC/ADH program, certified for 72 participants
Wilmington, NC (New Hanover County)

Region P (Carteret, Craven, Duplin, Greene, Jones, Lenoir, Onslow, Pamlico, Wayne)
Duplin Adult Day Services, ADC/ADH program, certified for 10 participants
Wallace, NC (Duplin County)

Region Q (Beaufort, Bertie, Hertford, Martin, Pitt)
Creative Living Center, ADC/ADH program, certified for 24 participants
Greenville, NC (Pitt County)

Region R (Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell, Washington)
Day Break Adult Day/Health Care Center, ADC/ADH program, certified for 30 participants
Elizabeth City, NC (Pasquotank County)

The provider interview question was two-fold:

1. Are you satisfied with the current adult day services reimbursement methodology systems for: Home and Community Care Block Grant (HCCBG), State Adult Day Care Fund (SADCF), and, the Community Alternatives Program for Disabled Adults (CAP/DA)?

2. If not, what changes would you make?

Overall Provider Interview Results

Among the adult day services providers, it was unanimous in that no provider was completely satisfied with the current reimbursement methodology systems for the HCCBG, SADCF, and CAP/DA. Providers were also unanimous in wanting an overall system that is consistent among systems and is consistent across the state (from county-to-county).

Providers recommended changes in each of the following areas for HCCBG and SADCF. The overall percentage of providers making each change request is shown in parentheses:

- Organization establishing the rates (12%)
- System for establishing the rates (100%)
- Frequency for rate change (100%)
- Absentee policy (71%)
- Rate per month (59%)
- What constitutes a unit of service (76%)

For CAP/DA (15 of the 17 providers interviewed access these funds), changes were recommended by providers in each of the following areas. The overall percentage of providers making each change request is shown in parentheses:

- Frequency for rate change (67%)
- How days of service are reimbursed (67%)
- What constitutes a unit of service (33%)

Due to time limitations, discussions have not been initiated with the Division of Medical Assistance to discuss this feedback from providers. The Division of Aging and Adult Services will follow up on this matter.

System Change Recommendations

To support and sustain adult day services in North Carolina, various reimbursement methodology changes need to be made to determine reasonable reimbursement rates, allow for negotiated rates with consideration of cost, and ease administration.

Based on discussions with the Division of Aging and Adult Services (DAAS), the North Carolina Adult Day Services Association (NCADSA), and adult day services providers across the state, the following changes to the HCCBG and SADCF systems are recommended (based on consensus):

FY 05-06

COST ANALYSIS SYSTEM

Issue:
As previously mentioned, a pilot project was conducted in North Carolina to determine the unit cost among adult day programs. The North Carolina Adult Day Services Association (NCADSA) extended an invitation in March 2004 to every certified adult day care and adult day health program in North Carolina to participate in a project to determine the cost of adult day programs to provide the service. Fifteen adult day center providers were trained as mentors to assist with completing a standardized form to calculate unit costs systematically. Sixty-six percent (66%) of North Carolina adult day care/day health programs (74) participated in the project through attending training and/or reporting data.

Some of the project goals included identifying funding streams for clients attending adult day programs, establishing a systematic approach to calculating unit cost, strengthening the financial management of programs by providing training about budgeting, and calculating an average unit cost for adult day programs certified as social, health, and combination. All respondents used a standard tool to present expenses and revenue, and to calculate unit costs. This tool has the potential to be a valuable mechanism for adult day programs for reporting unit cost in the future.

To date, there is no formal system in place to report and analyze adult day program unit cost. This information is needed in order to determine reasonable adult day services reimbursement rates through the Home and Community Care Block Grant and State Adult Day Care Fund. Since current reimbursement rates are not based on any concrete data, it is crucial that this information be systematically gathered and evaluated for further rate increases. Additionally, such information is needed to support the establishment of an automatic system for annual rate reviews and increases.

