A Long-Term Care Plan for North Carolina

Interim Report by the North Carolina Institute of Medicine Long-Term Care Task Force to the North Carolina Department of Health and Human Services

June 30, 2000

North Carolina Institute of Medicine

Citizens dedicated to improving the health of North Carolinians

A Long-Term Care Plan for North Carolina

Interim Report by the North Carolina Institute of Medicine Long-Term Care Task Force to the North Carolina Department of Health and Human Services

NORTH CAROLINA INSTITUTE OF MEDICINE

June 30, 2000

About the North Carolina Institute of Medicine

Chartered in 1983 by the North Carolina General Assembly, the North Carolina Institute of Medicine (NC • IOM) is an independent, nonprofit organization that serves as a non-political source of analysis and advice on issues of relevance to the health of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health issues, and a source of advice regarding available options for problem solution.

Suggested citation: *A Long-Term Care Plan for North Carolina: Interim Report to the North Carolina Department of Health and Human Services.* Chapel Hill, NC: North Carolina Institute of Medicine, June 30, 2000.

Task Force Members and Staff

Co-Chairs:

Robert A. Ingram
Chairman
Glaxo Wellcome Inc.

The Honorable H. David Bruton, MD
Secretary
NC Department of Health and Human Services

Task Force Members:

James W. Albright, MHA
Albright & Associates, LLC
Former President and CEO
Rex Healthcare

Carol R. Baker, PhD
Director
Services for Adults Division
Mecklenburg County Department of Social Services

Kimberly Dawkins Berry
Director
Area Agency on Aging
Piedmont Triad Council of Governments

Charles Blackmon, MBA
Senior Vice President
Special Markets
NC Mutual Life Insurance Company

Nan Campbell
Director
Alexander County Department of Social Services

The Honorable Lanier M. Cansler
Representative
North Carolina General Assembly

Brenda Cleary, PhD, RN, FAAN
Executive Director
North Carolina Center for Nursing

Jerry Cooper
Executive Director
NC Assisted Living Association

Beverly Cowdrick, MPPM, MBA, MPA
Chair, Regulatory Subcommittee
NC Association of Non-Profit Homes for the Aging, Inc.
Vice President for Resident Life
Carol Woods Retirement Community

Dorothy R. Crawford
Former Director
Macon County Department of Social Services
Aging Advocate, AARP

Fred Crisp
Former Publisher
News & Observer

Richard L. Daugherty
Executive Director
NCSU Research Corporation

The Honorable Beverly M. Earle
Representative
North Carolina General Assembly

The Honorable James S. Forrester, MD, MPH
Senator
North Carolina General Assembly

Daphne Haley
Vice President
NC Family Care Facilities Association

Laura C. Hanson, MD, MPH
Associate Professor, Department of Medicine
University of North Carolina at Chapel Hill

Lynn Hardy, RN
Executive Director
Duplin Home Care

Karol Harshaw-Ellis, RN, ANP
Nurse Practitioner, Carolina Permanente Medical Group
Consulting Associate, Duke University School of Nursing

Richard W. Hatch
Chairman, State Legislative Committee for AARP
Senior Leader, Duke University Long Term Care Program

Becky Heron
Durham County Commissioner

Watts Hill, Jr.
Chapel Hill

Carmen Hooker Buell
Group Vice President
Carolinas Healthcare System

Fred Johnson
NC Adult Day Services Association
Vice President, Resources for Seniors

Beverly Jones, MD
Associate Professor
Department of Psychiatry
Director, Telemedical Services
Director, Memory Disorders Clinic
J. Paul Sticht Center on Aging
Wake Forest University School of Medicine

Elizabeth Isler, RN, BSN, MEd
Director of Programs
NC Community College System

George L. Maddox, PhD
Program Director
Long Term Care Resources Program
Center for the Study of Aging and Human Development
Duke University

The Honorable William Martin, JD
Senator
North Carolina General Assembly

Barbara D. Matula, MPA
Director
Health Care Programs
NC Medical Society Foundation

Peyton Maynard
President
Developmental Disabilities Facilities Association

Beth Melcher, PhD
Director of Government Relations
NAMI-NC

Jim Mitchell, PhD
Professor of Sociology and Family Medicine
Director, Center on Aging
School of Medicine
East Carolina University

Jay Moskowitz, PhD
Senior Associate Dean
Wake Forest University School of Medicine

Inez Myles
Executive Director
NC Senior Citizens Federation

The Honorable William Purcell, MD
Senator
North Carolina General Assembly

David Richard
Executive Director
Arc of North Carolina

Jack St. Clair, EdD, NHA
Area Director
Duplin-Sampson Area Mental Health, Developmental Disabilities and Substance Abuse Services

Craig Souza
President
NC Healthcare Facilities Association

Carol Teal
Executive Director
Friends of Residents in Long Term Care

John Tote
Executive Director
Mental Health Association of NC

Lou Wilson
Executive Director
NC Association, Long Term Care Facilities

Sheryl Itkin Zimmerman, PhD
Associate Professor, School of Social Work
Co-Director, Program on Aging, Disablement and Long-Term Care
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

State Government Agency Directors:

Jim Bernstein
Director
NC Office of Research, Demonstrations and Rural Health Development

Jim Edgerton
Deputy Secretary
NC Department of Health and Human Services

Kevin Fitzgerald
Director
Division of Social Services
NC Department of Health and Human Services

Karen Gottovi, MSLS
Director
NC Division of Aging
NC Department of Health and Human Services

A. Dennis McBride, MD, MPH
Assistant Secretary of Health and State Health Director
NC Department of Health and Human Services

Lynda McDaniel
Director
Division of Facility Services
NC Department of Health and Human Services

Richard Perruzzi, MBA, MHA
Director
Division of Medical Assistance
NC Department of Health and Human Services

Holly Riddle, JD, MEd
Executive Director
NC Council on Developmental Disabilities

J. Iverson Riddle, MD
Director
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
NC Department of Health and Human Services

Consultants:

Elise J. Bolda, PhD
Assistant Research Professor
Edmund S. Muskie School of Public Service
University of Southern Maine

Advisory Staff:

Gordon H. DeFriese, PhD
President and CEO
North Carolina Institute of Medicine

Pam Silberman, JD, DrPH
Vice President
North Carolina Institute of Medicine

Cynthia M. Freund, PhD, RN, FAAN
Senior Staff Member
North Carolina Institute of Medicine
Professor and Former Dean, School of Nursing
University of North Carolina at Chapel Hill

Susan Harmuth, MS
Health Systems Analyst
Medical Facilities Planning
Division of Facility Services
NC Department of Health and Human Services

William E. Lamb, CMSW, MPA
Human Services Planner/ Evaluator
NC Division of Aging
NC Department of Health and Human Services

Sandra Crawford Leak, MHA
Associate Program Director
Long Term Care Resources Program
Center for the Study of Aging and Human Development
Duke University

Kirsten E. Leysieffer, MA
Research Associate
North Carolina Institute of Medicine

Bill Lohr, PhL
Research Associate
North Carolina Institute of Medicine

Suzanne P. Merrill, MSW
Adult Services Branch Head
Adult and Family Services Section
Division of Social Services

Bonnie Morell, MSW, DrPH
Branch Head
Community Initiatives
Adult Community Mental Health Section
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
NC Department of Health and Human Services

Debbie Pittard
Project Manager
Division of Information Resource Management

Philip D. Sloane, MD, MPH
Elizabeth and Oscar Goodwin Distinguished Professor of Family Medicine
UNC-CH School of Medicine
Co-Director, Program on Aging, Disablement and Long-Term Care
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

John Tanner, MSW
Chief
Adult & Family Services Section
NC Division of Social Services

Judy Walton, MSW
Administrator
Managed Care for Seniors
Division of Medical Assistance
NC Department of Health and Human Services

Kristie K. Weisner, MA
Research Associate
North Carolina Institute of Medicine

Dennis E. Williams
Associate Director, Research and Demonstrations
NC Office of Research, Demonstrations and Rural Health Development

Chapter 1

Introduction

...Long-term care lurks as the sleeping giant of the health-care system and the stakes are high unless steps are carefully taken to forge a long-term care system in this decade that is accessible to all the citizens of this State.[1]

BACKGROUND

North Carolina is in the midst of a major demographic change that has significant implications for the citizens of the state. The number of older adults in North Carolina is growing faster than in most other states.[2] By 2025, only 10 states will have a greater percentage of older adults age 65 or older. The number of older adults is expected to grow from 12.8% of the state's population in 1998 to 21.4% by 2025.

Sixty percent of persons who live to age 65 will need long-term care sometime in their lives.[3] Long-term care is the sum of health, social, housing, transportation and other supportive services needed by those with physical, mental, or cognitive limitations that compromise independent living.[4] Long-term care services can be provided in the home, in the community, in residential or institutional settings.

The NC•IOM Long-Term Care Task Force was charged with developing a long-term care system that provides a continuum of care for elderly and disabled individuals and their families.

Older adults are not the only people who need long-term care services. Children with developmental disabilities, as well as other adults with disabilities may need long-term care. National data suggest that children represent about 3.5% of those needing long-term care, disabled adults under age 65 represent 46%, and those 65 or older represent 50% of the people needing long-term care services.[5]

The growth in the number of people who will need long-term care services will affect both families and policy makers. Most people who need long-term care services rely on family and friends for their support—generally in the form of unpaid help in meeting daily needs.[6] Individuals and their families also pay a substantial portion of the costs of long-term care services—nationally, out-of-pocket spending accounted to 26% of nursing home and home care expenditures in 1998. For many individuals and families, the need for long-term care can result in financial ruin or hardship.

Government also plays a role in both financing long-term care services and in ensuring minimum levels of quality. Nationally, Medicaid paid approximately 40% of long-term care expenditures for nursing home and home care in 1998.[7] In North Carolina, Medicaid spent more than $1.5 billion in long-term care expenditures for older adults and people with disabilities in SFY 1999. As the number of people who need long-term care services grows, so will the need

for additional public expenditures. This demographic trend has major financial implications for state, county and federal governments.

Even if public or private financing is available, however, necessary services may not be. Nationally, one in five adults with long-term care needs reported an inability to obtain the care they needed.[8] The shortage of nurse aides and other paraprofessionals makes it particularly difficult for agencies to meet the need for long-term care services.

The growing demand for long-term care raises concerns about the proper balance between institutional and non-institutional services, assuring quality of care, ensuring an adequate supply of services, and financing. Yet, the 1998 State Auditor's Report on Long-Term Care raised significant questions about the state's ability to meet this challenge.[9] The current system is fragmented and difficult for many people to use. It is for these reasons, that the North Carolina General Assembly directed the North Carolina Department of Health and Human Services to develop a long-term care plan for the state.

Legislative Charge

In the 1999 General Assembly, the legislature directed the NC Department of Health and Human Services (DHHS) to develop a long-term care system that provides a continuum of care for older adults and disabled individuals and their families.[10] The Department was directed to develop this system in cooperation with other state and local agencies and representatives of consumer and provider organizations. The system was to include:

- a structure and means for screening, assessment, and care management across settings of care;
- a process to determine outcome measures of care;
- an integrated data system to track expenditures, consumer characteristics, and consumer outcomes;
- relationships between the Department and the state's universities to provide policy analysis and program evaluation support for the development of long-term care system reforms;
- an implementation plan that addresses testing of models, reviewing existing models, evaluation of components, and steps needed to achieve the development of a coordinated system; and
- provision for consumer, provider, and agency input into the system design and implementation development.

By January 1, 2001, the Department was to have a system in place that would:

- implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles, and consumer preferences; and

- develop a system of statewide long-term care services coordination and case management to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need.

The Department was also directed to pursue financing strategies that would shift the balance of the financial responsibility for long-term care services from the public to private sources by promoting public-private partnerships and personal responsibility for long-term care. Specifically, the Department was directed to explore:

- the flexible use of reverse mortgages;
- private insurance coverage for long-term care;
- tax credits or employment programs, such as medical savings accounts and deferred compensation plans, for long-term care; and
- changes in Medicaid eligibility and asset protection requirements that increase consumers' financial responsibility for their long-term care, such as revising the rules relating to the transfer of assets and estate recovery policies.

The Department was directed to report its progress to the General Assembly no later than April 15, 2000.

In the fall of 1999, the Secretary of the North Carolina Department of Health and Human Services (DHHS), the Honorable H. David Bruton, M.D., asked the North Carolina Institute of Medicine (NC•IOM) to convene a statewide task force to assist DHHS in developing a comprehensive long-term care plan. Robert A. Ingram, Chairman of Glaxo Wellcome Inc. agreed to co-chair the Long-Term Care Task Force along with Secretary Bruton. The full Task Force was appointed in the early fall, and included 49 additional members including representatives of the North Carolina General Assembly, county commissions, local governments, long-term care providers and industry associations, consumer advocacy groups and businesses. In addition, the Task Force included agency directors within DHHS charged with the provision or oversight of long-term care services to older adults or people with disabilities. The Task Force began meeting in November 1999 and met monthly through June 2000. In addition, the NC•IOM staff met periodically with other state agency staff to prepare materials and the agendas for the monthly Task Force meetings.

The Task Force examined long-term care issues for both older adults and people with disabilities—including physical, developmental,[11] cognitive and mental health disabilities. The Task Force identified eight key areas that needed to be addressed to response to the legislative charge:

1) how consumers enter the long-term care system;
2) assuring availability of services;

The Task Force examined long-term care issues for both older adults and people with disabilities—including physical, developmental, cognitive and mental health disabilities.

3) ensuring the quality of services;
4) workforce issues (particularly the availability of nurse aides and other paraprofessionals);
5) financing options;
6) data and data system requirements;
7) pilot and demonstration projects; and
8) DHHS organizational issues.

Over the course of the eight months since November 1999, the Task Force members met once each month in work groups and discussed entry, availability, workforce, quality and financing options. The results of these deliberations and interim recommendations are included in this report. The Task Force intends to continue meeting throughout the fall of 2000, to consider data and data system requirements, pilot and demonstration projects and DHHS organizational issues, as well as certain residual issues not resolved by the time of this interim report. Among these are statistical estimates of the level of need and demand for long-term care services over the coming decade by the state's older adults and disabled populations.

North Carolina's Long Term Care Policy

Ideally, long-term care services would be provided by home and community-based programs or families on behalf of their loved ones. These services should enable individuals to live as independently as possible without casting them into poverty. Without adequate private long-term care insurance or public funding, some individuals in need of long-term care services are faced with three options: find a family member to provide unpaid care; pay a caregiver out-of-pocket; or enter a long-term care facility (where, as they more quickly use up their resources to pay for institutional care, they are more likely to qualify for public subsidies). This raises the question of the availability of the services and financing needed for people to live at maximum independence without requiring them to become institutionalized.

North Carolina's policy for long-term care is to support older and disabled persons needing long-term care, and their families, in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.

Early in its deliberations, the Task Force members determined that North Carolina needed an overriding policy statement to guide the future direction of long-term care policy in this state. The goal of the Task Force was to design a seamless system of care that promotes individual autonomy, dignity and choice; and provides services to individuals in the least restrictive setting. Specifically, the Task Force recommends:

1. **North Carolina's policy for long-term care is to support older and disabled persons needing long-term care, and their families, in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.**

Chapter 2

Entry into the System

Definition of the Problem

Getting information about long-term care services and gaining access to those services can be a complex process—one that is often confusing to consumers. Some of the difficulties and complexities can best be illustrated by a case example provided by a member of the Task Force.

> *An 83 year old woman living at home with her disabled daughter fell and broke her hip. The ambulance took her to the hospital where her hip was pinned. A week later the woman returned home where she was greeted by her disabled daughter. The daughter directed the transporters to her mother's room and bed. Later that day, unable to move her mother or to get her out of bed, the daughter called the police for assistance. A police officer came, and seeing the situation, called the local public health department. The next door neighbor came over, and upset with the situation, went home and called the Senior Citizen's Center which gave her the Council on Aging phone number. The neighbor also called the Department of Social Services (DSS) to report her concern about the situation.*
>
> *Later that afternoon, a nurse from a home health agency called to schedule an assessment visit for the following day. The home health agency had received a referral from the hospital at discharge. An adult protective services social worker from the Department of Social Services arrived to evaluate the complaint called in by the neighbor and to assess the woman's condition. The social worker found the woman lying on the floor of her bedroom in great pain and called an ambulance and the doctor. The woman was taken back to the hospital for evaluation and another assessment.*

Fragmentation and dupication of services exists in North Carolina's long-term care system.

The above example is not intended to convey that all attempts to access needed services and that all efforts to deliver services are fraught with such difficulties. Many people receive the services they need more easily. At the same time, there is fragmentation and duplication in the State's long-term care system. The above example merely illustrates some of the problems.

The Current System

"Entry into the system" concerns issues surrounding consumer pathways into and through the system and includes the following types of general services: information, referral and assistance, screening, level of services assessment

and care planning. Given the fragmentation and duplication within the current system, and resulting confusion it causes for consumers, the Task Force concluded early in its deliberations that one of its goals would be to propose a system that would allow consumers to find their way into and through the system with ease, regardless of the consumer's source of payment for long-term care services. Thus, one of the overall recommendations of the Task Force is that:

North Carolina's Long-Term Care System should be accessible and understandable for both public and private pay consumers, and uniform for all in need of long-term care services.

2. **North Carolina's Long-Term Care System should be accessible and understandable for both public and private pay consumers, and uniform for all in need of long-term care services.**

Information, Referral and Assistance

Providing information to individuals in need of long-term care services, with referral to appropriate community resources is known as "information, referral and assistance." People needing information about long-term care services find that information in multiple ways. They may place a telephone call to some agency requesting information and assistance. Many local agencies and organizations that work with older adults or people with disabilities are knowledgeable about long-term care resources in the community and provide this information free of charge upon request. People may also go directly to an agency and request the service they need. Or, they may go to an agency for a specific service, only to find out that that particular agency does not provide the service they are seeking or need. In this latter instance, the agency contacted by the consumer will try to refer the consumer to the appropriate agency.

The system that people with developmental disabilities use to obtain long-term care services is more clearly established. Individuals with developmental disabilities needing services can obtain referrals through area mental health, developmental disabilities and substance abuse program. However, some people with developmental disabilities enter the long-term care system through other means. For example, a family member may place another family member in an adult care home without first seeking services through the area mental health, developmental disabilities and substance abuse program. While the system for people with developmental disabilities is more organized, some changes may be needed to ensure that individuals who enter the system through other means are identified and receive appropriate services.

Few individuals understand all the services available in the community, or what agencies can help with payment for these services.

Consumers face an array of agencies purporting to deliver long-term care services. Multiple agencies provide different types of long-term care services. Departments of Social Service, Councils and Departments on Aging, Area Programs on Aging, Health Departments, Area Mental Health, Developmental Disability, and Substance Abuse Programs, home health agencies, adult day care and day health care centers, adult care homes, assisted living facilities, nursing homes, hospitals, group homes for people with developmental disabilities or mental illness, adult developmental assistance programs, and community respite facilities and are some of the major providers of long-term care services. Some of these services are available to both publicly funded and private pay

individuals; other services are limited to individuals with specific sources of payment. Persons seeking services may know of some of these agencies, but not others. Few individuals understand all the services available in the community, or what agencies can help with payment for these services.

While most communities offer some form of information, referral and assistance to older adults and their family caregivers, it is also clear that the amount and quality of this help varies enormously around the state. Some communities and agencies have made this a priority while others have not. The Governor's Advisory Council on Aging emphasized the pressing need to develop a comprehensive, professional and uniform aging information resource system, especially as the older population and fragmented service system continue to grow.[12] Information, referral and assistance agencies are usually aware of the resources and services provided by other agencies in their communities. Some have computerized systems that serve as a databank for services available locally. Other communities use more informal mechanisms to keep apprised of available services. Sixty-two counties are currently using a computerized information and assistance system, IRIS, but this system is not used uniformly across all counties and may not include all the long-term care resources needed by people with disabilities.

Without a systematic means of providing up-to-date information about available services to all agencies, the likelihood of providing erroneous information to consumers increases. Further, without a systematic information database that is shared among counties, consumers might not be given all the information they need, and/or inappropriate referrals might be made. The Task Force recommends:

3. **The North Carolina Department of Health and Human Services should develop a framework for a computerized information and assistance system that can be used statewide, and which takes advantage of existing systems throughout the state.**

Screening

An initial screening is often conducted as part of the information and assistance process. When services are requested, an individual is screened to gather basic information as to the type of services needed and his or her *potential* level of care and financial eligibility for publicly funded programs and services. Screening helps to determine which individuals may potentially need long-term care services, and which individuals need a referral to other types of services. The goal of screening systems is to direct individuals to appropriate resources and agencies.

