Plan for Long-Term Solution for Adequate Reimbursement to Facilities Serving Recipients of State-County Special Assistance

SL 2016-94, Section 12C.7

Report to the

House Appropriations Committee on Health and Human Services,
and
Senate Appropriations Committee on Health and Human Services,
and
Joint Legislative Oversight Committee on Health and Human Services
and
Fiscal Research Division

By
North Carolina Department of Health and Human Services

April 1, 2017

Plan for Long-Term Solution for Adequate Reimbursement to Facilities Serving Recipients of State-County Special Assistance

Executive Summary

Session Law 2016-94, Section 12C.7. directs the Department of Health and Human Services to submit by April 1, 2017, to the House Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division a detailed plan for a long-term solution to ensure adequate reimbursement to facilities for serving recipients of State-County Special Assistance without increasing the Medicaid income eligibility limit for SA recipients and thereby expanding Medicaid.

The Division of Aging and Adult Services (DAAS) is the state agency within the NC Department of Health and Human Services (DHHS) responsible for the State-County Special Assistance Program (SA). In response to the legislation, DAAS convened a work group comprised of various stakeholders to help inform DHHS about long-term solutions for reimbursement. Developing a detailed plan proved to be a difficult task for DHHS as it quickly became apparent that options for a long-term solution were very limited. The barriers encountered in federal regulations from earlier studies required by the General Assembly still exist for a long-term solution required by Session Law 2016-94.

The work group studied the similar legislation previously enacted by the NC General Assembly, examined available data, and provided knowledge and expertise from their perspective and involvement with facilities serving SA recipients[1]. Work group members agreed that these facilities need to remain a viable component of the long-term care continuum of services and supports and that workable solutions must be found to sustain adequate levels of reimbursement. The plan represents the culmination of DHHS' work with input from the stakeholders and offers the viable and allowable solutions available to the NC General Assembly now.

While this plan concentrates on a long-term reimbursement solutions for facilities on behalf of SA residents, Medicaid Personal Care Services (PCS) is an important component of supporting individuals in residential settings and in their homes and needs to be examined. DHHS, through the Division of Medical Assistance, is working with stakeholders to review rates and determine the best path forward for Medicaid PCS.

A summary of the recommendations is on the following page. A more detailed description of the recommendations can be found beginning on page 10.

[1] Facilities licensed to serve SA recipients include: adult and family care homes, group homes for adults with intellectual and developmental disabilities, group homes for adults with serious mental illness, hospice residential facilities, and nursing homes with adult care home beds.

Summary of Recommendations

Recommendation 1**:** The NC General Assembly should consider continuing the Temporary Assistance payments for facilities licensed to accept SA recipients as established in Session Law 2016-94 as a time-limited solution.

Recommendation 2: The NC General Assembly should consider a process to incrementally adjust rates for SA based on cost reports and other economic factors. Any increase in SA must also include both in-home and residential settings.

Recommendation 3: The NC General Assembly should consider an increase in the personal needs allowance (PNA) for all SA recipients, in both residential and in-home settings.

Recommendation 4: The NC Department of Health and Human Services should continue working with stakeholders to review cost-effective funding options that support residential and in-home options for older adults and those with disabilities who need state-supported services. Options should consider support for capital costs, fundamental changes in the reimbursement structure for in-home and residential settings that focus on NC's unique needs, and providing the maximum choice for citizens.

Introduction

The Division of Aging and Adult Services (DAAS) is the state agency within the NC Department of Health and Human Services (DHHS) responsible for the State-County Special Assistance Program (SA). The SA Program is administered locally by county departments of social services (DSSs). Staff in county DSSs determine initial and ongoing eligibility for SA using the NC FAST Case Management System (NC FAST).

DAAS convened a work group comprised of internal and external stakeholders to develop a detailed plan for a long-term solution to ensure adequate reimbursement to facilities licensed to serve SA recipients as directed in Session Law 2016-94. The work group included associations representing adult care homes, assisted living, group homes, and nursing homes (with adult care beds): an advocacy group; the Long-Term Care Ombudsman Program: the North Carolina Association of County Directors of Social Services: and various DHHS divisions. See Appendix 1 for the complete work group membership. The work group met five times over the course of several months to develop this plan.