Recommendation:
Establish a formal reporting system, requiring adult day services providers, on an annual basis, to determine and report unit cost to DAAS. This information could also serve as a review by DAAS for potential rate changes. The cost analysis tool developed by DAAS (in conjunction with the NCADSA) provides an excellent basis for determining and gathering this information. This 2004 cost analysis project put North Carolina on the cutting edge as the first of its kind in adult day services at a state level. To be used effectively by providers, however, the current tool needs to be streamlined to be more user friendly. Partners in Caregiving will recommend revisions to the tool by March 31, 2005 for possible use by adult day programs in FY 05-06.

Action Required:
The establishment of a formal reporting system could potentially be incorporated into existing provider recertification requirements. Currently, the North Carolina Adult Day Care/Adult Day Health Care Standards for Certification require programs to submit a variety of information annually in order to comply with recertification requirements. Among the required information, programs are required to submit a 12-month budget. The addition of the requirement for programs to submit the cost analysis tool can be accomplished through an amendment to the current administrative rule. This process would require an administrative rule change, approved by the Social Services Commission and the Rules Review Commission.

Note:
A mandated cost analysis system through DAAS would add a major data collection/analysis responsibility to the Division with limited staff. DAAS would need to determine how such a system could effectively and efficiently be put in place.

CURRENT RATE PER MONTH FOR STATE ADULT CAY CARE FUND

Issue:
As previously explained, the SADCF has a monthly cap on reimbursement. This is interpreted differently from county to county. For instance, one program, serving multiple counties, reported a county that reimbursed them the monthly maximum, regardless of the number of days in the month. Another county only reimbursed the number of days of enrollment, up to the monthly maximum. Thus, the provider would receive different monthly third party public reimbursement amounts for the same number of enrolled client days. The elimination of the monthly maximum would help assure consistency in reimbursement from county to county.

Furthermore, since adult day services providers are generally reimbursed based on enrollment, not attendance, there is no purpose to having a stated monthly maximum. Basing reimbursement on the number of enrolled days per month would assure a program is paid for the actual number of days in the month and for the actual number of days a client is scheduled to attend the program.

Recommendation:
The formula for the rate per month (i.e., monthly maximums) for the SADCF should be deleted from the rules.

Action Required:
The monthly maximum rate is stated in administrative rules 10A NCAC 06Q .0201 and 10A NCAC 06T .0201. These rules would need to be amended to eliminate this maximum.

Note:
Rule 10A NCAC 06Q .0201 establishes the maximum reimbursement rate for the purchase of adult day services. General Statute 143B-181.1(a)(10) gives authority to the Division of Aging and Adult Services to "establish a fee schedule to cover the cost of providing in-home and community based services funded by the Division." The authority for this rule is cited as G.S. 143B-181.1(c) that states: "The Secretary of Health and Human Services shall adopt rules to implement this Part and Title 42, Chapter 35, of the United States Code, entitled Programs for Older Americans." The needed action required to enact this recommendation can be accomplished internally by the Department of Aging and Adult Services through amending this rule via the Secretary of the Department of Health and Human Services.

Rule 10A NCAC 06T .0201 defines the nature and purpose of the State Adult Day Care Fund. This rule identifies the appropriate use of the State Adult Day Care Fund and provides the maximum rate for the purchase under a vendor agreement between the county Department of Social Services and the adult day program. Authority for this rule is cited primarily as General Statute 143B-153. This statute refers to the Social Services Commission's creation, powers, and duties. It grants the Social Services Commission the "power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State ...." Amendment of this rule would require action by the Social Services Commission.

DAAS has agreed to work with the Social Services Commission to address the need for change to this rule. Dialogue, to include discussions with county departments of social services and other stakeholders, will begin on this process in the first quarter of 2005.

HCCBG REIMBURSABLE SERVICE UNIT

Issue:

A reimbursable service unit for HCCBG is a 6-hour day, but for the SADCF and CAP/DA it is a day. Interpretation of the HCCBG unit definition has led to confusion among HCCBG administrators and service providers. In some cases, it is interpreted to say a participant must be present a minimum of 6 hours per day in order to receive HCCBG reimbursement. This interpretation can be extremely restrictive to both day care participants and families. In other cases, HCCBG fund administrators have attempted to take the total number of hours a client has attended a program and divide it by 6 in order to arrive at the number of units. There is no clear advantage to maintaining the definition of a HCCBG reimbursable service unit as a 6-hour day. Furthermore, the majority of programs provide care for 8-10 hours per day. Reimbursement for the fixed rate of $28.07 (social) and $35.00 (combination/health) applies regardless of whether a program is open 6 or 10 hours per day.