Level of Services Assessment

A more in-depth information gathering process is needed to determine an individual's need for long-term care services. Information on physical health,

mental health, functional status, amount of informal support, condition of the home and financial ability to meet day-to-day needs must be collected. This assessment is conducted with the goal of determining what types of services are appropriate for an individual based on their functional and health status and their informal support network. Some assessment instruments also obtain information on the client's goals and preferences, which could lead to different services for two or more individuals with the same functional needs. The level of services assessment may be done as part of an eligibility determination for publicly subsidized long-term care programs (see level of service need eligibility, below) or may be done for private-pay consumers to identify the appropriate services based on the person's needs and preferences.

Eligibility Determination

Agencies that help pay for long-term care services use two types of criteria for determining eligibility for services—level of service need and financial status.

1. *Level of Service Eligibility*: To be eligible for services, a consumer must meet a level of service need that is based on the complexity or intensity of a person's chronic care needs. Level of service need is based on an assessment encompassing clinical, psychosocial, and functional criteria. Information gathered during the assessment is used to match the consumer's particular needs and preferences with an appropriate category or level of service. Data from this level of services assessment are used to determine whether a person qualifies for public-funding for a certain level of service.

2. *Financial Eligibility*: Eligibility for *some* publicly funded long-term care services is based on an individual's financial status. For example, eligibility for assistance in paying for adult care home services (through State County Special Assistance) or for nursing home care (through Medicaid) is based not only on level of service need criteria, but also financial criteria, such as income and assets.

Care Planning

Once a person's level of service needs and personal preferences are determined and the person is referred to the appropriate agency, a care plan must be developed. Care planning is the development of a package of services that meet an individual's long-term care needs, based on a more thorough assessment of the individuals' functional and health status. Assessors in the long-term care arena for older and disabled adults are usually nurses and social workers. The individual in need of care, the individual's family, the assessor(s) and the person's physician generally have input and reach consensus on the plan of care.

Different agencies use different screening, level of services assessment and care planning instruments. The federal government, under conditions of Medicare reimbursement, requires that nursing homes use specialized instruments for care planning purposes (MDS 2.0) and to determine whether residents with mental health problems or developmental disabilities are appropriate for nursing home placement (PASARR). Home health agencies are required to use a different tool called OASIS to obtain information on the client's functional and medical status. In addition to the tools required by the federal government, different state agencies require different forms or care planning processes. For example, some agencies provide specialized long-term care services, such as ICF-MR and CAP-MR, for persons with developmental disabilities or specialized long-term psychiatric care in hospital and community settings for persons with severe and persistent mental illness. These services require specialized care planning tools that addresses habilitation and treatment needs. Other agencies require different forms for level of services and care planning assessments. The following chart shows the various assessment tools currently in use by different agencies for different services. In some cases there may not be a standardized form that is required for the screening by an agency.

Individuals and families are often subjected to multiple assessments, and coordination of services between agencies may be lacking.

Table 2.1
State or Federally Required
Level of Services and Care Planning Instruments

	Level of Services Assessment	Care Planning Assessment
Nursing homes	• Medicaid: FL-2	• MDS 2.0 (federally required) • PASARR to determine if a resident who has a mental illness or developmental disabilities is appropriate for nursing facility care (federally required)
CAP-DA	• Medicaid: FL-2	• Medicaid: DMA 3012 (care planning) • Medicaid: DMA 3011 (assessment to determine specific services needed)
Adult Care Homes	• State County Special Assistance: FL-2 • Medicaid: DMA 3050 (for personal care services)	• Currently: DMA 3050 • SB10: RAI-ACH
Home Health	• OASIS (federally required)	• HCFA 485 (federally required)
In-Home Services	• SSBG: DSS 6220 (adult services assessment)	• SSBG: DSS 6220 • Medicaid: DMA 3000
ICF-MR	• Medicaid: MR-2	• Medicaid: DMA 3012 (care planning) • MHDDSAS: NC SNAP
CAP-MR	• Medicaid: MR-2	• Medicaid: CAP-MR/DD treatment/habilitation plan • MHDDSAS: NC SNAP
Other long-term care services offered by DMHDDSAS	• MHDDSAS: NC SNAP for all MR/DD clients • CAFAS for children • GAF for adults	• No instrument is used

The state lacks data about the use of long-term care services and the functional or health status of people using different types of services.

The use of multiple, and often incompatible, screening and assessment instruments by different agencies causes problems:

- There is little or no sharing of client assessment information across multiple agencies working with an individual and his or her family. Thus, individuals and families are often subjected to multiple assessments, and coordination of services between agencies may be lacking.
- Independent care planning and care management is limited. Care managers cannot monitor changes in functional or health status as individuals move throughout the long-term care system.
- It is difficult for government to plan for long-term care services because the state lacks data about the use of long-term care servic-

es and the functional or health status of people using different types of services.

- The state cannot easily monitor outcomes for other than nursing home level services because the state does not collect baseline functional and health status information about persons using long-term care services or changes over time.

Common Screening, Level of Services Assessment and Care Planning Instruments

North Carolina's situation is not unique; other states have a long-term care system similar to ours. A few states, however, have begun to address the problem of duplicative screening and assessment processes. *Inter*RAI, a non-profit corporation, developed a series of resident assessment instruments (RAI) to be used as assessment and care planning instruments for long-term care services. These instruments include:

- MDS 2.0 for nursing home services (mandated for use nationally by HCFA);
- RAI-AL, referred to as RAI-ACH in North Carolina, for assisted living and adult care home services;
- RAI-HC for home care services;
- RAI-AC for acute care services;
- RAI-MH for mental health services; and
- RAI-Post Acute Care.

Currently there is no RAI-type instrument to assess people with developmental disability, but *inter*RAI is contemplating the development of such an instrument.

Each instrument in the RAI family is a standardized assessment tool that measures common dimensions of functional and health status, such as cognition, communication, physical activity, continence, and behavior and mood. While each of the instruments has certain similarities, they also differ in that they reflect the more common care needs associated with different types of settings. Many of the RAI instruments used in care planning also include 'triggers' for changes in status signaling a need for a more thorough assessment and protocols for assessing and planning care.

States have used resident assessment instruments (RAI) for care planning, care management and to monitor quality of care.

As noted above, the RAI instruments are commonly used for care planning and care management. However, they are also used for other purposes. The demographic information about the users of long-term care services are used by states for planning purposes, and to monitor outcomes of care and performance of providers. Some states have used this information to establish a case-mix reimbursement methodology for long-term care services. Additionally, an RAI level of services assessment instrument has been used in at least one state to conduct level of

service need assessments to determine eligibility for public payment of services.

A Uniform Portal of Entry System With Uniform Assessment

In order to reduce fragmentation, multiple assessments and confusion on the part of consumers, the NC • IOM Long-Term Care Task Force recommends:

DHHS should develop a uniform portal of entry to reduce fragmentation and confusion for individuals & their families needing long-term care services.

4. **The North Carolina Department of Health and Human Services develop a "uniform portal of entry" system for long-term care services.**

   The uniform portal of entry system should be defined by functions, as opposed to place or agency. Uniform portal of entry characteristics include:

- **Common information and assistance, screening and level of service assessment tools;**
- **Automated information sharing between agencies (local to local and local to state);**
- **Entry functions (information and assistance, screening, initial level of service assessment and financial eligibility determination) as readily accessible and understandable to consumers as possible; and**
- **Simplification of the financial eligibility determination process. The state should develop mechanisms to simplify the application process, for example, by outstationing Division of Social Services personnel, collecting the financial information by other agencies and transmitting it to DSS, or where possible, having the same agency that conducts the initial level of service assessment conduct the financial eligibility determination.**

  The state should provide guidelines and parameters for the uniform portal of entry system, but which agency provides what services would be determined locally. In designing the uniform portal of entry, DHHS should examine whether this system should be expanded to include long-term care services for people with developmental disabilities, or if not, how the uniform portal of entry can be coordinated with the existing system for people with developmental disabilities.

In order to move forward with a uniform portal of entry system, the NC • IOM Long-Term Care Task Force recommends:

5. **The North Carolina Department of Health and Human Services begin using uniform screening, level of services assessment and care planning instruments based on the RAI family of instruments. These instruments should be used by the Division of Social Services (DSS), Division of Aging (DOA), and Division of Medical Assistance (DMA) for all long-term care services.**

While some standardized assessment instruments are fully developed (e.g., the Resident Assessment Instrument (RAI) for nursing homes and home care), other screening and assessment instruments are not fully developed. Additionally, modification of existing as well as yet-to-be-developed tools to meet North Carolina's system requirements may be needed. Thus, a work group inclusive of technical experts and provider and state agency representatives is necessary. The NC • IOM Long-Term Care Task Force recommends:

6. **The NC • IOM facilitate the formation of an Instruments Technical Work Group that would:**

- **Identify, modify or develop a Resident Assessment Instrument (RAI) compatible screening tool. The screening tool should be compatible with existing information and assistance systems, compatible with the to-be-developed level of service assessment instrument, and compatible with the RAI family of instruments;**
- **Develop a level of service instrument from the modules of the RAI family of instruments. The level of services assessment instrument should: be less detailed than the care planning instrument; help consumers and providers determine the level and type of service needed or desired, whether or not the consumer is seeking public funding for long-term care services; and eventually be used to substitute for the FL-2 and other level of services eligibility tools used by the state;**
- **Develop consumer preference items, if needed, for the RAI family of instruments;**
- **Explore whether to use the RAI family of instruments for long-term care services provided by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS), or whether the specialized assessment tools used by MHDDSAS can be coordinated with the use of the RAI family of instruments for long-term care services;**
- **Explore whether to use the RAI family of instruments for long-term care services provided by the Division of Vocational Rehabilitation and/or Services for the Blind;**

Further work is needed to refine screening, level of service and care planning instruments

- **Review RAI generated information to use in measuring outcomes and setting outcome goals for both individuals and the system;**
- **Develop training protocols and work with people in the field to garner support for the use of the new tools;**
- **Evaluate the cost of universal screening and assessment across the whole system; and**
- **Set a timetable for developing, modifying and testing instruments in the field.**

The Instruments Technical Work Group should help develop the level of services assessment instrument but would not determine the medical and functional status criteria to be used in determining eligibility for public payment of services. The medical and functional level of services eligibility criteria will continue to be set by state agencies. Everyone seeking out-of-home services in a long-term care facility or seeking public funding for in-home or community-based long-term care services would be required to use the universal level of service assessment instrument to determine what level and types of services are needed. In addition, the assessment would be available to anyone else on a private pay basis.

Members of the Instruments Technical Work Group should include state and local government agency representatives, care providers, consumers and academics experienced in tool development and outcome measurement. The Instruments Technical Work Group process should be open to the input of others.

The Secretary of DHHS would offer the public an opportunity for public comment on the tools before the state mandated their use.

Chapter 3

Availability of Long-Term Care Services

The NC General Assembly directed the NC Department of Health and Human Services to develop a system that provides a continuum of long-term care services for elderly individuals and people with disabilities.[13] To address this requirement, the North Carolina Institute of Medicine (NC•IOM) Long-Term Care Task Force examined three issues:

1) What core long-term care services should be available to all North Carolina citizens?
2) How available are these core services, and does availability vary by geography?
3) How can North Carolina project need for long-term care services? What is the appropriate availability of services now? In the future?

CORE LONG-TERM CARE SERVICES

North Carolina currently offers an array of services to individuals needing long-term care. They range from institutional services offered in a hospital or nursing home, to services provided to enable a person to live at home. For example, these services include:

Institutional Care:
- State mental hospitals
- State ICF-MR facilities
- Acute care hospitals
- Rehabilitation hospitals
- Skilled nursing facilities

Residential Care:
- Adult care homes
  - assisted living facilities
  - homes for the aged
  - family care homes
  - multi-unit assisted housing with services
- Continuing care retirement communities
- Retirement villages
- Congregate housing for the older adults
- Group homes for people with mental illness
- Group homes for people with developmental disabilities

Community-Based Care:
- Adult day care/day health care centers
- Community mental health centers
- Senior centers
- Congregate nutrition/meals

In-Home Services:
- Home health
- In-home aides
- Home delivered meals
- Respite care
- Sitter services
- Home modifications and repairs
- Medical alert services

Other Services Necessary to Support Older Adults and People with Disabilities:
- Information and Assistance
- Medical services
- Mental health and services for people with developmental disabilities
- Dental, vision, and hearing services
- Transportation
- Legal services
- Adult protective services

The Task Force identified the "core services" that should be available and accessible to consumers both geographically and economically.

Ideally, every individual should have a choice of long-term care services that would best meet their needs and would result in high-quality, cost-effective and least restrictive setting. However, the Task Force recognized that it was not realistic to expect all of these services to be readily available throughout the state. Instead, the Task Force identified the "core services" that should be available and accessible to consumers both geographically and economically. The Task Force recommended:

7. **Every North Carolinian should have access, either in the county or within reasonable distance from the county, to the following long-term care services:**

   - **Long-term care information and assistance services**
   - **Transportation**
   - **Housing and home repair and modification**
   - **Home delivered meals**
   - **Durable medical equipment and supplies**
   - **Medical alert or related services**
   - **Nursing services**
   - **Adult day care/day health care or attendant care (including respite care)**
   - **In-home aide services**
   - **Home health care**
   - **Adult care homes (various types)**
   - **Nursing homes**
   - **Care management for high-risk or complex conditions**

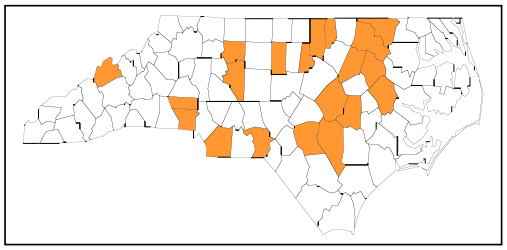
   In addition to the long-term care services listed above, older adults and people with disabilities need other medical, mental health, dental, vision, and hearing services to meet their health and functional needs. Individuals who have functional, medical or cognitive impairments may also need guardianship services or protective services to ensure that their long-term care needs are being met.

Availability of Long-Term Care Services

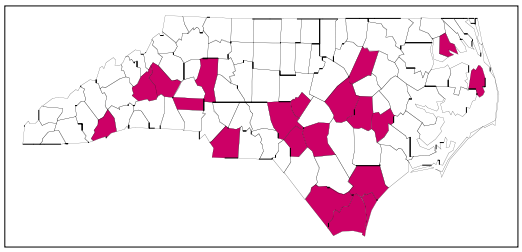
The Task Force tried to determine the availability of existing long-term care services. Limited data are available for this purpose. Specifically, the state collects data on nursing home and adult care home bed capacity; as well as expenditures and utilization of some long-term care services funded by Medicaid and the Home and Community-Care block grant (HCCBG) program, Social Services Block Grant (SSBG) programs and programs funded through Public Health. Building on an earlier study,[14] the Task Force obtained utilization data for Medicaid personal care services (PCS), Community Alternative Program for Disabled Adults (CAP-DA), and HCCBG and SSBG in-home aides, adult day care/adult day health and home delivered meals. While these utilization data are a useful starting point—they have serious limitations. First, the

state collects little information on the use or need for long-term care services in the private market.[15] Second, while the state maintains information about the use of some publicly funded long-term care programs, they do not collect similar information on the unmet need for these same services.

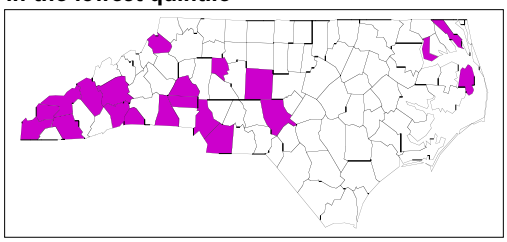
Counties with the CAP-DA ratios in the lowest quintile



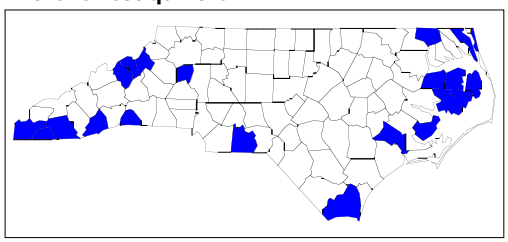
Counties with the Nursing Home Bed Supply in the lowest quintile



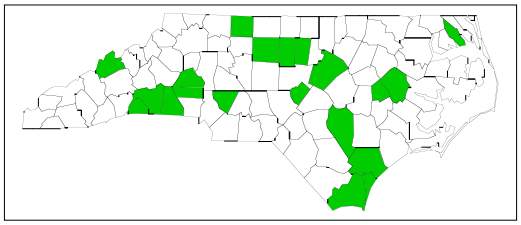
Counties with Medicaid Personal Care Services in the lowest quintile



Counties with the Adult Care Home Bed Supply in the lowest quintile



Counties with HCCBG In-Home Aide Services in lowest quintile



The availability of LTC services varies by county.

The Task Force used the data the state does collect to estimate the relative availability of long-term care services.[16] (See Appendix A). The availability of long-term care services varies greatly by county. For example, the rate of licensed nursing home beds per 1,000 older adults ranged from 25.4 in Brunswick county to 89.1 in Hyde county (state average: 42.2/1,000). There was even greater variation in utilization of CAP-DA services. Utilization varied from 8.39 individuals per 1,000 Medicaid aged and disabled in Johnston county to 200 per 1,000 in Avery county (state average: 36.0/1,000). The Task Force was unable to identify specific counties or regions of the state that consistently provided fewer long-term care services in comparison to other counties. Generally, counties offered more of some types of services and less of others (in proportion to their population).

Some of the counties that were low in the provision of in-home services among some funding streams were the same counties that were higher in the provision of in-home services among other publicly funded programs. The Task

Force heard testimony that some providers were willing to participate in certain publicly funded programs, but not in others. There were 112 agencies that provided in-home aide services through the HCCBG program in SFY99. Sixty of these agencies were either not enrolled as Medicaid providers, or were enrolled but did not bill Medicaid for any personal care services.[17] Medicaid establishes a fixed reimbursement rate that applies to all personal care providers, whereas each county has the flexibility of negotiating reimbursement rates for services provided through the HCCBG. The Medicaid personal care services reimbursement rate was $12.32 per hour, compared to the average HCCBG rate for in-home aide services of $12.92. The adequacy of the Medicaid reimbursement rate was an issue for some, but not all providers. Half of the 60 providers that did not bill Medicaid for personal care services had average reimbursement rates that were equal to or less than the Medicaid personal care services rate. In follow-up interviews with the HCCBG providers with higher reimbursement rates, the state found that many of these providers were offering their staff retirement and health insurance benefits.

Forcing individuals to change providers when they change their source of public subsidy causes disruption in the person's continuity of care.

There are different reasons why agencies do not participate in Medicaid: such as low reimbursement rates or a lack of capacity to accept additional clients. However, the failure of these agencies to participate in all publicly funded programs causes problems. First, individuals who are receiving services from one provider may be forced to switch to another provider if they change their source of public subsidy (for example, when a person who was receiving HCCBG or SSBG services becomes eligible for Medicaid). This shift in providers causes a disruption in the client's continuity of care. In addition, this system is an inefficient way to provide long-term care services, as the HCCBG and SSBG funds are limited and require higher state and county matches than does Medicaid.

The Task Force recognized that some people who are Medicaid-eligible may still legitimately use HCCBG or SSBG services. For example, Medicaid does not pay for adult day care. If a Medicaid eligible person wants adult day care, he or she would have to be covered through the HCCBG program. However, the Task Force wanted to ensure that Medicaid-eligible individuals obtain covered Medicaid services through the Medicaid program rather than through limited HCCBG or SSBG funds.

8. **The NC Department of Health and Human Services should explore the possibility of establishing uniform payment rates for in-home aide services across funding streams. The Department should explore the need, if any, for regional variations in reimbursement rates or shift differentials.**

9. **If the state establishes more uniform rates, the Department of Health and Human Services should consider requiring all licensed providers of long-term care services that participate in state-funded programs to provide some services to Medicaid clients. The goal of this recommendation is to ensure that consumers can continue to be served by the**

same provider if they change their source of public financing for these services, and to maximize the use of federal Medicaid funds.

Need for Long-Term Care Services

While the Task Force was able to get some information about the existing array of services, it did not have any data to determine whether the existing array of services was adequate to meet the long-term care needs of older adults or people with disabilities today or in the future. Further study is needed to determine the appropriate array of long-term care services, and to determine the minimum amount of core services which should be available in each county. A methodology is needed to project the need for long-term care services.

The North Carolina Institute of Medicine contracted with a private consulting firm to obtain projections of the need for in-home, community and residential long-term care services. These projections should be available later this summer and will be included in the final report.