Background

The SA Program is a state supplement to the federal Supplemental Security Income (SSI) Program as set forth in Section 1616 of the Social Security Act and 20 CFR.416.2001. Under these federal regulations, states may establish assistance payments to individuals to meet an identified need. Monthly assistance payments are made to individuals who meet all eligibility requirements for SSI except they may have income over the SSI income limit, currently $735, but have personal income within a state's established income limit for the program. Eligible individuals must also be 65 years of age or older, disabled, or legally blind in accordance with Social Security Administration criteria.

The Social Security Administration's SSI Program Operations Manual System, SI.00520.510, considers the types of facilities licensed to accept SA residents as community-based. They are residential settings located in communities where supportive and other services are provided.

North Carolina's Program

North Carolina's SA program was established by the NC General Assembly in NCGS 108A, Part 3 to assist eligible individuals to pay for room and board in adult and family care homes, group homes for individuals with intellectual and developmental disabilities or mental illness, and nursing homes with adult care home beds.

Maximum rates for SA are established by the NC General Assembly. Currently, the maximum rate for Basic SA (Non-SCU) is $1,182 per month per recipient and $1,515 per month per recipient in Special Care Units (SCUs) specifically established for individuals with Alzheimer's Disease and other types of dementia.

The NC General Assembly also established a Personal Needs Allowance (PNA) which is currently $46 per month per resident. The PNA is used by recipients for all personal items, including Medicaid prescription drug co-pays, over-the counter-medications, clothing, personal toiletries, incontinence supplies, and to pay for any other incidentals not covered by SA and Medicaid.

The SA payment made to the resident includes the $46 PNA. The income eligibility limit for SA is, by federal regulations, the SA maximum rate plus the PNA. To qualify for Basic SA, the income eligibility limit is $1,228 per month. For SCUs, the income eligibility limit is $1,561 per month. SA payments are funded with 50% State appropriation and 50% county match.

The rate SA recipients pay to facilities includes the SA recipient's own personal income from all sources plus the SA payment. The only other available funding available to an SA recipient is the $46 monthly PNA. All individuals who qualify are eligible to receive SA. There can be no cap on the number of eligible individuals per federal regulations.

Individuals eligible for SA also receive Medicaid as set forth in Section 1905 of the Social Security Act, 42 CFR.435.232.

SA Costs

The current average Basic (Non-SCU) SA payment is $408 per month and $517 per month for SCUs. SA payments decrease in the years there are Social Security and Veteran's Administration cost of living adjustments (COLA.) The SA payment decreases per the recipient's increase from the COLA. Appendix 2 shows the total State and county expenditures for SA.

SA payments are split equally between the State appropriation and the county match. This equates to $204 per month each for state and county costs or an average daily cost of $6.80 for Basic (Non-SCU) SA. For SCUs, the state and county costs each are $258 per month or $8.61 per day. The SA resident's other sources of income make up the remainder of the payment up to the approved SA rate, currently $1,182. The average payment made by SA residents from other income sources is $774 per month. Below are the costs based on a daily rate.

Source of Adult Care Home Services Funding	SA Rate Average Cost Per Day	Percentage
County Funds	$6.80	17.5%
State Funds	$6.80	17.5%
Resident Payments from Income	$25.26	65%
Total Daily SA Rate	$38.86	100%

Rate History and Caseload Decline

The expenditures for SA have declined over the past 10 years along with a decline in the size of the SA caseload. Because the maximum Basic (Non-SCU) rate that facilities can charge an SA resident has not changed since October of 2009, the income eligibility limit has remained constant since that time.

Overall, occupancy rates reported by facilities for the State Fiscal Year 2014-15 cost reporting are low and are negatively impacting their ability to manage overall costs. The larger are particularly affected by low occupancy. Non-SCU facilities with 91 or more beds report 71% occupancy. Appendix 3 provides information on occupancy rates.