Recommendation:
To ease administration and provide consistency among funding streams, the 6-hour stipulation from the HCCBG should be deleted, making the reimbursable unit “a day” (the same as the SADCF and CAP/DA). A day of service should be defined in the care plan and meet the needs of the caregiver and their loved one.
Action Required:

The definition of a 6-hour HCCBG day service unit is in the Home and Community Care Block Grant manual. This definition can be changed through an administrative letter from DAAS to Area Agencies on Aging who administer HCCBG funds.

Note:
The needed action required to enact this recommendation can be accomplished internally by the DAAS as described above. DAAS has agreed to proceed with drafting the administrative letter and will distribute it to all appropriate parties within the first quarter of 2005.

HCCBG AND SADCF ABSENTEE POLICY

Issue:

As previously detailed, HCCBG and SADCF policies establish different periods of time a participant can be absent and continue to received funding reimbursement. The HCCBG policy appears more lenient in the allowance of payment for 10 consecutive days of absenteeism. However, the SADCF could potentially reimburse longer than 10 consecutive days since, after 5 days, the DSS adult day care monitor determines whether the funding should be continued through the use of a holding fee. Neither fund limits the number of absentee days beyond consecutive absences. Thus, an absent HCCBG participant could be reimbursed based on enrollment for 10 consecutive days, return for a day or two, and then be reimbursed for an additional 10 consecutive days of absence.

To ease administration and provide consistency among funding streams, the absentee policy needs to be the same for both of these funding sources, as does the policy interpretation from county-to-county. For both funding streams, however, there is no consensus among adult day services providers as to the actual changes that should be made. Some providers feel that the SADCF should have the same number of consecutive days as the HCCBG. Other providers believe it should be the reverse or they feel providers should have leeway in both.

Recommendation:
DAAS needs to develop a task force to address this issue and arrive at consensus in the development of a consistent absentee policy and interpretation.

Action Required:
Following this consensus, an administrative letter needs to be sent from DAAS to all affected parties.

Note:
The current reimbursement study advisory committee and others deemed appropriate by DAAS could potentially serve as an initial task force for further examination of this issue. Input from county departments of social services will especially be important.

FY 06-07

HOME AND COMMUNITY CARE BLOCK GRANT (HCCBG)

Issue:

The current HCCBG system does not allow for negotiated rates for adult day services because the Division of Aging and Adult Services has chosen to utilize the same rate for HCCBG adult day services as that established by the Social Services Commission for adult day services funded by the State Adult Day Care Fund. This decision was made in order to establish equity between the two funding sources. Adult day care and adult day health care are the only services (of 17 HCCBG funded services) that have a fixed rate. Reimbursement rates for all the other services are not fixed rates, but rather negotiated rates per provider based on cost. The following HCCBG funded services are currently reimbursed based on negotiated rates: care management, in-home aide, congregate nutrition, home delivered meals, home health, senior center operations, housing and home improvement, information and case assistance, health screening, institutional respite care, mental health counseling, senior companion, transportation (excluding adult day services), volunteer program development, and group respite care. To provide consistency among HCCBG service providers, the same system should apply to adult day services. This change would also give adult day programs the flexibility to negotiate a rate more reflective of program costs.

Recommendation:

The HCCBG policy for adult day care and adult day health care reimbursement should be changed to allow negotiated rates per provider with consideration given to cost.

Action Required:

The maximum reimbursement rate referenced in 10A NCAC 06Q .0201 would need to be amended by an administrative rule change through the Secretary of the Department of Health and Human Services.

Note:

Prior to implementation of this recommendation, the impact of the July 1, 2004 $5.00 rate increase needs to be determined by DAAS. Has there been an increase or decrease in service delivery? Furthermore, due to limited HCCBG dollars, a cost analysis study by DAAS (during FY 05-06) would need to be conducted as to the impact of negotiated rates on service delivery. Would negotiated rates have a negative impact on the number of people served? DAAS should involve Area Agencies on Aging, county departments of social services, the North Carolina Adult Day Services Association, and other relevant parties in these discussions prior to moving forward on this recommendation.