Local Planning

As noted in Chapter 2, long-term care services are often fragmented, duplicative, complex, and not consumer-friendly. Further, many counties lack needed core long-term care services. Most, if not all, counties in the state have planning bodies that are charged with developing plans for specific long-term care services. Under state law, county commissioners must designate lead agencies for the Home and Community Care Block Grant (HCCBG) and the Medicaid Community Alternative Program for Disabled Adults (CAP-DA). In all but about 20 counties, these lead agencies are separate organizations. A small number of counties have initiated a more comprehensive and inclusive planning process to identify needed long-term care resources and to reduce fragmentation.

A comprehensive planning process is needed statewide to encourage capacity building for long-term care services and the development of a consumer friendly system of care and services.

A comprehensive planning process is needed statewide to encourage capacity building for long-term care services and the development of a consumer friendly system of care and services. Local or regional planning bodies could promote the development of a consumer-centered system of care and services with highly visible entry points, encourage the "balanced" development of core services in counties or regions, and develop the readiness to work with standardized instruments and data sharing across agencies. The NC • IOM Long-term care Task Force recommends:

10. **The NC General Assembly should encourage county commissioners designate a lead agency to organize a local long-term care planning process at the county or regional level.**

    The local planning initiative should broadly represent agencies involved in the provision of long-term care services, including: representatives of local social service departments, health departments, area mental health programs, aging councils and departments, HCCBG and CAP-DA lead agencies, hospitals, home health and home care agencies, nursing homes, assisted living facilities, adult day care/adult day health agencies, group homes for people with mental illness or developmental disabilities, independent living facilities, area agencies on aging, long-term care ombudsman, community advisory committees, older and disabled adults and their caregivers, advocates for older and disabled adults, and representatives of county government. The local planning committee should be required to:

    - **review and analyze service utilization data through county data packages;**
    - **track the flow of consumers from referral to disposition through core service agencies;**
    - **identify barriers to a comprehensive system of care and services;**
    - **determine how to design the uniform portal of entry;**
    - **determine the need for additional core long-term care services; and**
    - **communicate findings to local, state and federal policymakers.**

    To facilitate these local-planning efforts, DHHS, in conjunction with the NC•IOM, shall:

    - **develop county data packages which include information on the number of people age 18 or older using publicly-funded long-term care services at the county level, and expenditures for these services;**
    - **provide information on the availability and need for core services in each county and the balance of different services needed; and**
    - **provide technical assistance to counties to assist them with their long-term planning process.**

Chapter 4

Work Force

North Carolina is in the midst of a long-term care workforce crisis. Efforts to design a long-term care system that ensures availability of services and high-quality care is somewhat meaningless, absent a supply of trained professional and paraprofessional staff – including nurse aides, nurses, doctors and allied health professionals.

Nurse Aides

Nurse aides and other paraprofessionals provide most of the direct long-term care services to individuals, whether at home or in a facility. These workers help individuals with their most basic needs—including bathing, dressing, eating, and toileting. In addition, paraprofessionals often help with housekeeping tasks, and may help administer medications, change bandages or monitor changes in a person's health status.

North Carolina, like the rest of the nation, is experiencing a severe shortage of paraprofessionals trained and willing to work in the long-term care industry.

North Carolina, like the rest of the nation, is experiencing a severe shortage of paraprofessionals trained and willing to work in the long-term care industry. Between 1990 and 1998, there were almost 180,000 North Carolinians trained to work as nursing assistants.[18] Yet, less than half of these trained personnel are currently certified to work as a nurse aide. The annual turnover rate among aides who worked in nursing homes exceeded 100% in 1999. The annual turnover rate was even higher among aides who worked in adult care homes (140%). North Carolina will need more than 21,000 additional nurse aides and other paraprofessionals to meet the long-term care needs of older adults and people with disabilities over the next five years.

There are a number of reasons for the problems in recruiting and retaining paraprofessionals: low wages, few benefits, no career path, physically demanding work, lack of opportunity for meaningful input into client care, inadequate recognition and appreciation, and inadequate exposure to "real life" job demands during training.[19] The state's low unemployment rate (3.0% in April 2000 compared to 3.9% nationally[20]) further exacerbates the current worker shortage.

A recent study that examined the job history of nurse aides that stayed in the field compared to those that left the industry showed that people who left the industry have higher wages and are more likely to work for one employer (versus multiple part-time jobs).[21]

Table 4.1
Comparison of Nurse Aides Currently Working versus Not Working in the Long-Term Care Industry

	Currently working in the LTC industry	Not working in the LTC industry
Median wages from all sources	$11,358	$14,425
Wages for the highest 20% of earners from all sources	$18,369	$25,505
Average number of sources of income	1.89 employers	1.05

One caveat to this data is that it includes individuals who were certified as nurse aides during their training as nurses—that is, some of the people who are no longer working in the industry may be individuals who were being trained as nurses and who could command higher salaries than nurse aides. The state's database of nurse aides does not distinguish between those nurse aides who received training and intended to work as aides, versus those who were certified as nurse aides during their nursing education. However, most experts suggest that the findings of this study would remain the same even if the study excluded those individuals who were in training for a nursing position.

Most states around the country are struggling with the same problem. The NC Division of Facility Services conducted a study of other states' responses to this problem in 1999.[22] The study identified a number of different policy responses to try to increase paraprofessional recruitment and retention, including:

States have developed a number of strategies to address the severe shortage of paraprofessionals willing to work in the long-term care industry.

- *Wage and benefit pass throughs:* these pass-throughs require that increased reimbursement be used to enhance paraprofessional salaries. Some of the states implemented wage pass-throughs based on a set dollar amount per worker per hour or per client day; other states established a wage pass through as a percentage of the increase in the reimbursement rate.
- *Enhancement incentives:* tying reimbursement increases to increased performance by providers and staff. For example, Rhode Island is offering enhanced reimbursement based on shift differentials, client satisfaction, level of client acuity, level of provider accreditation, continuity of care, and level of worker satisfaction.
- *Higher reimbursement for shift differentials:* some states have addressed the problems agencies and facilities experience recruiting evening and weekend staff to work by paying higher reimbursement rates for in-home aide services provided during non-traditional work hours.
- *Transportation reimbursement:* one state (WA) passed legislation requiring home care providers to pay aides for the time spent in their cars traveling from one location to another.

- *Career ladders:* several states passed legislation creating career ladders for nurse aides. For instance, a separate set of standards for homemaker and personal care positions was legislated in Mississippi. In Missouri, the Advanced Personal Care Unit, which allows an aide with advanced training to serve consumers who need more complex care (this is an exception to the Nurse Practice Act) has had the unintended effect of serving as a career ladder for aides. There is also provision of more training and salary advancements for the aides, creating a step up within the home care industry. There is a higher reimbursement rate for these clients, which leads to higher aide wages.[23]
- *Training:* some states are developing additional training requirements for nurse aides; either as part of the minimum training or through continuing education requirements.[24]
- *Training former welfare recipients:* some states are encouraging welfare recipients to enter into nurse aide training programs.
- *Training volunteer populations:* some states have explored the idea of using volunteers to provide some in-home aide services.

The NC Division of Facility Services obtained a grant from the Kate B. Reynolds Charitable Trust to work with the NC Institute on Aging to identify strategies to address the nurse aide workforce shortage. Part of the grant was used to study the differences in salary and the job stability among certified nurse aides who are actively employed in health care facilities compared to those who left the field (described previously). In addition, the grant will be used to revise the state curriculum for nurse aides; test incentives that are effective in promoting continuing education and career paths; and educate the public about the long-term care workforce crisis.

Other Health Professionals

Registered nurses

Registered nurses (RNs) have the day-to-day responsibility for overseeing the health care needs of nursing home residents. While supported by on-call physicians, nurses are the first point of contact when residents have a health care problem. Most registered nurses working in the long-term care industry are graduates from two-year associate degree programs rather than four-year baccalaureate nursing programs.[25] There were 10,568 registered nurses in 1999 that listed their primary specialty as geriatrics, or listed their primary practice as long-term care or home care/hospice.[26]

A study of newly registered nurses in North Carolina in 1997 showed that new RNs were given very little orientation or training once entering the long-term care industry. On average, these nurses were given only two and a half weeks of orientation in nursing homes, compared to a six-week hospital orienta-

tion in rural areas, or a nine-week hospital orientation in urban areas.[27] Further, RNs in nursing home settings were asked to take on full resident loads more quickly than nurses in other settings. Nurses in long-term care settings are also more likely to have supervisory responsibilities, supervising LPNs or nurses aides. This may create problems, as few nursing programs offer extensive management training.

The NC Institute on Aging, along with the NC Division of Facility Services is in the process of surveying nursing administrators of long-term care facilities and agencies. They are gathering information on salaries, benefits, turnover and job satisfaction. The results of this survey are expected later this year.

Licensed practical nurses (LPNs) also play a critical role in the care for older adults and people with disabilities in long-term care settings. In nursing home settings, LPNs often have direct supervisory responsibility for nurse aides. Like RNs, LPNs have little opportunity for management training in school. In home care settings, LPNs perform duties within their scope of practice; however, they cannot perform supervisory visits for Home Health Aides, nor case management of clients. While they may not perform independent assessments, they do gather and document information. In 1999, there were 5,748 LPNs in North Carolina with their primary employment in the long-term care facilities; another 654 were serving in home care and hospice settings.[28]

Geriatricians and Geriatric Nurse Practitioners

There is also a dearth of geriatricians and geriatric nurse practitioners.

There is also a dearth of physicians who have specific geriatric expertise or training in long-term care issues. In North Carolina, there are only 20 physicians who list a primary specialty in geriatrics on their medical licenses; 65 physicians list their primary practice location as a nursing home or extended care facility.[29] Approximately half of the physicians who listed their primary practice location as a nursing home or extended care facility listed their primary specialty as family practice, internal medicine, general practice or psychiatry.[30] While this is not the universe of physicians caring for older adults or people with disabilities in long-term care settings; it does indicate a lack of specially trained physicians with expertise in the needs of the frail elderly or people with physical or cognitive disabilities. All four of the medical schools in North Carolina offer geriatric fellowships; but these programs only graduate approximately 10 to 12 fellows per year (and not all of these physicians set up practice in the state). This problem is not unique to North Carolina. In 1998 Medicare helped to support nearly 100,000 residency and fellowship programs, of which 324 were in geriatric medicine and geriatric psychiatry. In 1998 there were 8,000 geriatricians and geriatric psychiatrists practicing in the US.[31] The estimated population of people 65 and older in the United States in 1998 was 34.4 million.[32]

In addition to the geriatricians or physicians with specific geriatric expertise, there are 68 geriatric nurse practitioners in North Carolina. The communities with the highest concentration of specially trained physicians and nurse practitioners are those with major hospitals or medical schools. Twelve geriatri-

cians practice in Durham, Forsyth, or Orange counties. Twenty-five geriatric nurse practitioners are located in Forsyth and Guilford counties. Eighty-nine counties are without geriatricians and 74 counties are without nurse practitioners with specific geriatric or long-term care specialty.

Physical Therapists and Physical Therapy Associates

Physical therapists also play a critical role in addressing the long-term care needs of older adults and people with disabilities. Physical therapists are used in home care to provide services similar to those provided in out-patient settings or in the hospital. Clients have usually suffered paralysis, weakness, and/or decreased endurance due to an acute episode that required hospitalization, joint replacements, etc. Physical therapy services are usually of short duration, no more than 60 days and often from 3-6 weeks.[33] In 1998, there were 301 physical therapists employed by a nursing home in North Carolina, and another 440 employed by a home health agency.[34] In addition to the physical therapists, there were 332 physical therapy assistants who worked for nursing homes, and 323 employed by the home health industry. Physical therapists and physical therapy assistants are located throughout North Carolina; however, ten counties lack a physical therapist who is employed by a nursing home or home health agency, two counties lack a physical therapy assistant employed by a nursing home or home health agency, and two counties, Washington and Yancey, lack both physical therapists and physical therapy assistants in nursing home or home health settings.

Clearly more needs to be done to address the shortage of trained paraprofessional and professional staff to provide long-term care services. The Task Force recommends that the state implement policies that would improve the training, salaries and benefits offered to these staff. In addition, the industry has a role to improve the work environment and increase job satisfaction.

11. **The North Carolina General Assembly should enact a carefully monitored "labor enhancement" to publicly-funded long-term care reimbursement rates to improve staff recruitment and retention. Providers should be allowed flexibility in utilizing labor enhancement funds, so long as its use is directed toward its intended purpose. Managers need the flexibility to vary salary increases among staff, especially senior certified nurse aides. Further, adding staff, increasing benefits, offering shift differential payment levels, developing scholarship programs and other innovative mechanisms to stabilize the workforce may be more appropriate solutions in some cases. The NC Department of Health and Human Services should develop safeguards to ensure that the enhanced reimbursement rates are used for staff recruitment and retention.**

The Task Force recommends that the state implement policies that would improve the training, salaries and benefits offered to long-term care staff. In addition, the industry should take steps to improve the work environment and increase job satisfaction.

12. **The NC Department of Health and Human Services, along with the NC Department of Insurance, should explore ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and non-residential long-term care facilities and agencies.**

13. **The NC Department of Health and Human Services should convene a work group that includes the long-term care industry, medical schools, schools of nursing, the North Carolina Board of Nursing, community colleges and other appropriate groups to explore options to expand the availability of paraprofessional and professional staff available to provide long-term care services. As part of this study, the state may want to explore the need to re-engineer the long-term care workforce; to determine how to best utilize existing staff, the need for new or different training requirements, or whether new categories of staff are needed to address long-term care needs.**

14. **The NC Healthcare Facilities Association, NC Association of Long Term Care Facilities, NC Assisted Living Association, NC Association for Home and Hospice Care, NC Family Care Facilities Association, NC Adult Day Services Association, NC Association on Aging, Mental Health Association of North Carolina, Developmental Disabilities Facilities Association, and NC Center for Nursing should develop a plan, either together or independently, to improve the retention rates among paraprofessional and professionals in the long-term care industry. The plan may include mechanisms to improve job satisfaction, increase pay, develop career paths or improve working conditions. Report(s) should be presented to the NC General Assembly no later than March 15, 2001.**

Chapter 5

Assuring Quality of Long-Term Care

DEFINING QUALITY OF LONG-TERM CARE

Although it is assumed that any service provided by a health care organization or professional licensed to provide that service will meet minimum standards of quality, steps to assure that this is the case are not always taken. Often complaints, or more serious legal actions, by clients of these services bring shortcomings and deficiencies of care to light. Any responsible public or private system of care must include reliable and effective procedures for monitoring and assuring that services offered meet accepted standards, that clients of these services are not put in harm's way from having used these services, and that the expected outcomes of care are realized.

In order for such goals to be realized in long-term care, there must first be consensus regarding the definition of quality of care, whether in residential or in home and community-based settings. Given the diversity of facilities, programs and services that are conventionally subsumed under the rubric of "long-term care," the definition of what is meant by "quality" is not a straightforward concept.

The North Carolina Institute of Medicine Task Force on Long-Term Care began its consideration of issues related to quality assurance with a discussion of the "hierarchy of needs" promulgated by Abraham Maslow.[35] From this conceptualization, Maslow postulated a series of five levels of needs every person attempts to meet in various ways, regardless of their residential or general life situation. These are: physiological needs, security and freedom, social needs, self-esteem, and self-actualization. If these different levels of needs are applied to the field of long-term care, the following considerations may be identified:

- *Physiological needs:* nutrition, hydration, sleep, outdoor access, freedom from pain and discomfort.
- *Security and freedom:* freedom from hazards, privacy.
- *Social needs:* companionship, respect from others, affection, family relationships and social support.
- *Self-esteem:* independence, personalization, meaningful activities.
- *Self-actualization:* optimal quality of life.

One of the most challenging aspects of quality assurance, especially in long-term care, is the necessity of making "trade-offs" among different aspects of daily living arrangements, some having positive and some negative influence on the overall quality of life. For example, there is often a real dilemma in long-term care as decisions are made about the relative allowable freedom of movement for frail elders who are at risk of falls. While overall quality of life may be enhanced through allowing such persons to be mobile on their own, perhaps

One of the most challenging aspects of quality assurance, especially in long-term care, is the necessity of making "trade-offs" among different aspects of daily living arrangements, some having positive and some negative influence on the overall quality of life.

with the aid of a walker or the use of handrails instead of using a wheelchair or other mobility assistive technology, the risk of falls may be measurably increased. There are few issues in long-term care as sensitive as the issue of use of physical or pharmacological restraints. Here the trade-offs are between the relative values of physical comfort and sedation used to protect an individual from self-induced risk or potential harm to others. Though less use of restraints may lead to greater individual autonomy in many aspects of daily living, this may also increase the possibility of falls and therefore decrease safety.

The fact that such trade-offs are an unavoidable aspect of quality of care decision making in long-term care is well recognized, but there are often insufficient arrangements for the inclusion of clients/residents/families in making such decisions. When shared decision making occurs, there can be a mutual understanding of the difficulty of achieving goals that may seem diametrically opposed, but also an appreciation of the unfairness of judging quality from one side or the other of such decision dilemmas.

It is tempting to make quick and sporadic judgements of long-term care providers when one observes a choice has been made (either consciously or unintentionally) to opt for one side or another of these very complex trade-off situations. It is therefore useful to work toward the use of conceptual frameworks like the one developed by Maslow in evaluating overall strategies for the assurance of quality in long-term care. However, when one is faced with the task of measuring the on-going level of quality in a given facility or program of care, it is obviously difficult to select the most salient and valid indicators of quality of care.

Essential Steps Toward Quality Assurance

The Long-Term Care Task Force chose to make a distinction between two separate steps in the effort to assure quality of care in the state's long-term care arena. The first of these is quality *assessment* (or measurement*)*. The second is quality *assurance* (or improvement). While the former gives emphasis to technical issues related to the measurement of critical dimensions of health care quality, beginning with efforts to define those dimensions to be measured, the latter involves the implementation of a system of planned measurements and follow-up correctional/care improvement strategies that are intended to ensure accepted standards of care are met on a day-to-day basis by those offering these services. Both rely on the existence of consensus with regard to the *standards* by which quality will be defined.

Definitions of good quality long-term care may vary depending on whether quality is being defined by consumers (including resident/ clients/families), industry providers, regulators or by payers/purchasers/insurers.

Definitions of good quality long-term care may vary depending on whether quality is being defined by consumers (including residents/clients/families), industry providers, regulators or by payers/purchasers/insurers. The effort to agree on so-called "gold standards" of care is not an insignificant or easily attainable goal. Consumers (or their families) may wish to see evidence that day-to-day life in a residential care facility closely approximates the autonomy and range of activities that one might have enjoyed while living in more conven-

tional home and community-based settings. Industry providers face the difficult task of offering a similar level of nursing/medical/assistive and personal care for all residents for whom they are responsible while attempting to allow for individual differences in preferences and capacities. There will always be issues of relative deprivation, attention, acuity of needs, and preferences where multiple residents, often of different ages, genders and levels of functional capacity and health status, coexist in the same facility. Choosing either *generic* categories of service or outcomes within which to measure quality of care, or *specific* measures to reflect these broad categories, can be difficult. Providers have to face another major criterion in making such decisions that consumers rarely consider. This is the relative cost-efficiency of elements of care that might be offered to clients.

Assigning Responsibility for Quality Assurance in Long-Term Care

It is important that both quality assessment and assurance not be seen as solely the responsibility of regulators, but as useful tools of long-term care providers and as integral components of facility and program management. The criteria used for the assessment of quality of care ideally should be the *same* quality indicators whether being used by provider organizations or by agencies of county, state or federal government responsible for monitoring and regulating the provision of such care to the general public.

It is important that both quality assessment and assurance not be seen as solely the responsibility of regulators, but as useful tools of long-term care providers and as integral components of facility and program management.

The Long-Term Care Task Force takes the view that both sanctions and rewards are required to motivate efforts within this industry that will assure good quality of care. Whereas agencies of government charged with regulatory responsibilities have the task of monitoring quality and imposing penalties when deficiencies are observed in order to motivate quality-oriented change, the efforts of these agencies are usually mounted in relation to only minimal standards of care. These standards are ones for which readily available, reliable measures are obtainable by on-site inspectors in relatively short periods of observation or information collection. Regulatory agencies, like the Division of Facility Services (DFS) of the North Carolina Department of Health and Human Services (DHHS), are delegated the responsibility under federal law for collecting survey data pertinent to criteria prescribed by the Health Care Financing Administration (HCFA) from every nursing home approved for Medicare reimbursement in the state. DFS has 76 full-time equivalent (FTE) personnel assigned to the task of surveying nursing homes in North Carolina. These personnel receive two weeks of training by federal HCFA officials and must pass the Surveyor Minimum Qualifications Test before conducting surveys independently. Additional components in licensure and certification training are also federally required.