Appendix 2 shows the certified budget, expenditures, caseload size, rate and PNA history. It indicates the trending decline in the SA caseload and SA expenditures. The work group attributes the caseload decline to the rates for SA remaining flat for eight years; changes in the eligibility criteria and a decline in the rate for Medicaid PCS; closure of facilities accepting SA residents; and growth in facilities accepting only private-pay residents.

For facilities that accept both private pay and SA residents, the private pay residents' rates may be helping to offset the cost of care for SA residents, since the SA rates have not increased since 2009 and costs continue to increase. The current difference between the Basic (Non-SCU) SA maximum rate of $1,182 and the private pay rate is worth noting. Average private pay estimates for adult care facilities range between $3,500 and $4,500 per month. The gap reveals the lack of availability for this level of care for individuals whose incomes are above the SA income eligibility limit, but below the income required to pay the average private pay rate.

Prior Legislative Mandates

Because this detailed plan requires a long-term solution for reimbursement to facilities for SA recipients without increasing the Medicaid income eligibility limit, DHHS examined other similar legislative studies that would have changed the SA payment structure, but would have either reduced or eliminated the impact on Medicaid. These session laws, detailed below, and the accompanying research required to implement them, clarify the challenge this work group encountered to address the mandate to ensure adequate reimbursement to facilities serving SA recipients without increasing the Medicaid income eligibility limit for these recipients, and thereby expanding Medicaid.

S.L. 2013-360, Subpart XII-D required DAAS to establish a pilot program to implement a tiered-rate structure for facility and in-home SA recipients by allocating block grant funding to counties. This legislation directed what was required for the development of a tiered-rate.

The pilot was not implemented due to lack of interest from the counties (only one county volunteered to pilot the block grant tiered-rate structure). In addition, North Carolina cannot implement a block grant funding structure regardless of the lack of interest in the pilot. SA recipients are a Medicaid eligibility group within the NC Medicaid State Plan under 42 CFR 435.200 and SA and Medicaid must be available to all individuals in the state who qualify. Because the block grant capped budget could have created county waiting lists for SA, it would be noncompliant with federal regulations.

Prior to S.L. 213-360, a study of the feasibility of a tiered-rate structure was conducted under the Blue Ribbon Commission on Transitions to Community Living established in S.L 2012-142. The Blue Ribbon Commission report, "Transitions to Community Living" was submitted December 19, 2012. The methodology for creating tiered-rates centered on the individuals who would not qualify for PCS based on the independent PCS assessments. The study demonstrated that a tiered-rate system could be developed. However, there were outstanding questions that could not be addressed within the parameters of the study such as information technology system modification costs and the cost of developing and implementing a consistent assessment tool. Regardless, the analysis of tiered-rates demonstrated a marked increase in SA budget requirements, if implemented. No actions or recommendations were taken from the study.

S.L. 2014-100, Section 12D 1.(b) proposed setting the eligibility limit for SA at or below 100% of the federal poverty level (FPL) the Medicaid income limit for individuals who are Aged, Blind, or Disabled, and are in private living, while maintaining the current SA rates. This would have eliminated SA and Medicaid eligibility for new applicants with incomes over 100% of the FPL.

S.L. 2014-100 also proposed that individuals eligible prior to the effective date of November 1, 2014 would not be affected by the income limit change as they would be "grandfathered." A State Plan Amendment (SPA) to the NC Medicaid State Plan, 14-0048, was submitted to the Centers for Medicaid and Medicare (CMS) and denied because it would require different eligibility standards for those applying after November 2014. Moreover, the SA payment must be equal to the difference between the individual's countable income and the income eligibility limit used to determine eligibility for the supplement. With this restriction, the "rate" established by the NC General Assembly plus the PNA must always be the income eligibility limit (42 CFR 435.232).

Several times in the past, the NC General Assembly reduced the SA payment and allowed SA recipients who would not qualify based on the new income limits to be "grandfathered" or retain their eligibility with a minimal payment to continue active SA status. The purpose of "grandfathering" was to allow the SA recipients to keep their Medicaid eligibility intact. Grandfathering occurred in 1995, 2003, 2005, and 2009. It was also part of SL 2013-360.