STATE ADULT DAY CARE FUND (SADCF)

Issue:

The current SADCF system also does not allow for negotiated rates for adult day services. As previously mentioned, Rule 10A NCAC 06T .0201 defines the nature and purpose of the State Adult Day Care Fund. Authority for this rule is cited primarily as General Statute 143B-153. This statute refers to the Social Services Commission's creation, powers, and duties. Since the Social Services Commission currently has authority for setting the SADCF reimbursement rate, a change to a negotiated rate would necessitate discussions with the Social Services Commission.

Recommendation:
DAAS should initiate discussions with the Social Services Commission about the feasibility of moving towards a negotiated rate for adult day services funded by the SADCF.

Action Required:
DAAS needs to initiate initial discussions with the Social Services Commission to review the study reimbursement recommendations and explore the effect of moving towards a negotiated reimbursement system.

Note:
The same considerations would need to be examined prior to making this change as those listed previously under HCCBG funding changes.

Future Study Recommendations

TRANSPORTATION

For the HCCBG and SADCF, the reimbursement methodology being studied revolved around rates that excluded transportation. Transportation, however, did come up in the provider interviews in that the current reimbursement rate of $1.50 per trip is low for an extremely costly service. Reimbursement at such a low rate (based on a trip instead of by the mile) is a major financial drain on adult day programs.

Research conducted by Partners in Caregiving has shown that transportation is a predictor of financial success. In order to be financially viable, adult day programs must provide or arrange for transportation. Daily census increases when transportation is offered.

To address the issue of inadequate funding for adult day services transportation, additional State appropriations would be required.

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA)

Since the contract for the Adult Day Services Reimbursement Methodology Study was through the Division of Adult and Aging Services, the focus of this study was on the HCCBG and SADCF. Although CAP/DA is a funding stream for adult day services, it is administered through the Division of Medical Assistance, a separate division within the Department of Health and Human Services. As the chart in Appendix B details, there are further funding inconsistencies among HCCBG, SADCF and CAP/DA. Conversations with DMA regarding whether these inconsistencies should be addressed are needed prior to making system change recommendations. DAAS will review the report with DMA, with input from Partners in Caregiving.

Special Provision Activities Scheduled Through June 30, 2005

To support and sustain adult day services in North Carolina, the Special Provision also calls for training and consultation to adult day services providers and State and county adult day services consultants. As a result, the following additional activities will be conducted during the State FY 04-05:

Training and Technical Assistance

- Development of an assessment tool to identify adult day programs at-risk of closing (December 2004), and the creation of an adult day services program development assessment tool (January 2005).

- 5 regional training sessions for all certified adult day programs, anyone interested in opening an adult day program, and State and county adult day services consultants. Training includes a $250 scholarship available to any certified program needing funds to subsidize travel expenses or per diem coverage to attend the training (January – March 2005).

- 1 statewide training session specifically for the county adult day services consultants, in conjunction with an annual training workshop conducted by the Division of Aging and Adult Services (March 2005).

- Telephone technical assistance available to all training session attendees (February – June 2005).

- One-on-one technical assistance site visits to up to 40 certified adult day programs at-risk of closing, plus follow-up telephone technical assistance (March – June 2005).

- Development of recommendations for a system for sustainability (June 2005). Since the Special Provision funds are a major investment (no other state has done this), the key is to develop a system for sustainability so that these funds are not just a one-shot deal. Building on the training and technical assistance that will take place, how can the adult day services industry continue to move forward? With a system for sustainability in place, North Carolina would continue to be on the cutting edge.

A report will be presented to DHHS and the Legislative Study Commission on Aging to include a refined plan of action to support and sustain adult day services in North Carolina (July 2005).