All facilities licensed as nursing homes are surveyed at least annually by DFS personnel unless there are extenuating circumstances that require re-surveying more frequently. Periodic look-behind surveys are conducted by HCFA to determine the adequacy of DFS survey methods and assessment results. The criteria specified by HCFA for the assessment of nursing home quality of care include measures in each of the following categories: accidents, behavior/emo-

tional patterns, clinical management, cognitive patterns, elimination/incontinence, infection control, nutrition/eating, physical functioning, psychotropic drug use, quality of life and skin care.[36]

There are 631 adult care homes in North Carolina with seven or more beds, 801 family care homes with six or fewer beds, 217 facilities (nursing homes and hospitals) that have adult care beds, and 233 homes for developmentally disabled adults (licensed under N.C.G.S. §131D),[37] and 1,216 facilities providing long-term care services to people with mental illness or developmental disabilities that are licensed under N.C.G.S. §122C.[38] The responsibility for monitoring the quality of care of these institutions is split between the NC Division of Facility Services (DFS) and county Departments of Social Services (DSS). The Division of Facility Services has the responsibility for monitoring group homes for the developmentally disabled or people with mental illness licensed under N.C.G.S. §122C, and for inspecting the adult care home beds in nursing homes and hospitals. County DSS have responsibility for monitoring free-standing adult care homes, family care homes, and group homes for the developmentally disabled that are licensed under N.C.G.S. §131D. DFS specifies the criteria to monitor these facilities, but the Adult Care Home Specialists within county Departments of Social Services are responsible for the routine inspections, and also investigate most specific complaints.

County Adult Care Home Specialists are, as of 2000, generally classified as Social Worker III personnel under the state personnel system, though not all counties have implemented this change. A history of high turnover rates among county-level inspection personnel motivated this change in the position classifications for those performing these important tasks. Statewide there are 153 Adult Care Home Specialists that have the responsibility of inspecting 1,568 adult care homes.[39] Many of these specialists have other responsibilities in addition to their inspection work. On average each Adult Care Home Specialist works only .59 FTE on inspections. County DSS inspectors receive standardized training from the Division of Facility Services. The Division of Facility Services offers basic training for Adult Care Home Specialists twice a year. There is also extensive training available for specific areas such as how to write negative actions proposals or how to monitor medication administration. Specific criteria and measures of quality are required to be used across the state by county inspectors of adult care homes.

Some, but not all, of the information collected at the county level is reported to the state. For example, the Division of Facility Services collects reports that require the imposition of a fine and any inspection with DFS involvement (for example, for facilities that have serious or repeated violations). In addition, the counties are required to forward corrective action plans to the state. However, inspection reports that do not require the imposition of a penalty or a corrective action plan are not routinely reported to the state. This makes it difficult for the state to determine (as it does for nursing homes and home health agencies) the extent to which quality varies by county or region of the state, across different types of facilities (non-profit vs. for-profit) or by corporate ownership.

The assessment and monitoring of quality of care in home health agencies is done by the Division of Facility Services through the efforts of seven state inspectors on the DFS staff. These inspectors receive one week of basic orientation, one week of training on how to conduct investigations, one week of HCFA training, and four weeks of field training with another surveyor.[40] There are 186 agencies providing federally certified home health care in North Carolina; another 899 agencies provide home care (usually personal care services) but are not federally certified. Four DFS inspectors monitor the care provided in home health agencies; three inspectors monitor the care provided in home care agencies (i.e., agencies that are not federally-certified for the care of Medicare clients). All home health care services in North Carolina are monitored by DFS, except in the case of complaints or issues related to adult protective services, which are handled by county departments of social services. Twenty percent of all home health agencies are surveyed by DFS personnel on an annual basis, with the total number of such programs surveyed once every five years unless reasons for more frequent surveys occur. The Division of Facility Services receives few client/family complaints about the quality of services provided by home health agencies in our state, but quality of care concerns and conflicts between in-home consumers and providers do occur. Assuring the quality of care provided to individuals in their home is difficult, because of the numerous sites of care, the vulnerability and isolation of the person receiving care, and the lack of knowledge about the relationship between the care provided and outcomes.[41]

Definitions of what constitutes a good outcome may vary by type of setting or clientele.

Another important program addressing quality of care concerns in North Carolina long-term care facilities is the state's Ombudsman Program. North Carolina has a statewide Ombudman, along with 26 regional Ombudmen. The regional Ombudsmen work with over 1,500 community advisory member volunteers who work at the county level. The purpose of the long-term care Ombudsman program is to address complaints about long-term care facilities, to intervene where possible to work out understandings and mutually acceptable resolutions of identified problems arising between clients and staff in these facilities, and to report patterns of deficiencies to the state DFS or county Departments of Social Services where warranted. These complaints can come from anyone including families, residents, caregivers or the general public. The regional long-term care Ombudsmen are required to participate in a certification process which includes a four-day orientation, four internships (one each in a nursing home, adult care home, family care home, and developmentally disabled adults home), as well as reviewing extensive materials provided by the state and federal government. Additionally, in North Carolina there is mandatory training on a quarterly basis to ensure that the regional long-term care Ombudsmen are updated on regulations and processes. The community advisory committee volunteers are trained by the regional long-term care Ombudsmen, using a curriculum provided by the NC Division of Aging. Initially community volunteers must complete a minimum of fifteen hours of training, with an additional ten hours of in-service training each year in their role as grassroots advocates.[42]

The availability of long-term care Ombudsmen and community advisory committee volunteers with appropriate training across the state varies from

county-to-county, yet the service provided by the long-term care Ombudsmen has been considered valuable by both clients/families and by providers of care.[43] Prior to entering a nursing home, DFS calls on the appropriate regional long-term care Ombudsman regarding any complaints or concerns that have been filed for that facility. The inspection system for adult care homes does not routinely utilize reports from the community advisory committee volunteers or information from the regional long-term care Ombudsman.

In all of these on-going governmental efforts toward the monitoring of quality of care in North Carolina's long-term care facilities and programs, there is a need to standardize the definitions of the dimensions of quality to be assessed, the measurement of each dimension, and the collection and use of reports from inspections by both state and county officials. In the past, emphasis has been given to "structural" aspects of care (e.g., the presence or absence of certain physical facilities or personnel) and some minimal attention to the "process" of care (chart abstract evidence can substantiate such processes as bathing, feeding, changing of linens, etc.). It is generally easier for regulatory agencies to monitor "structure" and "process" than to measure "outcomes." Further, there is no clear consensus on what constitutes a good outcome, particularly among the frail elderly.[44] As noted earlier, issues of independence and freedom from restraints may conflict with concerns about falls and safety to self and others. In addition, definitions of what constitutes a good outcome may vary by type of setting or clientele. Older adults in their last months of life may not be expected to show significant improvement in functioning, whereas individuals with developmental disabilities may if provided appropriate services. The evaluation of quality in long-term care facilities that differ in such marked ways requires the adaptation of instruments and definitions of quality to these very different situations and sets of client/family expectations.

Past efforts at ensuring quality have been largely punitive. More emphasis should be placed on providing incentives to all facilities to improve quality.

In recognition of the complexity of quality assessment issues in long-term care, the Task Force took note of suggestions that there is a need to reconsider how quality is defined, what standards are possible, how these standards are incorporated in assessment instruments and measures used by regulatory agencies (county, state and federal), and how results of these assessments are shared with the general public. The Task Force recognized that past efforts at ensuring quality have been largely punitive, focusing on imposing penalties and correcting deficiencies among the few "bad" facilities; rather than trying to raise the level of quality among all facilities. More emphasis should be placed on providing incentives to all facilities to improve quality, and to remove regulatory and other barriers that impair these efforts. This effort should be a joint project between regulatory agencies, the long-term care industry, consumers and other interested parties. In addition, as the growth of home and community based services and consumer directed care is encouraged, adequate attention to defining and measuring quality for these services must be addressed. For these reasons, the Task Force recommends:

15. **The North Carolina Institute of Medicine, in partnership with the Division of Facility Services of the NC Department of Health and Human Services, should convene a Quality Standards Work Group with representatives from provider groups (nursing homes, adult care homes, and home care agencies), consumer groups, long-term care Ombudsmen, state regulatory agencies, local Departments of Social Services and academics. The purpose of this Quality Standards Work Group will be:**

    (a) **to come to consensus around interpretations of current rules and quality measures;**

    (b) **to develop broad multi-perspective definitions of quality for nursing homes, adult care homes, and/or home care agencies, including a consideration of resident case-mix in long-term care facilities;**

    (c) **to explore what aspects of the quality assessment/monitoring process can be changed and/or modified under state authority, and make recommendations to the appropriate authority accordingly; and**

    (d) **to explore those aspects of the quality assessment/monitoring process that require HCFA approval, and then, possibly in conjunction with North Carolina's Congressional delegation or with other states, request a HCFA waiver to demonstrate a quality indicator approach or some such innovative approach to assuring and monitoring quality.**

The Use of Quality Measures in Long-Term Care Management and Regulation

The Long-Term Care Task Force focused much of its attention on the way in which standards of quality are used in North Carolina, by county and state inspectors and by the long-term care industry itself, to monitor and encourage quality performance in these facilities and programs. In consideration of these issues, the following recommendation is offered:

16. **State (DHHS/DFS) and county (DSS) regulatory agencies should explore methods to improve and reward quality (and not limit their actions solely to imposing penalties for deficiencies) through such mechanisms as:**

    (a) **extending the licensure period from 1 to 2 years or extending the survey period from 2 to 6 months for adult care homes with a good track record and in the absence of complaints;**

(b) increasing the reimbursement rate for facilities that consistently perform over and above the minimum standard of care;

(c) providing financial rewards for facilities that demonstrate innovation in problem areas, such as maintaining low staff turnover and handling difficult behavior problems, as examples;

(d) providing financial rewards for facilities that seek and gain accreditation from nationally recognized bodies, attesting to performance above the minimum standards of care;

(e) considering a cap on allowable indirect costs for adult care homes similar to that imposed on nursing homes, but allowing a higher, but also capped, direct rate of reimbursement, so as to incentivize the provision of higher quality, direct care to residents of these facilities; and

(f) consider a different approach to setting reimbursement rates for adult care homes that would replace the current "state average" method in current use so that those facilities that operate more efficiently have some incentive to do so and can then reinvest these resources in higher quality care.

The Task Force took the further step of recommending that currently used measures of quality be expanded to include other dimensions of quality not presently included in standard survey instruments. Hence, the following recommendation is offered:

State and county regulatory agencies should explicitly incorporate measures of consumer satisfaction with care and consumer choice regarding care into the quality assessment process for each LTC facility and program.

17. State and county regulatory agencies should explicitly incorporate measures of consumer satisfaction with care and consumer choice regarding care into the quality assessment process for each long-term care facility and program. The proposed Instruments Technical Work Group should assure that appropriate measures of these considerations are included in various assessment instruments to be either developed or revised in the future.

In an effort to reinforce the notion that long-term care programs and facilities in our state should be encouraged to work toward quality of care goals, the Task Force recommends the following steps be taken:

18. The NC Department of Health and Human Services should develop a Quality Improvement Consultation Program to assist providers in the development of quality improvement plans for each facility and program offering long-term care services to the public in North Carolina.

HCFA restricts the extent to which DFS may offer consultation to nursing homes and home health agencies regarding quality improvement strategies using federally-funded staff during surveys and inspections; therefore, DHHS may need to operationalize the proposed Quality Improvement Consultation Program within another division of the Department or use non-federal dollars in the Division of Facility Services.

Finally, the Task Force took note of the fact that the financial penalties imposed on North Carolina long-term care programs and facilities that fail to meet established standards of care are not always used to any purpose that would further enhance the quality of care rendered to residents or clients of these programs or facilities. Under federal rules and regulations, fines levied against North Carolina nursing homes (amounting to approximately $300,000 per year) are placed in a fund administered by the Division of Facility Services for the benefit of residents of these facilities. As a result, DFS has initiated the Eden Alternatives Program, which offers small animal and horticultural therapy services in nursing homes statewide through a grant-in-aid program to which individual facilities may apply.

Fines collected through penalties assessed on adult care homes are handled differently since they are not affected by federal regulations. Under the North Carolina State Constitution, fines collected by state agencies are to be used to benefit the state's public schools.[45] Hence, none of these fines can be reinvested in improving the long-term care services for residents of these facilities where quality was found to be deficient. While the fines from adult care homes cannot be used to improve long-term care services, state law requires these facilities to correct the deficiencies identified through the inspection process.[46] Further, the state does have some limited authority to mandate staff training in lieu of a fine.[47] There was general sentiment within the Task Force that some alternative to the use of the fines should be considered as a means of further improving the quality of long-term care services. Since this may involve a state constitutional amendment, no formal recommendation is offered by the Task Force. The Task Force wishes to give further attention to such incentive approaches after receiving more thorough legal consultation on these matters.

Chapter 6

Financing Long-Term Care Services

The exact amount of money spent in North Carolina for long-term care services is unknown. Some data are available on the amount of money spent for publicly-funded long-term care services; however, few data are available on private financing of long-term care services.

The exact amount of money spent in North Carolina for long-term care services is unknown. Some data are available on the amount of money spent for publicly-funded long-term care services; however, few data are available on private financing of long-term care services.

The North Carolina General Assembly directed the NC Department of Health and Human Services to explore different ways to finance long-term care services. This chapter is divided into three sections: public expenditures for long-term care services; methods to expand public financing of long-term care services; and methods to expand private financing of long-term care expenditures.

Public Expenditures for Long-term Care Services

Long-Term Care Expenditures for Adults Age 18 or Older

North Carolina spends about $1.7 billion dollars *for individuals age 18 or older* on publicly funded long-term care services within programs operated out of the NC Department of Health and Human Services.[48] The exact amount spent is hard to determine, because some of the Divisions do not keep data on long-term care users and expenditures. Most of these services are financed through the Division of Medical Assistance (DMA), although some long-term care services are financed through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS), Division of Social Services (DSS), Division of Aging (DOA), Division of Vocational Rehabilitation, Division of Services for the Blind and Division of Public Health.

- *Division of Medical Assistance:* In SFY 99, DMA spent approximately $1.7 billion on long-term care services from federal, state and county funds for adults age 18 or older:[49]

Table 6.1
Division of Medical Assistance Long-Term Care Expenditures for SFY 99

Services	Elderly	Disabled	Total
Mental Hospital	$8,068,047	$27,488	$8,095,535
Skilled Nursing Facility	378,378,032	55,121,283	433,499,315
Intermediate Nursing Facility	327,321,715	30,112,197	357,433,912
ICF-MR	16,747,921	353,841,244	370,589,165
CAP-DA	115,954,074	34,638,242	150,592,316
CAP-MR	3,115,567	130,539,808	133,655,375 [50]
Home Health [51]	21,029,352	68,599,600	89,628,952
Hospice	3,677,382	4,594,051	8,271,433
Personal Care	52,456,974	21,043,332	73,500,306
Adult Care Home	44,072,402	28,243,836	72,316,238
Total	$970,821,466	$726,761,081	$1,697,582,547

The disability expenditures include both adults and children with disabilities. However, with the exception of ICF-MR and CAP-MR, most long-term care services are provided to adults 18 or older.

Medicaid service expenditures are split between the federal government (62.5%), state (31.9%) and counties (5.6%). Medicaid is an entitlement program, so federal, state and county governments must match any expenditures for eligible individuals.

- *Division of Mental Health, Developmental Disabilities and Substance Abuse Services*: The total funding for the MHDDSAS system was $1.6 billion in SFY 99. This includes funds for general administration, child mental health, adult mental health, developmental disabilities, and substance abuse services at the state and county level. The Division can not specifically break out all the money spent on long-term care services for adult populations, although $1.2 billion in federal and state funds were spent on mental health services for adults and the developmentally disabled (including expenditures for both children and adults with developmental disabilities). It is unclear how much of these funds are spent on long-term care services, versus those that address more acute or short-term needs, and it is difficult to break out the amount spent on different populations (such as adults versus children). The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS) is in the process of developing a new integrated payment and reporting system. Once developed, this system will capture and track individual specific service unit reporting and payment by type of funding source.

  MHDDSAS receives some of its funds for long-term care services from Medicaid, for Medicaid eligible clients. To serve non-Medicaid eligible clients, the Division relies on federal block grant and other state or federal appropriations. Unlike Medicaid, these funds are limited—so that funding is not assured for all people with mental illness or developmental disabilities who are in need of long-term care services.

- *Division of Social Services.* DSS administers two programs that provide long-term care services to older adults and people with disabilities: State County Special Assistance and the Social Services Block Grant.

  - *State County Special Assistance (SC/SA).* In SFY 99, SC/SA expenditures equaled approximately $111.8 million. Funding for SC/SA is 50% state and 50% county. About 22,000 people received SC/SA last year. SC/SA is an entitlement program, so that the state and county government must appropriate the necessary funds to pay for the residential care of any eligible individual.

  - *Social Services Block Grant (SSBG):* North Carolina's share of the SSBG is $47 million. About $14 million of

the SSBG funds are spent on services to older adults and persons with disabilities. Most, but not all, of this $14 million is spent on long-term care services. Counties are required to match federal SSBG funds. For most services, the matching rate is 75% federal, 25% county; although some services, such as adult day care/day health care or meals have a higher federal match rate: 87.5% federal, 12.5% county. Unlike SC/SA, the SSBG program is a block grant, which means that services can be limited to available funding.

- *Division of Aging.* The Division of Aging administers the Home and Community Care Block Grant (HCCBG). This program includes funding from the Older Americans Act, Social Services Block Grant, state appropriations and local match. The HCCBG program had a budget of $30,821,941 in SFY 99. Thirty-six percent of the funds are federal (Older American's Act and Social Services Block Grant), 54% state and 10% local. The Older American's Act only requires a 15% non-federal (state and/or county) match; but the state and counties' match rate exceeds this federal requirement. These funds are used for long-term care services including: in-home aides ($16 million), adult day care/adult day health ($2.8 million), home-delivered meals ($9 million) and care management ($0.9 million).

- *Division of Vocational Rehabilitation.* The Division of Vocational Rehabilitation provides personal assistance, medical equipment and non-medical equipment through their Independent Living Rehabilitation program. In SFY 99, the Division spent $2.2 million for personal care services, and approximately $4.2 million on equipment to support people with disabilities living independently.[52] Most of the funding for this program is from state sources (97%); the federal government contributed approximately $364,000 for personal care services. The funds for the Independent Living Rehabilitation program are limited, so not every eligible person can receive services.

- *Division of Services for the Blind.* The Division of Services for the Blind operates three long-term care programs for people with visual impairments. The total amount spent in these programs in SFY 99 was $1.8 million:

  - *Home management services* (Level I in-home aides). Home management services for people with visual impairments are funded through the Social Services Block Grant. The home management program is funded with 75% federal, 12.5% state and 12.5% county funds;
  - *Personal care services.* This is an entitlement program funded through Medicaid; and

- *Special Assistance for the Blind (SAB).* SAB helps low-income people with visual impairments pay for the cost of adult care homes. The costs are split 50% state, 50% county. Special Assistance for the Blind, like SC/SA, is an entitlement program so it provides services to all in need.

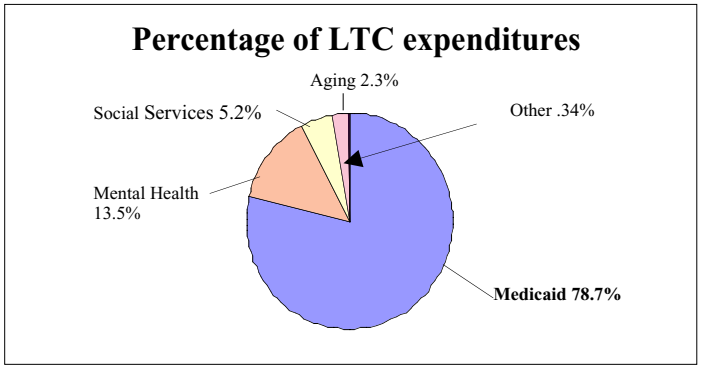
- *Division of Public Health.* In SFY 99, the Division of Public Health paid $1.3 million for home health services for adults.

In addition to the funds spent by state and local governments on long-term care, Medicare also pays for some home health and nursing home services. There were approximately 1.1 million Medicare recipients in North Carolina in 1998.[53] Medicare pays for up to 100 days of nursing home care, and unlimited number of home health visits if the person is homebound and needs intermittent care. While Medicare covers some nursing home and home health services, these services are typically limited to individuals who need acute or rehabilitative care. Medicare is an entitlement program and is financed 100% by the federal government. In FY 98 Medicare paid approximately $329.9 million for North Carolinians on skilled nursing facility stays.[54] In FY 98 the total Medicare Home Health expenditure was $281,460,811.[55]

North Carolina spent $1.3 billion in SFY 99 on publicly-funded long-term care services for older adults 60 or older.