APPENDIX A
Adult Day Services Funding
Through the Home and Community Care Block Grant (HCCBG), State Adult Day Care Fund (SADCF) and Community Alternatives Program for Disabled Adults (CAP/DA)

NOTE: The CAP-DA program is funded and administered through the Division of Medical Assistance

SFY 03-04

HCCBG	Federal Older Am. Act **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$459,149	$852,705	$145,762	$1,457,616	$1,504,224	96.90%	615	
Day Health Care	$409,640	$760,760	$130,045	$1,300,445	$1,319,755	98.54%	558	
HCCBG Total	**$868,789**	**$1,613,465**	**$275,807**	**$2,758,061**	**$2,823,979**	**97.67%**	**1,173**	74*

*Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$1,355,019	$460,751	$259,396	$2,075,166	$2,098,961	98.87%	958	
Day Health Care	$775,849	$263,814	$148,523	$1,188,186	$1,201,811	98.87%	382	
SADCF Total	**$2,130,868**	**$724,565**	**$407,919**	**$3,263,352**	**$3,300,772**	**98.87%**	**1,340**	96*

*Unduplicated count of adult day services centers receiving SADCF resources

CAP-DA	Federal Medicaid **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget*	% Expended	Clients Served
Day Health Care	**$925,431**	**$0**	**$462,715**	**$1,388,146**	**N/A**	**N/A**	**332**

* The Division of Medical Assistance does not budget CAP-DA funding for specific services

SFY 04-05

HCCBG	Federal Older Am. Act **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Care	$471,266	$919,356	$154,514	$1,545,136	
Day Health Care	$432,233	$843,210	$141,716	1,417,159	
HCCBG Total	**$903,499**	**$1,762,566**	**$296,230**	**$2,962,295**	73**

* Service providers are continuing to budget shares of the $482,565 appropriation that increases daily care rates by $5.00
** Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Services	**$2,155,301**	**$1,252,875**	**$486,882**	**$3,895,058**	92**

* Funding includes $520,000 appropriation to increase daily care rates by $5.00. The Division of Aging and Adult Services does not allocate SADCF funding to county DSS's by specific service.
** Unduplicated count of adult day services centers receiving SADCF resources

APPENDIX B

Adult Day Services
Third Party Public Reimbursements
through the
North Carolina Department of Health & Human Services

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Rates Established by	Division of Aging and Adult Services utilizes Social Services Commission rate setting	Social Services Commission	Division of Medical Assistance (DMA)
Current Rates Established	July 1, 2004	July 1, 2004	November 1, 1999
System for Establishing Rates	Standard Fixed Rate	Standard Fixed Rate	Standard Fixed Rate After collecting volume and costs, and each center's actual cost/day/client, DMA tallies volume by center from the least to the most, and at the 50% mark identifies the cost/ day/client.
Frequency for Rate Change	No Automatic System	No Automatic System	No Automatic System
Days Reimbursed	Enrollment (versus attendance)	Enrollment (versus attendance)	Attendance (versus enrollment)

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Absentee Policy	When an enrollee is absent for 10 consecutive days, units for the person will no longer be reported until such time the person returns.	The program must notify the county DSS when an enrollee has been absent for 5 consecutive scheduled days. The case manager makes a decision as to whether it would be appropriate to terminate the service, hold the slot through the use of a holding fee, or revise the enrollment plan.	Reimbursement is for days of attendance only; participants are not reimbursed for absent days.
Current Rate Per Day (without transportation)	Up to $28.07 (social)* Up to $35 (combination/health)* May add on an administrative fee calculated by the program based on reasonable expenses	Up to $28.07 (social) Up to $35 (combination/health)	$36.51 (combination/health)
Current Rate Per Month	Division of Aging & Adult Services automated service information system calculates monthly reimbursement on the basis of units reported times the provider unit rate recorded in the system.	Up to $608/mo.(social) Up to $758/mo.(combination/health) Formula: daily rate x 21.66 operating days/month	Reimbursement is based on a per day basis and not per month.
Unit	A 6-hour Day	A Day Month: 21.66 operating days (260 operating days per year ÷ 12)	A Day

* This rate reflects the recent $5.00 per day rate increase.

APPENDIX C

Southern States Comparison Chart

	South Carolina	Virginia	Georgia	Florida
Type of Service	*Adult Day Health Care and Adult Day Health Care Nursing	Adult Day Health Care Only	Adult Day Health Care Only	Adult Day Care and Adult Day Health
Rates Established by	General Legislature	Legislature	Legislature	Florida Medicaid Program
Days Reimbursed	Attendance	Attendance	Attendance	Attendance
Absentee Policy	None	None	None	None
Current Rate Per Day	*$38.00 (includes transportation if within 15 miles of the program) Pays additional $15.00 for Adult day Care Nursing	$47.25 (Northern VA) $43.05 (Other VA areas)	**Level I (3 hour day) $30.27 Level I (5 hour day) $50.45 Level II (3 hour day) $37.00 Level II (5 hour day) $63.07	$10.00 per hour Maximum limit per day is 8 hours or $80 per day
Current Rate Per Month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on hourly basis and ½ day basis, not per month
Unit	A 5-hour Day	A 6 or more hour a Day	Minimum Day = 3 hours Full Day = 5 hours	Hour (Max. hours paid per day is 8)
Funding Source	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver
Frequency for Rate Change	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Medicaid program

* In South Carolina, "Adult Day Health Care" is equivalent to North Carolina's "Adult Day Care" model (social model; clients do not receive nursing care). "Adult Day Health Nursing" is equivalent to NC "Adult Day Health" model; in SC providers receive $38.00 as a base rate plus an additional $15.00 for total of $53.00.

** Level I and Level II refer to the type of care that a client may need. Level II indicates a more complex plan of care.

APPENDIX F

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SHz-3 [v.7] (12/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/4/2005 2:57:22 PM

Short Title: CAP/DA Audit Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS AND TO DIRECT THE STATE AUDITOR TO CONDUCT AN AUDIT TO DETERMINE THE MEDICAL AND CLINICAL QUALITY AND THE ADEQUACY OF CARE AND SERVICES DELIVERED THROUGH THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA), AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Office of the State Auditor shall conduct an audit of the medical and clinical quality and the adequacy of care and services delivered through the Community Alternatives Program for Disabled Adults (CAP/DA). This audit shall build upon the results of the audit conducted by the Office of the State Auditor in accordance with S.L. 2003-284, Section 10.29B(a) and the study conducted by the North Carolina Institute of Medicine in accordance with S.L. 2002-126, Section 10.16(c).

SECTION 1.(b) In conducting this audit, the Office of the State Auditor shall determine compliance with CAP/DA waiver guidelines and program goals. The audit shall include review of: case files to assure compliance with the requirement for medical necessity, plans of care, and the provision of needed services; service provider standards and monitoring of these standards; safeguards to protect the health and welfare of clients; whether clients are institutionalized when necessary; an independent assessment function for the program; and any other items the Auditor considers appropriate. Components of the study shall include: a qualifications review of case managers and providers; a documentation review of medical justification, care plans, and a comparison of services provided to services prescribed by the attending physicians; and in-home client visits to discuss care and document services.

SECTION 1. (c) The Office of the State Auditor shall report the results of this audit, as well as the current status of recommendations resulting from the audit authorized by S.L. 2003-284, Section 10.29B(a), to the North Carolina Study Commission on Aging by February 1, 2006.

SECTION 2. There is appropriated from the General Fund to the Office of State Auditor, the sum of one hundred fifty thousand dollars ($150,000) for the 2005-2006 fiscal year to fund the audit of the medical and clinical quality, and the adequacy of care and services delivered through the Community Alternatives Program for Disabled Adults (CAP/DA).

SECTION 3. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SWz-11 [v.8] (12/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/7/2005 9:37:05 AM

Short Title: Home Care Changes.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AND TO APPROPRIATE FUNDS TO INCREASE THE SURVEY CYCLE FOR LICENSED IN-HOME AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"§ 131E-140. Rules and enforcement.

(a) The Commission ~~is authorized to~~ may adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules defining geographic service areas and staffing qualifications for licensed home care agencies.

(a3) The Commission shall adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(a4) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. G.S. 131E-136 reads as rewritten:

"§ 131E-136. Definitions.

As used in this Part, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.

(2) "Home care agency" means a private or public organization that provides home care services.

(2a) "Home care agency director" means the person having administrative responsibility for the operation of the agency.

(2b) "Home care client" means an individual who receives home care services.