Long-Term Care Expenditures for Older Adults

The Division of Aging is required by statute to maintain information about services provided to older adults.[56] Since 1991, the Division of Aging has produced a state/county expenditure profile of services provided to persons 60 and older. North Carolina spent $1.3 billion in SFY 99 on publicly-funded long-term care services for older adults.[57] This is an increase of 8% over SFY 98, and a 173% increase since 1990. Over this same time period the population of older adults in North Carolina increased by 19.4%.



Medicaid finances almost four-fifths of the long-term care expenditures for older adults.[58]

More than two-thirds of the long-term care expenditures for older adults are spent on institutional care, but over the last nine years there has been a shift of public expenditures into more home and community-based services.

Table 6.2
Long-Term Care Expenditures for Older Adults, SFY 99

Division	Expenditure
Medicaid	$1,043,583,993
Social Services	69,216,453
Aging	30,821,941
Mental Health	162,162,742
Public Health	1,836,848
Services for the Blind	2,889,408

More than two-thirds of the long-term care expenditures for older adults are spent on institutional care (70.4%), which includes nursing homes, intermediate care facilities for the mentally retarded (ICF-MR), mental health/substance abuse inpatient care, and mental retardation centers. Over the last nine years, there has been some shift in financing away from institutional care, such as from nursing homes, intermediate care facilities for the mentally retarded, mental health/substance abuse inpatient care, and mental retardation centers, to adult care homes and home and community care services.

Table 6.3
Financing Changes in Long-Term Care Expenditures 1990 - 1999

Category	1990	1999
Home and Community Care	16.0%	20.8%
Institutional Care	76.2%	70.4%
Adult Care Homes	7.7%	8.7%

Long-Term Care Expenditures for Disabled Adults

Similar trend data about publicly-financed long-term care services for younger disabled adults (18-59) are not routinely collected or reported. One of the Task Force's recommendations is to ensure that these data are collected at the state and county level and shared with the counties for local planning purposes:

> **To facilitate local-planning efforts, DHHS, in conjunction with the NC•IOM, shall:**
>
> **Develop county data packages that include information on the number of people age 18 or older using publicly-funded long-term care services at the county level, and expenditures for these services.**

Methods to Expand Public Funding of Long-Term Care Services

The Task Force explored different options to expand public funding of long-term care services. Medicaid appeared to be one of the most viable options since the federal government will pay approximately 62.5% of long-term care costs for Medicaid-eligible individuals. No other federal funding sources were identified.

In addition to drawing down federal funds, expanding Medicaid offers another advantage to counties. The Medicaid county match rate is lower than under other programs, or spending 100% county funds.

Table 6.4
County Match Rates by Funding Sources, SFY 99

Funding Source	County Match Rate
Medicaid	5.6%
Mental Health and Developmental Disabilities	5.6% for Medicaid funded inpatient and outpatient hospital services and ICF-MR 2.0% for outpatient services provided by area programs No set rate for non-Medicaid funded services[59]
State County Special Assistance	50%
Social Services Block Grant	25%
Home and Community Care Block Grant	10%

Medicaid expansion options

The Task Force recognized that there are current inequities in Medicaid income eligibility rules. Individuals can qualify for institutional nursing home care or residential care with higher income limits than can individuals living at home. Further, not all individuals living at home are treated equitably. As a general policy, the Task Force wanted to strive towards more equitable treatment of all Medicaid eligible individuals, whether living at home or in an institution. As the state expands Medicaid eligibility, it should first move to eliminate inequities in the treatment of individuals living at home and then move to eliminate any potential institutional bias.

Medicaid is the most viable source of public financing of long-term care services since the federal government pays 62.5% of costs.

Increase Medicaid medically needy income limits

The Task Force discussed ways to expand Medicaid eligibility for long-term care services. Under current eligibility rules, individuals with income in excess of the amounts listed below may still be able to qualify for Medicaid under the medically needy program if they have high medical expenses.

Table 6.5
Monthly Income Eligibility Requirements for Individuals

	Countable monthly income limits
Medicaid eligibility for nursing home[60]	$2,289 (skilled nursing) $1,608 (intermediate care)
Medicaid eligibility for ICF-MR	$5,480
State County Special Assistance for adult care home	$1,018
Medicaid eligibility for people living in their homes[61]	$ 696
Medicaid medically needy income limits	$ 242

The medically needy income limits are $242/month for an individual or $317 for a couple. To qualify, a person must incur medical bills equaling or exceeding the difference between their countable income and the medically needy income limits:

Example: Elderly woman living on own with $742 in Social Security retirement benefits.

$742	- countable income
- 242	- current medically needy income limits
500	- consumer monthly "spend-down"
x 6	- six month prospective eligibility determined
$3,000	- deductible or spend-down for 6 months

The individual would have to *incur* medical bills equaling $3,000 before Medicaid would begin covering medical bills.

As the state expands Medicaid eligibility, it should first move to eliminate current inequities in the treatment of individuals living at home and then move to eliminate Medicaid eligibility rules that favor institutionalization.

The state's medically needy income limits are linked by federal Medicaid law to the state's welfare payments under North Carolina's prior Aid to Families with Dependent Children program (AFDC). Under federal Medicaid law, the medically needy income limit cannot be greater than 133% of the highest AFDC cash payment for a family of the same size with no income. The Welfare Reform Act of 1996 allowed states to increase their medically needy income limits by the increase in the Consumer Price Index. Between July 1996 (when the welfare reform law was passed) and December 1999, the Consumer Price Index increased 7.2%. This translates into a $17/month increase for an individual (from $242/month to $259/month) and a $22/month increase for a couple (from $317/month to $339/month).

The state is also working with the National Medicaid Directors to try to get Congress to de-link the medically needy income limits from past welfare payments, but currently the state is limited by this federal Medicaid law. The Task Force made two recommendations to try to increase the medically needy income limits. Changing the current Medicaid laws which link the medically needy income limits with past welfare payments is the Task Force's top priority for Medicaid expansion.

19. **The North Carolina Congressional delegation should be requested to help change federal Medicaid laws which link the medically needy income limits with old and outdated AFDC cash payment levels. Congress should give states increased flexibility to set their own the medically needy income limits.**

20. **In the short-term, North Carolina should increase the medically needy income limits to keep pace with cost of living increases since 1996.**

Removing the institutional bias in Medicaid eligibility rules

Institutional services accounts for the largest share of publicly funded expenditures. Institutional care is usually more expensive than home and community based care, which explains part of the reason why the state spends so much of its resources on institutional care. For example, the average annual cost per nursing home recipient was $21,656 in SFY 99.[62] This includes both the residential and acute care costs. In contrast, the average cost for a Community Alternative Program for Disabled Adults (CAP-DA) recipient was $19,171, including CAP services, acute care and other home care costs. CAP-DA recipients typically receive services for longer periods of time (278 days versus 242 days for the average nursing home resident). The average daily costs for a nursing home resident is $89 compared to $69 for a CAP-DA recipient.

Another reason that public funding is weighted toward institutional care is that Medicaid and other public program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community. Under existing laws, individuals can qualify for either nursing home care or State County/Special Assistance (SC/SA) for adult care homes with higher monthly incomes than they can if they want to obtain Medicaid coverage for health services provided in their own home (See Table 6.5).

With these different income eligibility limits, individuals living at home may have too much income to qualify for Medicaid coverage as long as they remain in their home, but may qualify if they move into a more costly institutional or residential setting. Home and community based services under the SSBG and HCCBG are available without regard to a person's income; but the availability of these services is severely limited by the lack of program funding. Rather than expand SSBG and HCCBG programs—which would be funded through 100% state and county funds—the Task Force sought ways to expand Medicaid eligibility to draw down additional federal funds.

To minimize the program bias toward institutionalization, the Task Force recommends two options:

21. **If permitted under federal law, North Carolina should increase the Medicaid income guidelines for older adults and people with disabilities up to the State County Special Assistance income limits (currently $1,018/month for an individual).**

    Under current Medicaid rules, an individual living at home can qualify for Medicaid if his or her income is no greater than $696/month. However, if their income is less than $1,018/month, they can qualify for State County Special Assistance (SC/SA) to pay for the cost of residential care in an adult care home. Individuals who qualify for SC/SA are automatically eligible for Medicaid to pay for their health care and personal care services. The higher Medicaid income eligibility limits for SC/SA than for individuals living at home may force some individuals to move into adult care homes rather than stay at home and receive in-home services.[63]

22. **North Carolina should increase the Community Alternative Program (CAP) income eligibility limits to 300% SSI (currently $1,536/month for an individual), and allow the individual to deduct the same maintenance amount as allowed for individuals in nursing homes to support the community spouse.**

    Federal law allows states to increase the Medicaid income limits for people under the CAP programs. The maximum the state can increase the Medicaid income limits for this population is to 300% of SSI (currently $1,536 per month). Under this option, the state can determine a "reasonable amount" that the person can deduct from their income to use to maintain a home and meet the needs of a spouse. The remaining income must first be spent on long-term care services, before the state will begin paying. The Task Force recommends that the state use the same maintenance amount as allowed for individuals in nursing homes to support the community spouse (currently $1,383 per month).

Other Public Funding Options

The Task Force recognized the state's strong interest in maximizing the use of federal dollars to pay for long-term care services. Medicare, which is funded in whole by the federal government, will pay for some home-health services and nursing home care for Medicare-eligible individuals. Coverage for these services may be denied if they do not meet federal requirements for coverage. However, denials of coverage can be appealed; and some states have been very effective in overturning initial Medicare denials of covered services. Before using state resources to pay for long-term care, the state should ensure that all federal funds are explored.

Another way to maximize federal revenues is to leverage federal Medicaid dollars. The state and county governments currently appropriate funds that are

not being matched by the federal government—for example, through State County Special Assistance and in the provision of other long-term care services to non-Medicaid eligible individuals. To the extent possible, North Carolina should explore ways of using existing state and county funds to leverage federal Medicaid funds.

The Task Force recommends:

23. **North Carolina has a strong public interest in maximizing the use of federal dollars to fund long-term care services. The state should ensure that Medicare pays for covered services for Medicare-eligible individuals by appealing the denials of Medicare coverage of long-term care services, including home health care. North Carolina should also maximize the use of Medicaid funds for long-term care services prior to using other more limited sources of state funds.**

The Task Force lacked the information to determine whether there were other ways to leverage existing funds to expand services and eligibles. Therefore, the Task Force recommends:

24. **The NC Department of Health and Human Services explore methods to use existing resources as the state's match in further Medicaid expansion to cover more older adults and people with disabilities, additional long-term care services, or to pay for long-term care administrative costs. As part of its analysis, the Department should:**

    - **Identify possible sources of state funds (e.g., state funds not required as federal match for HCCBG, SC/SA); and**
    - **Determine whether the Medicaid expansion would cover the same eligibles and services as covered by the other programs.**

Private Financing of Long-Term Care Services

The NC General Assembly also directed the Department of Health and Human Services to examine ways to expand private financing of long-term care services. Specifically, the Department was directed to examine:

- reverse mortgages;
- private long-term care insurance;
- tax credits or employment programs such as medical service accounts and deferred compensation plans; and

- changes in Medicaid eligibility and asset protection requirements that increase consumers financial responsibility for long-term care.

In addition, the Task Force examined the idea of charging mandatory sliding scale fees for long-term care services provided through the SSBG or HCCBG programs.[64]

Reverse Mortgages

The Task Force explored the concept of using reverse mortgages to finance long-term care services. A reverse mortgage is a type of loan that is secured by a person's house.[65] Proceeds of the loan may be paid in a number of different ways, including tenure payments, term payments, line of credit (may be a one time lump sum), or a combination of tenure or term, with a line of credit. At the end of the loan period, the loan is paid with the proceeds of the borrower's house. Generally, the loan is not paid back until the person dies, sells the house, or moves.

Reverse mortgages are not a viable method of financing long-term care services or insurance for most people.

To be eligible for a reverse mortgage, the borrower must be at least 62 years old; live in the home as their permanent residence; and own the home outright, or be able to pay the balance of the mortgage with the proceeds of the reverse mortgage. Before a borrower can obtain a reverse mortgage loan, they must receive face-to-face counseling by a certified reverse mortgage counselor in a U.S. Housing and Urban Development (HUD) approved non-profit counseling agency. All the counselors receive training from the NC Housing Finance Agency, and may not receive a commission from the proceeds of a loan. The borrowers may not be charged for the counseling. Counselors provide information about reverse mortgages, as well as other options that may be available to assist the borrower (including property tax exemptions, Medicaid and home repair programs).

The typical borrower is an older person who gets a reverse mortgage to prevent foreclosure (by paying outstanding mortgage payments, taxes or insurance), make home repairs, or pay other creditors. Many borrowers use the money to pay outstanding health bills—for example, to buy prescription drugs or pay the balance of medical expenses. Some also use proceeds of the money to pay for services that would not be covered under long-term care policy, such as shopping, chore services, or yard maintenance.

While reverse mortgages are available throughout the state, not many borrowers choose this option. Centura Bank makes most of the reverse mortgages in North Carolina. Last year, Centura closed 123 reverse mortgage loans and 144 loans in 1998. Reverse mortgages have fluctuating interest rates, and are very expensive loans. Typically, borrowers don't have money to pay origination fees, closing costs, appraisal fees, so these costs get folded into the cost of the loan. If the borrower's house is in disrepair, this will lower the value of the loan. Further, the amount of the loan relative to the property value is less for younger borrowers, since the bank will have to wait longer, actuarially, to have the loan paid back.

Under specific circumstances, reverse mortgages could be used to finance long-term care services. However, it is not a viable method of financing long-term care services or insurance for most people. For most people, the amount of the monthly payment is relatively small so the payments would not be sufficient to pay for extensive in-home long-term care services. The option to take the payment in a one time lump sum may be sufficient for financing long-term care services in the short-run but not over a longer period of time. Also, many borrowers are required to use part of proceeds to pay off the existing mortgage, pay for repairs or pay off other debts before they can use income for other services. For some, a better option may be to move out of a larger house and into smaller house, and use the proceeds of the sale to help pay for supportive services.

Given these caveats, the Task Force made the following recommendation:

25. The Task Force does not recommend that the General Assembly rely on reverse mortgages as a means of financing long-term care services.

Reverse mortgages are appropriate for a *small* segment of the older population to pay for some in-home services. However, reverse mortgages are not appropriate or available for most older adults as a means of paying for long-term care services. Additionally, reverse mortgages are generally not useful as a source of payment to purchase private long-term care insurance. By the time a person is eligible for a reverse mortgage (62 or older), the cost of private long-term care insurance may be prohibitive. One of the primary goals of private long-term care insurance is to protect personal assets. Reverse mortgages may be counterproductive in that instance, as the older adult would need to mortgage their primary asset in order to obtain long-term care insurance.

Private long-term care insurance

Private long-term care insurance can help pay for the costs of long-term care.[61] Most long-term care policies provide coverage for home health, adult day care, assisted living facilities in addition to nursing home care. Some policies also provide coverage of alternative benefits—for example, if the insurer can maintain the person in home cheaper than by putting them in an institution, then they will pay to keep the person in the home if the provider, insurer and insured agree. The primary reason to buy long-term care insurance is to preserve assets. However, long-term care policies offer another important benefit—people with private long-term care policies will have more choice of providers than do people who rely on Medicaid or other public sources to pay for services.

There are currently about 67 companies selling long-term care insurance in North Carolina. Information from the National Association of Insurance Commissioners show that there were 41,468 individuals covered by private long-term care insurance in North Carolina in 1998.[67] Insurers incurred $57,081,808 in long-term care claims and earned $200,487,055.

Long-term care insurance typically pays a certain amount per day. The standard daily benefit is $100/day. Long-term care products have different elimination periods (like deductibles). For example, if a policy has a 60-day elimination period, the insured must pay for the first 60-days of long-term care services before the policy begins paying. Companies also offer different inflation protection options, which increase the dollar amount of coverage to keep pace with inflation. People can purchase inflation options that will increase on a simple or compound basis over five year intervals. Inflation policies are particularly important for younger purchasers (including those who are 60 or 70 years old). Policies also have non-forfeiture benefits. Individuals who can not afford to pay premiums (after paying for a certain length of time) can stop paying premiums and maintain some coverage (or can get some reimbursement if the policy is dropped). Another common protection is a waiver of premium feature. An insured may stop paying premiums after he or she becomes eligible for long-term care services.

Long-term care policies are deductible from federal income taxes if the policy is federally qualified and the premiums and other unreimbursed medical expenses exceed 7.5% of the adjusted gross income. To be federally qualified, the policy must provide coverage if the insured needs assistance with two of the five activities of daily living.[68] In addition, North Carolina offers a tax credit of 15% of the premium cost up to $350/year to people who purchase long-term care insurance for themselves, spouses or dependents. Both of these provisions make the purchase of private long-term care insurance products more attractive.

Because of the multiplicity of products, it is difficult for consumers to go into the market to find the product that is best for them. The NC Department of Insurance offers independent counseling about long-term care policies through the Seniors Health Insurance Information Program (SHIIP). While SHIIP was originally set up to help seniors understand private Medicare supplemental policies, it has been expanded to provide information to individuals of all ages about private long-term care policies.

Long-term care insurance is not always easy to get. Companies are very selective in who they will cover. Insurers typically examine a person's health status (medical underwriting) before offering coverage to individual non-group purchasers. Insurers generally do not require medical underwriting if offered through a group plan (if the person purchases the policy during the group's open enrollment period). If a person tries to purchase the group long-term care policy outside of the open enrollment period, then they may be subject to medical underwriting.

The cost of long-term care policies varies with the age of the purchaser and the benefits package chosen.[69] Policies are much more expensive for older purchasers than for younger purchasers. For example, a policy with a 60-day elimination period and daily benefit of $100 for nursing homes, assisted living facilities or home care might cost on an *annual* basis:

Table 6.6
Average Annual Long-Term Care Insurance Premiums in North Carolina

Benefit Plan	50	60	70	80
Lifetime*	$1,680	$2,203	$4,306	$9,205
6 years*	1,226	1,670	3,378	7,345
4 years**	420	743	1,891	4,990

*5% compound inflation adjustment annually
**No inflation adjustment

The Task Force recognized that private long-term care insurance is not a significant financing source for long-term care services in the immediate future. Private long-term care insurance is not a panacea for everyone. If a person already has health problems that are likely to mean they will need long-term care, they may not be able to buy a policy. Also, long-term care policies are expensive, especially for people who are already older adults. Many older adults and people with disabilities cannot afford to purchase Medicare supplement policies or prescription drugs, much less be able to afford private long-term care policies. For these reasons, private long-term care policies will never be a viable option for certain segments of the population.

While private long-term care policies are not viable for everyone, and may not be a significant source of financing of long-term care services in the immediate future, it may be a more viable financing source over the longer-term. Therefore, the Task Force recommends the following:

Private long-term care insurance may be a more significant financing source in future years.

26. **The NC Department of Insurance in conjunction with the NC Division of Aging, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and other appropriate groups should develop an outreach strategy to inform the public about long-term care funding or payment options. The outreach effort should include information on what Medicare covers, what Medicaid covers, what individuals must pay on their own, and what private long-term care insurance can cover. Public education efforts should target employers, "baby-boomers," financial advisors, CPAs, banks and the legal community. The state should develop multiple outreach strategies including community education, the Internet, and mass media. Further information on the long-term care options could be incorporated into the curricula of courses offered in the community college system on estate and financial planning. Also the outreach should include information about the impartial counseling services offered by the NC Department of Insurance's SHIIP program.**

Such an outreach effort would cost $268,000.

Tax credits or employment programs such as Medical Savings Accounts (MSAs) and deferred compensation plans

The Task Force explored the possibility of using Medical Savings Accounts to finance long-term care services or insurance premiums. Federal law currently allows two groups of people to establish Medical Savings Accounts: individuals who work for small employers (under 50 employees) and Medicare recipients. Medical Savings Accounts are high deductible health insurance policies combined with pre-tax medical IRAs. Funds can be withdrawn from the medical IRA to pay for health care costs to meet the deductible. In addition, the medical IRA funds can be used to pay for long-term care costs or insurance premiums.

Many people argue about the merits of MSAs as a mechanism to pay for health care costs or long-term care. Concerns have been expressed about whether MSAs will attract the healthy and wealthy, leaving those who are sicker in the traditional health insurance pool. Regardless of the merits of MSAs as a means of providing health insurance or paying for the costs of long-term care, these policies are not currently a viable option of paying for long-term care costs. There are few, if any, insurers selling MSAs to the small group market in North Carolina.[70] The federal law that established the MSA demonstration project for small employers will expire in 2001, absent reauthorization. In addition, nationally there are no insurers selling MSAs to the Medicare population.