(3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home;

c. Medical social services;

d. In-home aide services that involve hands-on care to an individual;

e. Infusion nursing services; and

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C; schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed

under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided.

(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.

SECTION 3. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter, apply in this Part.

"**§131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.
(11) To be informed of supervisory accessibility and availability.
(12) To be advised of the agency's procedures for discharge.
(13) To receive a reasonable response to his or her requests of the agency.
(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"**§131E-144.4. Notice to client.**

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:
(1) A copy of the declaration of home care clients' rights.
(2) The address and telephone number for information, questions, or complaints about services provided by the agency.
(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.
(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"**§131E-144.5. Implementation.**

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"**§131E-144.6. Enforcement and investigation.**

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department or department shall initiate an investigation as follows:
(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.
(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).
(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).
(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72-hours, complaints made to the agency by a home care client or the client's family, and must document both the existence of the complaint and the resolution of the complaint.

"**§131E-144.7. Confidentiality.**

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of five hundred and fifty thousand dollars ($550,000) for the 2005-2006 fiscal year and the sum of five hundred and fifty thousand dollars ($550,000) for the 2006-2007 fiscal year to increase the survey cycle to every two years for licensed only home care agencies.

SECTION 5. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 6. Section 4 of this act is effective July 1, 2005, Section 3 of this act is effective January 1, 2006, the remainder of act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SWz-10 [v.2] (12/17)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/26/2005 12:31:07 PM

Short Title: Falsify info/adult care home license/penalty.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IMPOSE A CIVIL PENALTY ON ANY ADULT CARE HOME LICENSURE APPLICANT WHO FALSIFIES OR OMITS MATERIAL INFORMATION ON THE APPLICATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-34 is amended by adding a new subsection to read:

"(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on an application. The amount of the penalty shall be as is prescribed for a Type A violation."

SECTION 2. This act becomes effective December 1, 2005, and applies to violations committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SWz-4 [v.4] (12/1)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/16/2004 5:19:51 PM

Short Title: Senior Games/Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR NORTH CAROLINA SENIOR GAMES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to North Carolina Senior Games, Inc. one hundred fifty thousand dollars ($150,000) for the 2005-2006 fiscal year and one hundred fifty thousand dollars ($150,000) for the 2006-2007 fiscal year to fund the Senior Games in North Carolina.

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SHz-1 [v.3] (12/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 11:38:06 AM

Short Title: HCCBG Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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 and Adult Services, the sum of four million dollars ($4,000,000) for the 2005-2006 fiscal year and the sum of four million dollars ($4,000,000) for the 2006-2007 fiscal year for the Home and Community Care Block Grant.

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SHz-6 [v.3] (12/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 11:39:02 AM

Short Title:	Re-Enact Long-Term Care Insurance Tax Credit. (Public)
Sponsors:	.
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO RE-ENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-151.28 is re-enacted.

SECTION 2. G.S. 105-160.3(b)(7) is re-enacted.

SECTION 3. This act is effective for taxable years beginning on or after January 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SWz-8 [v.3] (12/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/24/2005 3:04:27 PM

Short Title: Adult Protective Services TF/Collaborate.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Adult Protective Services Task Force shall collaborate with stakeholders and other persons interested in improving adult protective services and report its findings and recommendations to the North Carolina Study Commission on Aging and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

BILL DRAFT 2005-SWz-12 [v.4] (12/21)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/26/2005 1:58:40 PM

Short Title:	Wage Enhancement/Funds.	(Public)
Sponsors:	Representative Weiss.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR LABOR ENHANCEMENT PAYMENTS FOR NURSE AIDES IN NONINSTITUTIONAL SETTINGS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of fifty-one million, five hundred eight-three thousand, seven hundred twenty-four dollars ($51,583,724) for the 2005-2006 fiscal year and the sum of sixty-one million, eight hundred sixty-six thousand, five hundred eighty-nine dollars ($61,866,589) for the 2006-2007 fiscal year. These funds shall be used to match federal Medicaid funds to provide a thirty-two and seven hundredths percent (32.07%) labor enhancement payment for Medicaid-reimbursed long-term care services. These funds shall be in addition to funds provided for routine inflationary increases in Medicaid reimbursements for long-term care services. The funds appropriated in this act shall be used only to increase wages or benefits for long-term care aide workers in noninstitutional settings, or to provide for shift differential payments for long-term care aides in noninstitutional settings who work during hard-to-fill working hours or shifts. Counties shall not be required to pay any of the funds required to match the federal Medicaid funds for the labor enhancement payments authorized by this act.