For these reasons, the Task Force made the following recommendation:

27. The Task Force does not recommend that the General Assembly rely on Medical Savings Accounts as a means of financing long-term care services.

The Task Force also examined the possibility of using other methods to encourage people to purchase long-term care insurance. State law already gives individuals a 15% tax credit up to $350/year for the purchase of long-term care insurance. Federal law allows a tax deduction if medical expenses (including long-term expenses) exceed 7.5% of income. However, there are currently bills in Congress that would provide additional financial incentives to encourage people to purchase private long-term care insurance policies.[71] These bills generally fall into four areas:

- federal tax deduction for long-term care insurance (not tied to medical expenses);
- group coverage option for federal employees and certain family members;
- use of funds in flexible spending accounts; or
- allow long-term care insurance coverage in cafeteria plans.

The Task Force was supportive of enacting further financial incentives to encourage more people to purchase private long-term care insurance. Therefore, the Task Force recommends:

28. The General Assembly should pass a resolution to encourage the NC Congressional delegation to support federal incentives to purchase private long-term care insurance, such as federal tax credits or deductions, flexible savings accounts or cafeteria plans.

Congress should be encouraged to enact additional financial incentives to encourage more people to purchase private long-term care insurance.

Additionally, the Task Force recommends that Congress give states additional flexibility to implement Medicaid long-term care partnership plans. Partnership plans were created to encourage people to purchase private long-term care insurance. If a person purchases a private long-term care insurance policy that meets certain coverage criteria and meets other requirements, then they can later qualify for Medicaid if their private coverage is exhausted. Individuals are still expected to contribute their income toward the cost of Medicaid covered long-term care services, but could retain some or all of their assets. Federal laws limit these partnership programs to four states: (CA, IN, NY, CT). Task Force members thought this was another viable way to encourage individuals to purchase long-term care insurance policies. Therefore, the Task Force recommends:

29. The General Assembly should pass a resolution to encourage the NC Congressional delegation to eliminate federal barriers to expansion of Medicaid long-term care partnership plans.

Changes in Medicaid eligibility to increase personal responsibility for the payment of long-term care services

There are two federal Medicaid laws that try to increase personal responsibility for the payment of long-term care services: transfer of assets disqualification periods and estate recovery rules. Federal laws establish requirements that states must implement, and gives states the flexibility of imposing more stringent requirements. North Carolina has implemented these basic federal requirements—but has not taken the option to implement more stringent laws.

Transfer of Assets Penalties

Under federal law, nursing home residents or individuals receiving Community Alternative Placement (CAP) services may be subject to a Medicaid disqualification period if they give away or dispose of certain countable assets without receiving fair market value in return.[72] The transfer of assets provisions apply if an applicant, an applicant's spouse or legal representative transfers or gives away assets, or if these individuals eliminate or reduce ownership interest in the assets. Individuals are subject to disqualification periods if they transfer assets within 36 months of applying for Medicaid (or 60 months if the transfer was into a trust).

The disqualification period is determined based on the amount of the uncompensated value divided by the average nursing home costs ($3,000).

> Example: In November 1999, a person transferred $10,000 in stock to an adult child. In March 2000, the person enters the nursing facility and applies for Medicaid. There is a 3-month period of ineligibility ($10,000/$3,000=3 months). The disqualification period begins in the month of transfer—so in this instance, the penalty would begin in November and last through January. The person would be eligible for Medicaid when they applied in March. The "sanction" period ended before Medicaid was needed.

Under federal law, individuals can transfer certain assets without being subject to a disqualification period. For example, an individual can transfer his or her home to a spouse or, under certain circumstances, a child. Individuals are also allowed to create trusts for "sole benefit" of spouse or disabled child. Federal law only allows states to apply transfer of assets provisions to individuals who are institutionalized or using long-term care services. States may not impose transfer of assets penalties to individuals living at home who transfer assets to qualify for Medicaid for non-long term care services.

The state also allows transfers of other assets without applying the transfer of assets penalty. Individuals can transfer any asset that would not be counted in determining Medicaid eligibility if the person still retained the asset. One of these allowed transfers revolves around homesites. An individual can convert a former homesite into "income producing" property. The value of income producing property is not counted in determining Medicaid resource eligibility (although the income is counted in the calculations of income eligibility). Because the property is exempt from consideration in determining Medicaid eligibility, it can be transferred with no penalty.

Individuals can also transfer property owned by many people (tenancy-in-common). Individuals can "convert" fee simple ownership to tenancy in common by transferring a small percentage of ownership to another person. This transfer of ownership may create a small disqualification period. However, the individual is then free to transfer the remaining property without being subject to a transfer of assets disqualification penalty because the value of tenancy-in-common property is not counted in determining Medicaid eligibility.

The Division of Medical Assistance (DMA) also exempts the value of household goods and personal property. Thus, a person is free to transfer these assets without being subject to a disqualification period.

Task Force members considered different ways to tighten these provisions. For example, the Task Force considered whether to apply a penalty for transfers of:

- Income producing property. Federal law permits the state to impose a penalty if the equity value in the property is greater than $6,000 and the property is transferred. If the person retains the homesite and it produces income, there would not be a penalty.
- Tenancy by the entirety property. North Carolina could impose a penalty on the remaining share "owned" by the recipient if part of the fee-simple property was transferred.
- Household goods and personal effects. North Carolina could count any transfer of property if the value exceeds $2,000.

The state conducted a study to determine the prevalence of transfers of assets to qualify for Medicaid.[73] In a 1996 study of 194 nursing home residents, DMA found that 35% of nursing home residents had given away assets prior to applying for Medicaid. Transfers usually involved the person's homesite. Of those who gave away property, 44% waited to apply for Medicaid until the penalty period had expired, and 55% applied within 36 months after the transfer. Less than 7% of individuals were subject to a disqualification period.

Estate Recovery

Under the federal Medicaid statute, states must attempt to recover some of the Medicaid costs for individuals who are in a nursing home, ICF-MR, or from those who receive CAP services.[74] The estate recovery rules apply differently, depending on the person's age and the services that were covered by Medicaid:

- *Individuals who are under age 55:* The state must attempt to recover the costs of institutionalization (nursing home or ICF-MR) and CAP-services to individuals who enter long-term care facilities—if the individuals are expected to permanently reside in the facilities. Individuals who have short-stays in long-term care facilities (e.g. for rehabilitative purposes) are not subject to estate recovery.

- *Individuals who are 55 or older*: The state must attempt to recover the costs of institutionalization, CAP services, prescription drugs and inpatient hospitalization for any individual who enters long-term care institution (whether for a short rehabilitative stay or long-term-stay).

Medicaid is currently seventh in the state's list of priority of claims in the estate settlement process. Recovery can be waived in certain circumstances:

- real property in estate if residence of spouse or child under certain conditions;
- Medicaid paid less that $3,000 in claims;
- estate is valued at less than $5,000;

- there is surviving spouse or dependent; or
- undue hardship.

North Carolina has a number of different options to expand estate recovery:

- The state can change state laws to give Medicaid a higher priority in the estate settlement process.
- The state could expand the types of services that are subject to estate recovery. For example, the state can attempt to collect all of the costs of medical and long-term care services provided to individuals who receive long-term care services (regardless of the age of the individual).
- The state could require that a lien be imposed on the property of the surviving spouse or dependent, to ensure recovery at their death or when the property is sold.

North Carolina does not collect significant funds through the estate recovery process. In SFY 99, North Carolina collected $1.2 million. This year, the state expects to collect $1.4 million. These are gross receipts and do not include the costs incurred in collecting funds from a decedent's estate. The funds collected through estate recovery are split between the federal, state and county government—which means that the state effectively recoups little from current estate recovery efforts.

The Task Force did not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery.

In general, the Task Force did not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery. Fear of estate recovery is already a barrier for some older adults who are afraid to apply for Medicaid, CAP or other long-term care services. Further, people who have a lot of assets can afford to buy legal advice about how to shelter the assets. The only people who are likely to be "caught" in the transfer of assets provisions are those with fewer resources. Therefore, the Task Force made the following recommendation:

30. The Task Force does not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery.

Sliding scale fees for long-term care services

In general, the Task Force was supportive of the concept that individuals should be required to contribute to the cost of long-term care services when they can afford to do so. However, there are currently some legal barriers that prevent the state from mandating that individuals contribute toward their long-term care services. First, the Older American's Act prohibits states from mandating that older adults (60 or older) contribute to the cost of their long-term care services. The Division of Social Services used to require fees for younger individuals needing in-home aide services (under the Social Services Block Grant). However, the state changed this provision after a complaint was filed

with the US Department of Justice over the discriminatory treatment of younger disabled individuals versus older adults needing similar long-term care services. The state changed its regulations to remove all mandatory fees for long-term care services, replacing it with a voluntary fee schedule.[75]

The Older Americans Act is currently pending reauthorization in Congress. If the reauthorization gives states more flexibility to impose fees, then the Task Force recommends:

If permitted under federal law, North Carolina should establish a sliding scale fee based on an individual's ability to pay.

31. **If permitted under federal law, North Carolina should establish a sliding scale fee based on an individual's ability to pay. This sliding scale fee should be imposed on long-term care services provided under the HCCBG and SSBG programs. The Department of Health and Human Services should establish a mechanism to waive the fees for people who are unable to pay.**

Chapter 7

Next Steps

The North Carolina Institute of Medicine's Long-Term Care Task Force has conducted extensive discussions regarding entry into the long-term care system, availability of services, assuring quality of services, workforce issues and financing options in the State of North Carolina. Early in its monthly meetings, the Task Force recognized that the timetable initially set by the General Assembly would not allow enough time to complete all of the tasks assigned by the legislative charge. The Task Force intends to continue to meet over the next six months. Three key areas remain to be addressed: data and data system requirements, pilot and demonstration projects and DHHS organizational issues, as well as residual issues raised during Task Force deliberations. The Task Force will also work with appropriate state agencies to estimate the potential costs of the Task Force's recommendations, as well as identify existing or new revenue sources.

In addition to the work on the remaining issues from the original legislative charge, the North Carolina Institute of Medicine will create an Instruments Technical Work Group (Recommendation 6). The Instruments Technical Work Group will identify, modify or develop needed screening, level of services and care planning assessment instruments and consumer preference questions that are needed to help individuals more easily access needed services, and assist the state in its long-term care planning and quality oversight efforts. The members of the Instruments Technical Work Group will include representatives of state and local agencies, care providers, consumers and academics with expertise related to assessment tools. Potential members have been contacted and have agreed to serve on this committee once it is operational. The North Carolina Institute of Medicine has also arranged to contract with *inter*RAI for consulting assistance. The results from this work group will be reported to the full Task Force. In addition, the Secretary will offer the public an opportunity to comment on any proposed new instruments before these tools are implemented.

The North Carolina Institute of Medicine will also create a Quality Standards Work Group to consider how quality standards are defined, what standards are possible, how these standards are incorporated into assessment instruments and measures used by regulatory agencies, and how results of these assessments are shared with the general public (Recommendation 15).

In view of the work that still needs to be completed by the Task Force, the following changes in the implementation schedule are proposed:

32. **By January 1, 2001, the North Carolina Institute of Medicine, in conjunction with the North Carolina Department of Health and Human Services should:**

- **identify screening, level of services, and care planning instruments to be used for all DHHS long-term care services;**
- **develop a timetable for testing and implementing these instruments; and**
- **compile county-level data on the number of people age 18 or older who use DHHS long-term care services and expenditures by Division and type of program.**

By July 1, 2002, the North Carolina Department of Health and Human Services should:

- **implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles, and consumer preferences; and**
- **develop a system of long-term care services coordination and case management to minimize administrative costs, improve access to services and minimize obstacles to the delivery of long-term care services to people in need.**

Notes

[1] Maddox G. Program Director of the Duke Long-Term Care Resources Program in a speech to the North Carolina Study Commission on Aging, Cited in Campbell, R. Performance Audit: Long-Term Care Programs in North Carolina as administered by the Department of Health and Human Services, April 1998.

[2] Long-Term Care Policy Office. National Trends in Long-Term Care: How Does North Carolina Stack Up? NC Department of Health and Human Services. October 1, 1998.

[3] Long-Term Care Policy Office. National Trends in Long-Term Care: How Does North Carolina Stack Up? NC Department of Health and Human Services. October 1, 1998. The report also notes that 40% of older adults will spend some time in a nursing home.

[4] Bodenheimer T. Long-Term Care for Frail Elderly People - The On-Lok Model. New England Journal of Medicine. 1999 Oct21;341(17):1324-1328.

[5] Long-Term Care Policy Office. National Trends in Long-Term Care: How Does North Carolina Stack Up? NC Department of Health and Human Services. October 1, 1998, citing National Conference of State Legislatures. New Thinking on Financing and Regulating Long-Term Care. April 1998, p. 2.

[6] Feder J, Komisar HL, Niefeld M. Long-Term Care in the United States: An Overview. Health Affairs. 2000 May/June:19(3):40-56.

[7] Ibid.

[8] Ibid, citing Komisar HL, Niefeld M. Long-Term Care Needs, Care Arrangements, and Unmet Needs among Community Adults. Findings from the National health Interview Survey on Disability. Working Paper No. IWP-00-102. Washington: Georgetown University, Institute for Health Care Research and Policy, 2000.

[9] State Auditors Office. Long-Term Care Programs in North Carolina as Administered by the Department of Health and Human Services. Performance Audit. April 1998.

[10] Chapter 237, Sec. 11.7A of the 1999 Session Laws.

[11] Developmental disabilities is defined under N.C.G.S. 122C-3(12a) as "a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental or physical impairments;
b. Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
c. Is likely to continue indefinitely;
d. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
e. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or
f. When applied to children from birth through four years of age, may be evidenced as developmental delay."

People with developmental disabilities may have different experiences and need for long-term care services than the elderly or other adults with disabilities. By definition, people with developmental disabilities require a long-term care system of support that may begin at birth. The focus of this report is on adults (age 18 or older) who need long-term care services, although the Task Force did consider the needs of individuals with mental illness or developmental disabilities. Because of the ongoing State Auditor's study of the state's mental health, developmental disabilites and substance abuse system, the Task Force concentrated their efforts on older adults and other people with disabilities, and not on people with developmental disabilities or mental illness who may need long-term care services.

[12] Duke Long Term Care Resources Program, Occasional LTC Policy Paper Series. Paper No. 10 (july 1999).

[13] Sec. 11.7A(a) of HB 168, 1999 Session.

[14] Goins R. Turner and Leak SC. Distribution of Home and Community-Based Long Term Care Services for the Elderly in North Carolina. Occassional LTC Policy Paper Series. Duke Long Term Care Resources 1999 Nov;Program Paper No. 11.

[15] The NC Department of Health and Human Services, Division of Facility Services collects information on use of nursing homes among individuals with private sources of funding. Utilization of nursing home beds among both private and public pay residents is used to determine the need for additional nursing home beds that is part of the state's Certificate of Need process. In addition, adult care homes report some information about private pay residents in their cost-reports to the Department. This is limited to adult care homes that take some State/County Special Assistance funding and does not include facilities that serve solely private pay residents.

[16] Medicaid CAP-DA and Personal Care Services were converted into ratios based on the number of users per 1,000 Medicaid-eligible aged or disabled individuals. Home and community care block grant services were converted into ratios based on the number of users per 1,000 older adults (60+). Nursing home and adult care homes were converted into ratios based on the number of beds per 1,000 older adults (65 or older).

[17] NC Division of Facility Services. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. Sept. 1999. Note: the 112 agencies that provided in-home aides services provided the same type of services that would meet the criteria for Medicaid reimbursement (e.g., Level II or Level III in-home aide services).

[18] Where have All the Nurses Aides Gone. Presentation by Thomas R. Konrad to the NCIOM Long Term Care Task Force, May 31, 2000. North Carolina Institute on Aging. Note: The 180,000 people who have been certified as nurse aides include nursing students who are certified as nurse aides during their training. The actual number of individuals who are being trained as nurse aides, rather than nurses, is unknown. It is likely that some of the people who are no longer certified as nurse aides are those who were being trained as nurses—and never part of the nursing aide workforce.

[19] NC Division of Facility Services. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. September 1999.

[20] Press release by the North Carolina Employment Securities Commission, May 19, 2000. [http://www.esc.state.nc.us/].

[21] Where have All the Nurses Aides Gone. Presentation by Thomas R. Konrad to the NCIOM Long Term Care Task Force, May 31, 2000. North Carolina Institute on Aging.

[22] NC Division of Facility Services. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. September 1999.

[23] The Department of Facility Services plans to survey states regarding this issue starting in Fall 2000.

[24] The Department of Facility Services plans to survey states regarding this issue starting in Fall 2000.

[25] North Carolina Center for Nursing. A Profile of Newly Licensed Registered Nurses in North Carolina: 1997. June 1998.

[26] Cecil G. Sheps Center for Health Services Research. North Carolina Health Professions: October 1999. University of North Carolina, Chapel Hill. In 1999, the licensure board changed the practice settings categories – eliminating Nursing Home and adding Long-Term Care and Home Care/Hospice as options. In 1999, 4,955 registered nurses listed their primary specialty as geriatrics; 4,704 RNs reported their primary practice location as long-term care and an additional 5,205 reported their primary practice location as home care/hospice.

[27] North Carolina Center for Nursing. A Profile of Newly Licensed Registered Nurses in North Carolina: 1997. June 1998.

[28] Cecil G. Sheps Center for Health Services Research. North Carolina Health Professions: October 1999. University of North Carolina, Chapel Hill. In 1999, the licensure board changed the practice settings categories – eliminating Nursing Home and adding Long-Term Care and Home Care/Hospice as options.

[29] Only two geriatricians listed their primary practice location as a nursing home or extended care facility.

[30] Cecil G. Sheps Center for Health Services Research. North Carolina Health Professions: October 1998. University of North Carolina, Chapel Hill.

[31] US Senate Special Committee on Aging Sponsors Forum on the National Shortage of Health Professionals Trained in Geriatrics. http://www.americangeriatrics.org/policy/ger_need.shtml. May 20, 1998, Washington, DC.

[32] US Census Bureau Web Page: http://www.census.gov/population/estimates/nation/intfile2-1.txt.

[33] Information from Lynn Hardy, North Carolina Association for Home and Hospice Care, June 8, 2000.

[34] Cecil G. Sheps Center for Health Services Research. North Carolina Health Professions: October 1998. University of North Carolina, Chapel Hill.

[35] Maslow, Abraham H. 1971. *The Farthest Reaches of Human Nature*. Viking: New York, NY. Maslow, Abraham H. 1962. *Toward a Psychology of Being*. Van Nostrand: Princeton, NJ.

[36] Facility Quality Indicator Profile. Information provided by: Cynthia DePorter, Feb. 18, 2000.

[37] Information is for State Fiscal Year 1999, from Lynda McDaniel at the NC Department of Facility Services. June 15, 2000.

[38] The Division of Facility Services licenses and inspects mental health, developmental disability and substance abuse facilities licensed under N.C.G.S. §122C. Some of these facilities provide residential or community-based long-term care services to people with mental illness or developmental disabilities, including: psychosocial rehabilitation (69 facilities), specialized community residential care (30 facilities), adult developmental activity programs (147 facilities), community respite services (122 facilities), day activity (40 facilities), MH supervised living (86 facilities), DD/BD supervised living for children or adults (505 facilities), DD supervised living for adults (517 facilities), MD supervised living for adults (96 facilities). There are additional long-term care facilities that focus on the needs of children and adolescents. Personal communication with Lynda McDaniel, Division of Facility Services. June 27, 2000.

[39] Information from Sue Madson, Division of Social Services, June 21, 2000. In March, 2000, there were 153 Adult Home Specialists statewide, amounting to 91.03 FTE (for an average of .59 FTE for each Adult Home Specialist).

[40] Information from Cynthia DePorter, Division of Facility Services, June 21, 2000.

[41] Feder J, Komisar HL, Niefeld M. Long-Term Care in the United States: An Overview. Health Affairs. 2000 May/June;19(3):40-56.

[42] Information from Sharon Wilder, Division of Aging, June 21, 2000. Topics covered by the regional Ombudsmen for the training of the community advisory committee volunteers include: roles and responsibilities as defined by state statutes; residents' bill of rights; licensure processes for the different types of facilities; Adult Protective Services laws and reporting requirements; complaint resolution; and confidentiality requirements.

[43] *The Long-term Care Ombudsman Program in North Carolina: Report on the Consumer Satisfaction Survey on 1997*. The Center for Aging Research and Educational Services (CARES), Jordan Institute for Families, School of Social Work, The University of North Carolina at Chapel Hill. September 1998. A random sample was drawn from four constituencies: 120 members of the public who filed formal complaints through the program; 108 people who called for information, referral, and technical assistance; 243 representatives of long-term care facilities; and 148 members of community advisory committees answered the survey. There was also a job satisfaction survey completed by 21 regional long-term care ombudsmen.

[44] A national consensus about what constitutes good outcomes for people with developmental disabilities is growing. Information about how to measure outcomes is included in the National Core Indicators Project. The Core Indicators Project is a collaboration among participating member agencies of the National Association of State Directors of Developmental Disabilities Services to develop a nationally recognized set of performance and outcome indicators. This project is not intended to supersede a state's ongoing quality assurance, enhancement, and monitoring systems. There are four domains of study, with sixteen sub-domains, in the Core Indicators Project:

- Consumer Outcomes: Work, Community Inclusion, Choice and Decision Making, Supporting Families, Family Involvement, Relationships, and Satisfaction.
- System Performance: Service Coordination, Utilization and Expenditures, and Access.

- Health and Welfare Rights: Safety, Health, and Respect/Rights.
- Service Delivery System Strength and Stability: Acceptability, Stability, and Staff Qualifications/Competency.

More information regarding this ongoing project can be found at http://www.hsri.org/manage/core.html.

[45] North Carolina Constitution, Art. IX, Sec. 7 "All moneys, stocks, bonds, and other property belonging to a county school fund, and the clear proceeds of all penalties and forfeitures and of all fines collected in the several counties for any breach of the penal laws of the State, shall belong to and remain in the several counties, and shall be faithfully appropriated and used exclusively for maintaining free public schools." The term "penal laws" has been defined to mean laws that impose a monetary payment for their violation; the payment is punitive rather than remedial in nature and is intended to penalize the wrongdoer rather than compensate a particular party. *See*, McMillan v. Robeson County, 262 N.C. 413, 137 S.E.2d 105 (1964).

[46] N.C.G.S. §131D-34. Type A penalties of between $250-$5,000 (or between $500 and $10,000 for larger facilities) are imposed for violations that result in death or serious physical harm or a substantial risk that death or serious physical harm will occur. Type B violations are violations that present a direct relationship to the health, safety or welfare of a resident, but do not result in substantial risk of death or serious physical harm. A corrective action plan is required for both Type A and Type B violations. If a facility fails to correct a Type A violation, an additional penalty of up to $500/day may be imposed. If a facility fails to correct a Type B violation, a penalty of up to $200/day may be imposed. Treble penalties may be imposed for repeat violations. County Departments of Social Services make initial recommendations of the amount of the penalty, but the NC Department of Health and Human Services makes the ultimate determination of the amount of the fine. Adult care facilities have appeal rights to contest the imposition or amount of the penalty.

[47] The Department has the authority to authorize staff training in lieu of a fine if: (1) the cost of training does not exceed $1,000; (2) the penalty is the facility's only violation within a 12-month period preceding the current violation and the facility is under the same management; and (3) the training is specific to the violation, approved by the Department and taught by someone approved by the Department and other than the provider. N.C.G.S. §131D-34(g1).

[48] The $1.7 billion excludes long-term care services operated through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, because their accounting can not specifically identify long-term care expenditures.

[49] NC Division of Medical Assistance. Medicaid Tables for SFY 1999. Table 1: Federal Matching Rates; Table 13: Expenditures for the Elderly; Table 14: Expenditures for the Disabled and Blind.

[50] About 92% of CAP-MR expenditures are for children under the age of 18.

51 Home health expenditures were included in this chart, but home health services are for long term care. Many home health services are provided as rehabilitative services after an acute illness or episode.

[52] Information from Donna Holt. Division of Vocational Rehabilitation. May 26, 2000.

[53] Health Care Financing Administration. Medicare Enrollment as of July 1, 1998.

[54] State Summary of Nursing Facilities, 2000. American Health Care Association, Research and Information Services. Web Page: http://www.ahca.org. In 1998, there were 48,539 Medicare skilled nursing facility stays at an average payment of $234.33/day. The average stay per Medicare beneficiary was 29 covered days with an average co-payment per Medicare beneficiary of $1,595 per care episode.

[55] 1998 pay claims data from HCFA statistics, compiled by Palmetto Government Benefits Administrator (PGBA). At this time the 1999 figures have not been released for the period July1, 1999 to December 31, 1999. The 1998 North Carolina home health data include 4,090,749 visits to 101,043 people. The average reimbursement per person was $2,786 and the average number of visits per person was 40. Nationally the average reimbursement per person was $3,384 and the average number of visits per person was 50, so North Carolinians on average receive fewer home health visits and lower average reimbursement.

[56] N.C.G.S. §143B-181.1

[57] Division of Facility Services. Long-Term Care Expenditures for Older Adults Reported for SFY 98-99. April 10, 2000, based on information provided by the Division on Aging.

[58] Division of Aging. SFY 1998-99 Long-Term Care Expenditures: Persons 60 and Older. Information from Bill Lamb, Division of Aging June 5, 2000.

[59] Local area programs negotiate the budget at the county level. There are no set requirements across counties, and county contributions vary as a function of wealth of the county. Communication with Bonnie Morell, NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, June 9, 2000.

[60] This chart lists the lowest Medicaid nursing home and ICF-MR reimbursement rates. To determine eligibility for nursing facility or ICF-MR, the Division of Medical Assistance (DMA) first looks at a person's countable income compared to the lowest reimbursement rate in the state. If the person's countable income exceeds the lowest reimbursement rates, then DMA looks at the specific facility's rate for the level of care to determine if the person's countable income is less than the specific facility's rate. Individuals are allowed to take certain deductions from their gross income to determine their countable income. For example, a person who has applied for Medicaid to pay for nursing home care can deduct up to $1383 to help support a spouse living at home. Additional deductions are allowed to support minor or dependent children, to meet excess shelter costs for the spouse or children living at home, or to pay for personal needs while in the nursing home.

[61] Medicaid eligibility for people living at home is set at 100% of the federal poverty guidelines. The Medicaid income eligibility guidelines are adjusted annually to reflect changes in the federal poverty guidelines.

[62] Division of Medical Assistance. Letter to CAP-DA Supervisors and Case Managers. April 17, 2000.

[63] Resources are also considered in determining eligibility for both Medicaid and State/County Special Assistance. Each program has slightly different rules about which resources are counted or excluded; however the amount of the resource limits for each program is similar: $2,000 for an individual and $3,000 for a couple. Conversation with Matt Oathout, DMA, June 13, 2000.

[64] Currently NC 143B 181.1(a) #10 requires that the Division of Aging "establish a fee schedule to cover the cost of providing in-home and community-based services funded by the Division. The fees may vary on the basis of the type of service provided and the ability of the recipient to pay for the service. The fees may be imposed on the recipient of a service unless prohibited by federal law. The local agency shall retain the fee and use it to extend the availability of in-home and community-based services provided by the Division in support of functionally impaired older adults and family caregivers of functionally impaired older adults."

[65] Presentation by Mary Reca Todd to the NCIOM Long Term Care Task Force. NC Housing Finance Agency. April 25, 2000.

[66] Presentation by Carla Obiol to the NCIOM Long Term Care Task Force. NC Department of Insurance. April 25, 2000.

[67] National Association of Insurance Commissioners. 1998 Long-Term Care Insurance Experiences Reports—Form C. December 20, 1999.

[68] There are six activities of daily living: feeding, bathing, dressing, grooming, transfers (e.g., moving from bed to chair or getting out of a chair), mobility (ability to walk). Some long-term care policies exclude the need for bathing assistance as one of the qualifiers for long-term care services. Since most people need assistance with bathing before other activities of daily living, these policies effectively require that a person show a need for help with three of the six activities of daily living before qualifying for benefits under the policy.

[69] LTC premiums can be based on attained age (which increases as the person gets older), or on issue age (which is a constant premium based on the age of the purchaser). State law prohibits LTC insurers from selling policies based on attained age once the person reaches age 65.

[70] Presentation by Tom Jacks to the NCIOM Long-Term Care Task Force. Deputy Commissioner. NC Department of Insurance. May 31, 2000.

[71] Presentation by Susan Harmuth to the NCIOM Long-Term Care Task Force. NC Division of Facility Services. May 31, 2000.

[72] Presentation by Barbara Brooks to the NCIOM Long-Term Care Task Force. NC Division of Medical Assistance. March 17, 2000.

[73] NC Department of Health and Human Services. Study and Comparison of Eligibility Requirements: Report to House and Senate Appropriations Subcommittee on Human Resources and Study Commission on Aging. March 1998.

[74] Presentation by Andy Wilson to the NCIOM Long Term Care Task Force. NC Division of Medical Assistance. April 25, 2000.

[75] 10 NCAC 35F.

APPENDIX A:
AVAILABILITY OF SERVICES COMPARISONS

Table 1
Comparison of Nursing Home Beds to Adult Care Home Beds per 1000 of the Population Aged 65 and Greater

Table 2
Comparison of Community Alternative Program for Disabled Adults (CAP-DA) and Medicaid Personal Care Services (PCS) Clients Served per 1000 of Medicaid Eligible Aged and Disabled Population

Table 3
Comparison of Adult Day Care and Adult Day Health (Home and Community Care Block Grant) versus Adult Day Care (Social Services Block Grant) Clients Served per 1000 of Population Aged 60 and Older

Table 4
Comparison of Home Delivered Meals (Home and Community Care Block Grant) and Meals (Social Services Block Grant) Clients Served per 1000 Population Aged 60 and Older

Table 5
Comparison of In-Home Aides Clients Served (Home and Community Care Block Grant versus Social Services Block Grant) per 1000 of Population Aged 60 and Older

Table 6
Comparison of Nursing Home Beds and Community Alternative Program (CAP-DA) Clients Served per 1000 of Eligible Population

Table 1
Comparison of Nursing Home Beds to Adult Care Home Beds per 1000 of the Population Aged 65 and Greater

County Name	Population Aged 65 and Older	Nursing Home Beds per 1000 Aged 65 or Older	Adult Care Home Beds per 1000 Aged 65 or Older	County Name	Population Aged 65 and Older	Nursing Home Beds per 1000 Aged 65 or Older	Adult Care Home Beds per 1000 Aged 65 or Older
ALAMANCE	19508	42.09	39.68	JOHNSTON	13731	32.77	45.15
ALEXANDER	4071	44.95	16.21	JONES	1293	61.87	8.51
ALLEGHANY	2050	43.90	50.73	LEE	7411	31.57	46.28
ANSON	3855	41.76	0	LENOIR	8826	37.62	43.39
ASHE	4646	38.74	16.36	LINCOLN	7516	33.26	35.66
AVERY	2598	49.27	15.40	MACON	7074	38.17	7.35
BEAUFORT	6897	42.05	26.10	MADISON	3308	54.41	16.32
BERTIE	3024	46.96	26.79	MARTIN	3951	38.98	41.76
BLADEN	4755	40.80	58.89	MCDOWELL	6598	33.34	58.05
BRUNSWICK	12345	25.44	6.97	MECKLENBURG	60133	51.12	33.76
BUNCOMBE	32527	51.68	42.03	MITCHELL	2940	43.20	11.90
BURKE	12329	36.99	34.80	MONTGOMERY	3298	46.39	50.64
CABARRUS	15855	37.65	57.21	MOORE	17101	33.92	33.57
CALDWELL	10421	39.34	36.46	NASH	11435	36.64	27.37
CAMDEN	951	42.06	6.31	NEW HANOVER	20802	34.08	41.39
CARTERET	9790	41.88	23.80	NORTHAMPTON	3796	39.25	55.58
CASWELL	3629	37.75	67.79	ONSLOW	8405	42.71	56.16
CATAWBA	17284	38.71	26.04	ORANGE	10136	43.71	32.06
CHATHAM	7456	45.60	24.81	PAMLICO	2387	40.22	0
CHEROKEE	4785	37.62	12.54	PASQUOTANK	5057	52.60	52.60
CHOWAN	2700	62.96	24.44	PENDER	6048	35.22	17.03
CLAY	1832	43.67	6.55	PERQUIMANS	2168	35.98	27.21
CLEVELAND	13538	40.18	41.44	PERSON	4941	40.48	26.11
COLUMBUS	7793	37.60	22.71	PITT	12626	43.40	49.50
CRAVEN	11821	39.42	42.13	POLK	4377	50.49	8.68

County Name	Population Aged 65 and Older	Nursing Home Beds per 1000 Aged 65 or Older	Adult Care Home Beds per 1000 Aged 65 or Older	County Name	Population Aged 65 and Older	Nursing Home Beds per 1000 Aged 65 or Older	Adult Care Home Beds per 1000 Aged 65 or Older
CUMBERLAND	23254	34.23	38.66	RANDOLPH	16343	38.55	34.57
CURRITUCK	2238	37.98	0	RICHMOND	6609	41.76	51.29
DARE	3518	35.82	0	ROBESON	12450	42.41	49.88
DAVIDSON	18826	37.66	21.14	ROCKINGHAM	13636	39.97	37.55
DAVIE	5029	39.37	31.42	ROWAN	19323	41.14	31.00
DUPLIN	6492	38.82	61.31	RUTHERFORD	9594	43.78	63.37
DURHAM	19614	67.91	61.69	SAMPSON	8161	38.23	38.23
EDGECOMBE	6956	45.57	39.39	SCOTLAND	4004	49.70	39.46
FORSYTH	38420	49.92	47.92	STANLY	8277	49.05	23.68
FRANKLIN	5657	45.61	47.73	STOKES	5493	58.62	32.22
GASTON	23023	42.22	32.92	SURRY	10959	39.42	39.88
GATES	1438	48.68	0	SWAIN	2037	58.91	24.55
GRAHAM	1361	58.78	22.04	TRANSYLVANIA	6346	37.35	12.61
GRANVILLE	5474	43.84	35.99	TYRRELL	640	46.88	0
GREENE	2536	45.35	20.50	UNION	11176	31.94	31.50
GUILFORD	50371	44.19	36.93	VANCE	5393	43.02	37.83
HALIFAX	8097	42.61	21.24	WAKE	47585	40.66	42.01
HARNETT	10354	41.63	54.38	WARREN	3655	38.30	51.71
HAYWOOD	11053	39.90	29.77	WASHINGTON	2022	41.54	0
HENDERSON	19448	42.27	26.07	WATAUGA	4883	38.09	20.89
HERTFORD	3299	48.80	53.65	WAYNE	13071	36.19	53.17
HOKE	3035	30.31	24.71	WILKES	9461	44.08	24.63
HYDE	898	89.09	0	WILSON	9343	40.14	47.52
IREDELL	15714	35.83	45.18	YADKIN	5754	42.93	29.37
JACKSON	4609	41.22	30.16	YANCEY	3126	44.79	9.28

Sources: Nursing Home Beds data from the State Medical Facilities Plan 2000 (Draft), May 1999
Homes for the Aged and Family Care Homes data from Division of Facility Services, 1999

Table 2
Comparison of Community Alternative Program for Disabled Adults (CAP-DA) and Medicaid Personal Care Services (PCS) Clients Served per 1000 of Medicaid Eligible Aged and Disabled Population

County Name	Medicaid Eligible Aged & Disabled	CAP-DA Clients Served per 1000 Medicaid Aged & Disabled	Personal Care Services Clients Served per 1000 Medicaid Aged & Disabled	County Name	Medicaid Eligible Aged & Disabled	CAP-DA Clients Served per 1000 Medicaid Aged & Disabled	Personal Care Services Clients Served per 1000 Medicaid Aged & Disabled
ALAMANCE	4367	14.43	46.71	JOHNSTON	5602	8.39	31.42
ALEXANDER	1131	66.31	66.31	JONES	720	87.50	86.11
ALLEGHANY	645	106.98	62.02	LEE	2141	49.98	71.93
ANSON	1800	55.00	66.67	LENOIR	4112	22.86	94.36
ASHE	1654	113.66	39.30	LINCOLN	2013	21.36	5.46
AVERY	990	200.00	129.29	MACON	1454	63.27	24.07
BEAUFORT	2990	47.49	65.55	MADISON	1424	14.04	33.71
BERTIE	2241	89.25	159.30	MARTIN	2114	35.00	95.55
BLADEN	2962	44.23	126.60	MCDOWELL	1868	21.95	70.66
BRUNSWICK	3048	24.61	68.90	MECKLENBURG	16091	27.90	25.85
BUNCOMBE	8253	23.87	17.81	MITCHELL	1077	80.78	138.35
BURKE	3553	73.46	38.00	MONTGOMERY	1472	33.97	51.63
CABARRUS	3758	112.83	26.88	MOORE	2682	22.74	23.86
CALDWELL	3073	76.80	32.54	NASH	4832	18.00	66.23
CAMDEN	260	42.31	15.38	NEW HANOVER	5871	22.65	63.36
CARTERET	2088	61.78	38.31	NORTHAMPTON	2237	21.46	120.25
CASWELL	1395	70.25	62.37	ONSLOW	3405	47.28	73.72
CATAWBA	3956	38.17	15.67	ORANGE	2020	50.50	36.14
CHATHAM	1503	40.59	64.54	PAMLICO	702	69.80	105.41
CHEROKEE	1821	81.82	22.52	PASQUOTANK	1800	26.67	30.56
CHOWAN	948	62.24	22.15	PENDER	1916	75.16	64.72
CLAY	504	81.35	29.76	PERQUIMANS	662	39.27	40.79
CLEVELAND	4622	36.13	24.88	PERSON	1804	26.61	52.11
COLUMBUS	5323	24.80	157.43	PITT	6362	16.50	117.10
CRAVEN	3795	41.63	54.81	POLK	646	71.21	0.00

County Name	Medicaid Eligible Aged & Disabled	CAP-DA Clients Served per 1000 Medicaid Aged & Disabled	Personal Care Services Clients Served per 1000 Medicaid Aged & Disabled	County Name	Medicaid Eligible Aged & Disabled	CAP-DA Clients Served per 1000 Medicaid Aged & Disabled	Personal Care Services Clients Served per 1000 Medicaid Aged & Disabled
CUMBERLAND	9577	16.60	67.56	RANDOLPH	3753	49.83	22.65
CURRITUCK	522	55.56	28.74	RICHMOND	3136	9.89	60.59
DARE	547	27.42	12.80	ROBESON	9807	43.64	113.59
DAVIDSON	4698	20.01	34.70	ROCKINGHAM	4718	80.54	41.75
DAVIE	1028	120.62	8.75	ROWAN	4213	49.85	35.13
DUPLIN	3244	37.61	67.20	RUTHERFORD	3082	31.15	31.15
DURHAM	6391	17.84	50.54	SAMPSON	3835	8.87	102.48
EDGECOMBE	4781	14.22	78.85	SCOTLAND	2601	40.37	86.89
FORSYTH	8586	16.77	63.59	STANLY	2204	40.83	56.26
FRANKLIN	2622	36.61	73.61	STOKES	1603	43.67	44.92
GASTON	7850	16.31	27.77	SURRY	3479	45.99	50.88
GATES	587	97.10	30.66	SWAIN	948	90.72	12.66
GRAHAM	677	116.69	23.63	TRANSYLVANIA	1101	67.21	41.78
GRANVILLE	2028	18.24	71.50	TYRRELL	332	39.16	69.28
GREENE	1016	47.24	94.49	UNION	2660	20.68	19.92
GUILFORD	12297	23.58	57.98	VANCE	3371	13.35	64.08
HALIFAX	5950	12.44	71.09	WAKE	11518	26.57	42.19
HARNETT	3861	27.97	60.87	WARREN	1652	21.79	83.54
HAYWOOD	2583	40.26	5.03	WASHINGTON	978	42.94	58.28
HENDERSON	3152	35.22	2.54	WATAUGA	1161	73.21	18.95
HERTFORD	2210	47.51	199.10	WAYNE	5877	10.55	81.67
HOKE	1455	51.55	57.04	WILKES	3337	76.42	36.56
HYDE	509	60.90	76.62	WILSON	4332	31.63	48.48
IREDELL	3618	36.76	52.79	YADKIN	1407	52.59	51.88
JACKSON	1525	81.97	35.41	YANCEY	1210	56.20	95.87

Source: CAP-DA and PCS data from the Division of Medical Assistance, SFY 1999

Table 3
Comparison of Adult Day Care and Adult Day Health (Home and Community Care Block Grant) versus Adult Day Care (Social Services Block Grant) Clients Served per 1000 of Population Aged 60 and Older