SECTION 2. Funds appropriated in this act shall be allocated in accordance with the following:

(1) The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.

(2) Long-term care facilities and agencies that receive labor enhancement funds shall have the flexibility to determine whether labor enhancement funds are used for wages, benefits, or shift differentials, or any combination thereof.

(3) If labor enhancement funds are used to enhance wages, the long-term care facility or agency shall determine which aides receive wage increases and the amount of the increase provided. The determination shall be based on local market wage demands, rewarding longevity of service by the worker, and other wage-related needs of the agency or facility.

(4) Long-term care facilities and agencies that receive labor enhancement funds shall, as a condition of receiving the funds, submit reports and information required by the Department for the purpose of verifying use of the labor enhancement funds. Reports and information provided by facilities and agencies shall include for each facility and agency information needed to determine annual labor turnover rates in the agency or facility, including data on prelabor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

SECTION 3. Not later than January 15, 2007, the Department of Health and Human Services shall report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the North Carolina Study Commission on Aging on the use of labor enhancement funds appropriated under this act. The report shall include detailed information on:

(1) The amount of funds used for wages, for benefits, and for shift differentials.

(2) Comparative information on average hourly wages paid to aides and turnover rates by setting for fiscal year 1999-2000 through fiscal year 2005-2006.

SECTION 4. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SQz-1 [v.5] (1/3)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/26/2005 12:40:22 PM

Short Title: Increase Geriatric Care Providers.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE PRESIDENT OF THE UNIVERSITY OF NORTH CAROLINA AND THE PRESIDENT OF THE NORTH CAROLINA SYSTEM OF COMMUNITY COLLEGES TO UNDERTAKE CERTAIN STUDIES TARGETED TO INCREASE GERIATRIC CARE PROVIDERS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The President of The University of North Carolina and the President of the North Carolina System of Community Colleges shall study ways to increase the capacity of their institutions to produce geriatricians, geriatric-social workers, geriatric pharmacists, geriatric allied health workers, and graduates specialized in geriatric nursing and geriatric dentistry; and study how to improve the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program to increase the number of graduates specializing in geriatric care. The President of The University of North Carolina and The President of the North Carolina System of Community Colleges shall report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-SWz-14 [v.6] (1/5)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/13/2005 2:29:45 PM

Short Title: Criminal Records Checks/LTC Changes.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE PROCEDURE FOR CONDUCTING NATIONAL CRIMINAL HISTORY RECORDS CHECKS FOR LONG TERM CARE FACILITIES TO CONFORM WITH FEDERAL REQUIREMENTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-80(b) reads as rewritten:

"(b) Requirement. – An offer of employment by an area authority licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An area authority shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, an area authority shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person,

the Department of Health and Human Services, ~~Division of Facility Services,~~Criminal Records Check Unit shall ~~provide to~~ notify the area authority ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the area authority. Area authorities shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of an area authority a State criminal history record check required by this section without the area authority having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the area authority. All criminal history information received by the area authority is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section."

SECTION 2. G.S. 131D-40(a) reads as rewritten:

"(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the adult care home. Adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section."

SECTION 3. G.S. 131D-40(a1) reads as rewritten:

"(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the adult care home. Contract agencies of adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 4. G.S. 131E-265(a) reads as rewritten:

"(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition,

employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. If the applicant for employment or if the current employee who is changing employment status has been a resident of this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status. A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~Criminal Records Check Unit shall ~~provide to~~ notify the nursing home or home care agency ~~the results of the national criminal history check.~~as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the nursing home or home care agency. Nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section."

SECTION 5. G.S. 131E-265(a1) reads as rewritten:

"(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant

has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the nursing home or home care agency ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the nursing home or home care agency. Contract agencies of nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 6. This act is effective when it becomes law.