County Name	Population Aged 60 and older	Adult Day Care and Adult Day Health Clients Served per 1000 Population Aged 60 and older: HCCBG	Adult Day Care Clients Served per 1000 Population Aged 60 and older: SSBG	County Name	Population Aged 60 and older	Adult Day Care and Adult Day Health Clients Served per 1000 Population Aged 60 and older: HCCBG	Adult Day Care Clients Served per 1000 Population Aged 60 and older: SSBG
ALAMANCE	25105	1.31	0	JOHNSTON	18500	0	1.03
ALEXANDER	5523	0	0	JONES	1740	0	0
ALLEGHANY	2611	0	3.83	LEE	9818	0	0.20
ANSON	4897	0	0	LENOIR	11639	0.34	0
ASHE	6138	1.63	0.33	LINCOLN	10187	0	0
AVERY	3398	0	0	MACON	8740	2.40	0.46
BEAUFORT	9139	0	0	MADISON	9090	0	0
BERTIE	3971	4.78	0.25	MARTIN	4337	0	0
BLADEN	6226	0	0	MCDOWELL	5244	0	0
BRUNSWICK	16980	0.41	0.12	MECKLENBURG	80644	1.13	0.04
BUNCOMBE	41686	0.82	0.46	MITCHELL	3817	0	0
BURKE	16487	0.97	0	MONTGOMERY	4324	0	0
CABARRUS	21043	2.71	0.24	MOORE	21312	0.38	0
CALDWELL	14045	0.57	0.28	NASH	15132	2.25	0
CAMDEN	1296	3.09	0	NEW HANOVER	27539	1.34	0.18
CARTERET	13241	0	0	NORTHAMPTON	4952	1.82	0.20
CASWELL	4779	0	0	ONSLOW	11877	0.34	0
CATAWBA	23250	1.72	0.09	ORANGE	13569	0	0.52
CHATHAM	9600	0	0	PAMLICO	3159	0	0
CHEROKEE	6163	2.60	0	PASQUOTANK	6368	2.51	0
CHOWAN	3423	0.29	0	PENDER	8249	0	0
CLAY	2333	0	0	PERQUIMANS	2848	1.76	0
CLEVELAND	18000	1.67	0	PERSON	6497	0	0
COLUMBUS	10435	0	0	PITT	16387	0.85	0.12
CRAVEN	15575	0.90	0	POLK	5387	0	0

County Name	Population Aged 60 and older	Adult Day Care and Adult Day Health Clients Served per 1000 Population Aged 60 and older: HCCBG	Adult Day Care Clients Served per 1000 Population Aged 60 and older: SSBG
CUMBERLAND	32949	0.61	0
CURRITUCK	3034	0.33	0
DARE	4964	0	0
DAVIDSON	25443	1.06	0.28
DAVIE	6622	0	0
DUPLIN	8708	0.11	0.46
DURHAM	25683	0.27	0.19
EDGECOMBE	9112	4.06	0.11
FORSYTH	50260	0.78	0.22
FRANKLIN	7608	0.26	0.39
GASTON	30516	0	0.62
GATES	1928	0	0
GRAHAM	1829	0	4.37
GRANVILLE	7339	0	0.55
GREENE	3385	0	0
GUILFORD	66182	1.39	0.06
HALIFAX	10561	1.23	0.47
HARNETT	13810	0.87	0.51
HAYWOOD	14405	1.80	0
HENDERSON	24386	0.53	0.04
HERTFORD	4233	0	0.71
HOKE	4153	0	0
HYDE	1172	0	0
IREDELL	21155	0.66	0.19
JACKSON	6133	1.96	0
RANDOLPH	21804	0.50	0.18
RICHMOND	8585	0	0
ROBESON	16881	0	0.36
ROCKINGHAM	17977	0	0
ROWAN	24749	1.45	0.08
RUTHERFORD	12506	0.56	0
SAMPSON	10780	2.23	0
SCOTLAND	5325	3.19	0.94
STANLY	10764	0	0
STOKES	7639	0	0.26
SURRY	14519	0	0
SWAIN	2693	0	0
TRANSYLVANIA	8100	1.48	1.36
TYRRELL	816	0	0
UNION	15752	0.83	0
VANCE	7045	0	0
WAKE	66104	1.03	0.11
WARREN	4658	0.21	0.21
WASHINGTON	2637	0	0
WATAUGA	6588	0	0
WAYNE	18092	0	0.06
WILKES	12717	0	0
WILSON	12408	0	0.97
YADKIN	7548	0	0.40
YANCEY	4077	0	0.49

Sources: HCCBG services data from the Division of Aging, SFY 1999
SSBG services data from the Division of Social Services, SFY 1999

Table 4
Comparison of Home Delivered Meals (Home and Community Care Block Grant) and Meals (Social Services Block Grant) Clients Served per 1000 Population Aged 60 and Older

County Name	Population Aged 60 and Older	Home Delivered Meals Clients Served per 1000 Population Aged 60 and Older: HCCBG	Meals Clients Served per 1000 Population Aged 60 and Older: SSBG	County Name	Population Aged 60 and Older	Home Delivered Meals Clients Served per 1000 Population Aged 60 and Older: HCCBG	Meals Clients Served per 1000 Population Aged 60 and Older: SSBG
ALAMANCE	25105	44.57	1.12	JOHNSTON	18500	24.59	0
ALEXANDER	5523	9.23	0	JONES	1740	22.99	0
ALLEGHANY	2611	36.00	0	LEE	9818	7.54	0
ANSON	4897	38.19	0	LENOIR	11639	6.36	0
ASHE	6138	35.03	0	LINCOLN	10187	0	0
AVERY	3398	20.89	0	MACON	8740	12.01	0
BEAUFORT	9139	26.15	0	MADISON	9090	5.39	0
BERTIE	3971	22.16	0	MARTIN	4337	35.28	0
BLADEN	6226	11.08	0	MCDOWELL	5244	58.54	0
BRUNSWICK	16980	23.14	0	MECKLENBURG	80644	23.59	0
BUNCOMBE	41686	14.78	0	MITCHELL	3817	45.32	0
BURKE	16487	13.04	0	MONTGOMERY	4324	20.35	0
CABARRUS	21043	0	0	MOORE	21312	7.41	0
CALDWELL	14045	7.19	0	NASH	15132	12.03	0
CAMDEN	1296	29.32	0	NEW HANOVER	27539	16.34	0
CARTERET	13241	3.40	0	NORTHAMPTON	4952	13.73	0
CASWELL	4779	29.50	0	ONSLOW	11877	9.35	0
CATAWBA	23250	16.86	0	ORANGE	13569	0	0
CHATHAM	9600	13.02	0	PAMLICO	3159	22.16	0
CHEROKEE	6163	19.47	0	PASQUOTANK	6368	16.49	0
CHOWAN	3423	15.48	0	PENDER	8249	30.91	0
CLAY	2333	39.86	0	PERQUIMANS	2848	26.33	0
CLEVELAND	18000	10.00	0	PERSON	6497	18.78	0
COLUMBUS	10435	11.31	0	PITT	16387	24.59	0
CRAVEN	15575	8.67	0	POLK	5387	29.33	0

County Name	Population Aged 60 and Older	Home Delivered Meals Clients Served per 1000 Population Aged 60 and Older: HCCBG	Meals Clients Served per 1000 Population Aged 60 and Older: SSBG	County Name	Population Aged 60 and Older	Home Delivered Meals Clients Served per 1000 Population Aged 60 and Older: HCCBG	Meals Clients Served per 1000 Population Aged 60 and Older: SSBG
CUMBERLAND	32949	9.56	0	RANDOLPH	21804	19.26	0
CURRITUCK	3034	14.50	0	RICHMOND	8585	18.75	0
DARE	4964	12.09	0	ROBESON	16881	11.49	0
DAVIDSON	25443	12.14	0	ROCKINGHAM	17977	18.19	0
DAVIE	6622	24.16	0	ROWAN	24749	0	0
DUPLIN	8708	15.85	0	RUTHERFORD	12506	22.23	0
DURHAM	25683	20.56	0.43	SAMPSON	10780	13.17	0
EDGECOMBE	9112	8.67	0	SCOTLAND	5325	11.08	0
FORSYTH	50260	19.48	2.53	STANLY	10764	37.44	0
FRANKLIN	7608	14.98	0	STOKES	7639	41.10	0
GASTON	30516	10.16	0	SURRY	14519	18.94	0
GATES	1928	30.60	0	SWAIN	2693	29.71	0
GRAHAM	1829	53.03	0	TRANSYLVANIA	8100	18.52	0
GRANVILLE	7339	47.96	0	TYRRELL	816	41.67	0
GREENE	3385	18.61	0	UNION	15752	35.23	0
GUILFORD	66182	19.36	0	VANCE	7045	31.80	0
HALIFAX	10561	16.95	0	WAKE	66104	21.62	0
HARNETT	13810	26.29	0	WARREN	4658	31.56	0
HAYWOOD	14405	10.14	0.62	WASHINGTON	2637	22.37	0
HENDERSON	24386	26.37	0	WATAUGA	6588	30.81	0
HERTFORD	4233	13.70	0	WAYNE	18092	29.79	0
HOKE	4153	9.39	0	WILKES	12717	24.61	0
HYDE	1172	21.33	0	WILSON	12408	15.55	0
IREDELL	21155	14.04	0	YADKIN	7548	23.18	0
JACKSON	6133	22.34	0.82	YANCEY	4077	41.94	0

Sources: HCCBG services data from the Division of Aging, SFY 1999
SSBG services data from the Division of Social Services, SFY 1999

Table 5
Comparison of In-Home Aides Clients Served (Home and Community Care Block Grant versus Social Services Block Grant) per 1000 of Population Aged 60 and Older

County Name	Population Aged 60 and Older	In-Home Aides Clients Served per 1000 Population Aged 60 and Older: HCCBG	In-Home Aides Clients Served per 1000 Population Aged 60 or Older: SSBG	County Name	Population Aged 60 and Older	In-Home Aides Clients Served per 1000 Population Aged 60 and Older: HCCBG	In-Home Aides Clients Served per 1000 Population Aged 60 or Older: SSBG
ALAMANCE	25105	1.83	0.16	JOHNSTON	18500	15.46	5.24
ALEXANDER	5523	16.30	3.62	JONES	1740	16.67	10.92
ALLEGHANY	2611	40.60	5.36	LEE	9818	0	2.65
ANSON	4897	12.87	0	LENOIR	11639	13.23	3.35
ASHE	6138	20.69	0.33	LINCOLN	10187	2.55	1.77
AVERY	3398	26.78	0.29	MACON	8740	6.75	0.57
BEAUFORT	9139	7.88	6.13	MADISON	9090	1.76	2.20
BERTIE	3971	8.56	0.76	MARTIN	4337	18.45	1.15
BLADEN	6226	12.37	3.53	MCDOWELL	5244	16.40	0
BRUNSWICK	16980	2.89	3.42	MECKLENBURG	80644	12.62	0.48
BUNCOMBE	41686	4.68	0.86	MITCHELL	3817	17.55	8.38
BURKE	16487	10.31	0.42	MONTGOMERY	4324	12.95	0.69
CABARRUS	21043	3.18	1.52	MOORE	21312	6.62	0.23
CALDWELL	14045	5.41	1.71	NASH	15132	7.27	0.86
CAMDEN	1296	6.17	0	NEW HANOVER	27539	4.25	0.11
CARTERET	13241	5.36	0.38	NORTHAMPTON	4952	9.69	9.49
CASWELL	4779	10.04	0	ONSLOW	11877	11.11	0
CATAWBA	23250	2.37	0.90	ORANGE	13569	4.20	0.15
CHATHAM	9600	8.85	2.29	PAMLICO	3159	14.56	13.93
CHEROKEE	6163	6.81	4.54	PASQUOTANK	6368	2.83	0
CHOWAN	3423	9.06	0	PENDER	8249	2.67	0.48
CLAY	2333	13.72	12.00	PERQUIMANS	2848	6.67	0
CLEVELAND	18000	3.56	0.50	PERSON	6497	8.62	0.77
COLUMBUS	10435	4.89	0	PITT	16387	3.78	0.43
CRAVEN	15575	4.69	2.89	POLK	5387	4.08	0

County Name	Population Aged 60 and Older	In-Home Aides Clients Served per 1000 Population Aged 60 and Older: HCCBG	In-Home Aides Clients Served per 1000 Population Aged 60 or Older: SSBG	County Name	Population Aged 60 and Older	In-Home Aides Clients Served per 1000 Population Aged 60 and Older: HCCBG	In-Home Aides Clients Served per 1000 Population Aged 60 or Older: SSBG
CUMBERLAND	32949	7.44	2.25	RANDOLPH	21804	4.86	0.05
CURRITUCK	3034	12.52	1.32	RICHMOND	8585	15.84	0.12
DARE	4964	18.73	19.14	ROBESON	16881	9.66	0.71
DAVIDSON	25443	5.11	0.63	ROCKINGHAM	17977	6.17	0.06
DAVIE	6622	13.14	1.06	ROWAN	24749	5.01	2.02
DUPLIN	8708	30.55	0.23	RUTHERFORD	12506	2.32	2.96
DURHAM	25683	6.11	1.05	SAMPSON	10780	3.90	1.48
EDGECOMBE	9112	22.28	0.22	SCOTLAND	5325	11.83	0.56
FORSYTH	50260	10.27	2.55	STANLY	10764	12.91	2.23
FRANKLIN	7608	10.25	0.13	STOKES	7639	1.44	7.59
GASTON	30516	10.06	0.39	SURRY	14519	10.74	0
GATES	1928	24.38	21.27	SWAIN	2693	19.31	0
GRAHAM	1829	22.96	2.19	TRANSYLVANIA	8100	9.51	0
GRANVILLE	7339	20.44	0.27	TYRRELL	816	51.47	0
GREENE	3385	3.84	3.84	UNION	15752	11.36	2.79
GUILFORD	66182	4.41	0.76	VANCE	7045	16.04	2.98
HALIFAX	10561	10.51	1.52	WAKE	66104	1.98	1.54
HARNETT	13810	8.54	0.22	WARREN	4658	21.04	0.21
HAYWOOD	14405	5.48	2.15	WASHINGTON	2637	21.24	2.28
HENDERSON	24386	7.18	3.28	WATAUGA	6588	31.72	3.34
HERTFORD	4233	7.32	1.42	WAYNE	18092	21.17	0.33
HOKE	4153	11.56	1.20	WILKES	12717	9.91	0.16
HYDE	1172	22.18	7.68	WILSON	12408	7.41	0.81
IREDELL	21155	8.37	0.52	YADKIN	7548	28.62	0
JACKSON	6133	19.08	0.33	YANCEY	4077	12.51	0.74

Sources: HCCBG services data from the Division of Aging, SFY 1999
SSBG services data from the Division of Social Services, SFY 1999

Table 6
Comparison of Nursing Home Beds and Community Alternative Program (CAP-DA) Clients Served per 1000 of Eligible Population

County Name	Population Aged 65 and greater	Nursing Home Beds per 1000 older adults (65+)	Medicaid Eligible Aged & Disabled	CAP-DA people served per 1000 Medicaid Aged & Disabled	County Name	Population Aged 65 and greater	Nursing Home Beds per 1000 older adults (65+)	Medicaid Eligible Aged & Disabled	CAP-DA people served per 1000 Medicaid Aged & Disabled
ALAMANCE	19508	42.09	4367	14.43	JOHNSTON	13731	32.77	5602	8.39
ALEXANDER	4071	44.95	1131	66.31	JONES	1293	61.87	720	87.50
ALLEGHANY	2050	43.90	645	106.98	LEE	7411	31.57	2141	49.98
ANSON	3855	41.76	1800	55.00	LENOIR	8826	37.62	4112	22.86
ASHE	4646	38.74	1654	113.66	LINCOLN	7516	33.26	2013	21.36
AVERY	2598	49.27	990	200.00	MACON	7074	38.17	1454	63.27
BEAUFORT	6897	42.05	2990	47.49	MADISON	3308	54.41	1424	14.04
BERTIE	3024	46.96	2241	89.25	MARTIN	3951	38.98	2114	35.00
BLADEN	4755	40.80	2962	44.23	MCDOWELL	6598	33.34	1868	21.95
BRUNSWICK	12345	25.44	3048	24.61	MECKLENBURG	60133	51.12	16091	27.90
BUNCOMBE	32527	51.68	8253	23.87	MITCHELL	2940	43.20	1077	80.78
BURKE	12329	36.99	3553	73.46	MONTGOMERY	3298	46.39	1472	33.97
CABARRUS	15855	37.65	3758	112.83	MOORE	17101	33.92	2682	22.74
CALDWELL	10421	39.34	3073	76.80	NASH	11435	36.64	4832	18.00
CAMDEN	951	42.06	260	42.31	NEW HANOVER	20802	34.08	5871	22.65
CARTERET	9790	41.88	2088	61.78	NORTHAMPTON	3796	39.25	2237	21.46
CASWELL	3629	37.75	1395	70.25	ONSLOW	8405	42.71	3405	47.28
CATAWBA	17284	38.71	3956	38.17	ORANGE	10136	43.71	2020	50.50
CHATHAM	7456	45.60	1503	40.59	PAMLICO	2387	40.22	702	69.80
CHEROKEE	4785	37.62	1821	81.82	PASQUOTANK	5057	52.60	1800	26.67
CHOWAN	2700	62.96	948	62.24	PENDER	6048	35.22	1916	75.16
CLAY	1832	43.67	504	81.35	PERQUIMANS	2168	35.98	662	39.27
CLEVELAND	13538	40.18	4622	36.13	PERSON	4941	40.48	1804	26.61
COLUMBUS	7793	37.60	5323	24.80	PITT	12626	43.40	6362	16.50
CRAVEN	11821	39.42	3795	41.63	POLK	4377	50.49	646	71.21

County Name	Population Aged 65 and greater	Nursing Home Beds per 1000 older adults (65+)	Medicaid Eligible Aged & Disabled	CAP-DA people served per 1000 Medicaid Aged & Disabled	County Name	Population Aged 65 and greater	Nursing Home Beds per 1000 older adults (65+)	Medicaid Eligible Aged & Disabled	CAP-DA people served per 1000 Medicaid Aged & Disabled
CUMBERLAND	23254	34.23	9577	16.60	RANDOLPH	16343	38.55	3753	49.83
CURRITUCK	2238	37.98	522	55.56	RICHMOND	6609	41.76	3136	9.89
DARE	3518	35.82	547	27.42	ROBESON	12450	42.41	9807	43.64
DAVIDSON	18826	37.66	4698	20.01	ROCKINGHAM	13636	39.97	4718	80.54
DAVIE	5029	39.37	1028	120.62	ROWAN	19323	41.14	4213	49.85
DUPLIN	6492	38.82	3244	37.61	RUTHERFORD	9594	43.78	3082	31.15
DURHAM	19614	67.91	6391	17.84	SAMPSON	8161	38.23	3835	8.87
EDGECOMBE	6956	45.57	4781	14.22	SCOTLAND	4004	49.70	2601	40.37
FORSYTH	38420	49.92	8586	16.77	STANLY	8277	49.05	2204	40.83
FRANKLIN	5657	45.61	2622	36.61	STOKES	5493	58.62	1603	43.67
GASTON	23023	42.22	7850	16.31	SURRY	10959	39.42	3479	45.99
GATES	1438	48.68	587	97.10	SWAIN	2037	58.91	948	90.72
GRAHAM	1361	58.78	677	116.69	TRANSYLVANIA	6346	37.35	1101	67.21
GRANVILLE	5474	43.84	2028	18.24	TYRRELL	640	46.88	332	39.16
GREENE	2536	45.35	1016	47.24	UNION	11176	31.94	2660	20.68
GUILFORD	50371	44.19	12297	23.58	VANCE	5393	43.02	3371	13.35
HALIFAX	8097	42.61	5950	12.44	WAKE	47585	40.66	11518	26.57
HARNETT	10354	41.63	3861	27.97	WARREN	3655	38.30	1652	21.79
HAYWOOD	11053	39.90	2583	40.26	WASHINGTON	2022	41.54	978	42.94
HENDERSON	19448	42.27	3152	35.22	WATAUGA	4883	38.09	1161	73.21
HERTFORD	3299	48.80	2210	47.51	WAYNE	13071	36.19	5877	10.55
HOKE	3035	30.31	1455	51.55	WILKES	9461	44.08	3337	76.42
HYDE	898	89.09	509	60.90	WILSON	9343	40.14	4332	31.63
IREDELL	15714	35.83	3618	36.76	YADKIN	5754	42.93	1407	52.59
JACKSON	4609	41.22	1525	81.97	YANCEY	3126	44.79	1210	56.20

Sources: Nursing Home Beds from State Medical Facilities Plan 2000 (Draft), May 1999
CAP-DA and PCS from Division of Medical Assistance, SFY 1999