"Grandfathering" is inconsistent with the Medicaid comparability requirements described in Section 1902(a)(17) of the Social Security Act, which require that states establish standards for determining eligibility that are comparable for all beneficiaries. One group of recipients, the grandfathered group, would have an income eligibility limit higher than the other recipients.

Cost Reports

Historically, the DHHS Office of the Controller has been responsible for collecting audited cost reports annually from adult care facilities licensed under NCGS 131D and NCGS 122C in accordance with NCGS 131D-4.2. Data from the adult care facility cost modeling study reports served as the basis for SA rates for all settings included under the SA and Special Assistance In-Home (SA/IH) programs. The NC General Assembly has historically adopted a rate lower than the recommended rate or enacted no rate change at all.

A committee of DHHS and facility representatives was formed in 2003 to address provider concerns about the rate-setting methodology and to seek solutions to more accurately capture the true cost of operating an adult care facility. The final recommendation was to develop a more applied approach utilizing adult care licensure rules and regulations covering, for example, staffing requirements and building requirements. The committee published the **Report of the Findings and Recommendations of the Adult Care Cost Modeling Committee** in December 2004. The recommendation was made to adopt cost modeling as the mechanism for setting rates. The NC General Assembly approved the recommendation in the SFY 2005-06 legislative session, and it was effective October 1, 2005. The result was that every three years cost modeled rates were to be calculated using the new parameters.

Due to the economic recession beginning in 2008, the Secretary of DHHS suspended indefinitely the requirement for adult care facilities to submit cost reports. The last cost reports received were for SFY 2008-09 and included information for facilities licensed under NCGS 131D and costs for group homes licensed under NCGS 122C. Legislation passed in SFY 2013-14 reinstated DHHS's requirement to conduct rate-setting for adult care facilities.

Findings from the cost modeling study for the SFY 2014-15 rate-setting cycle, indicate increases for both Basic (Non-SCU) and SCU SA rates. Basic (Non-SCU) rates would increase from $1,182 per month to $1,395 per month. The SCU rate would increase from $1,515 per month to $1,705 per month. The uninflated Basic (Non-SCU) SA rate from the cost model equaled the average of the raw data reported. The overall rate for SCUs indicated from the initial cost report data was $1,949 per month, but was adjusted upon examination of the data to the cost-modeled rate of $1,705. Appendix 4 illustrates the SFY 2014-15 raw cost report data.

The current rate-setting methodology centers on adult care and SCU facilities licensed under NCGS 131D. Group homes licensed under NCGS 122C submit cost reports which are used primarily for statistical and historical tracking purposes, but are not factored into the recommendations for SA rates. The group homes have a different business model than the larger adult care and SCU facilities.

Examining Medicaid for SA Recipients and Costs

Medicaid eligibility is critical to support overall facility costs for residents to obtain adequate medical care and because the facilities provide personal care reimbursed through Medicaid PCS. Based on Division of Medical Assistance (DMA) March 2017 data, 55% of Medicaid residents are approved to receive PCS. Any personal care required must be provided by the staff with no reimbursement when an individual does not meet the criteria for Medicaid PCS, but has some personal care needs. Appendix 5 demonstrates the impact to facility profits and loss from the cost modeling for SA residents for whom they cannot bill Medicaid PCS. The losses are greater when the PCS billing costs were examined. These data include SA revenues and receipts from private payments. Appendix 6 shows that Medicaid PCS reimbursement is less than PCS cost and some personal care assistance provided by the facility for non-Medicaid PCS SA residents is administered which cannot be billed and no reimbursement is available from any source.

Another factor to consider when examining Medicaid costs for SA recipients is that SSI recipients are automatically eligible for Medicaid. Currently, North Carolina has approximately 250,000 SSI recipients. As of January 2017, approximately 12,250 SA recipients receive SSI. They are automatically eligible for Medicaid whether residing in an adult care or group home or in private living in the community. When calculating the cost of an SA rate increase on Medicaid, projections should consider that new SA eligibles receiving SSI are already Medicaid recipients.

Other Options Explored

DHHS researched and discussed several other options with the work group which are described below.

Eliminating SA as a Medicaid Eligibility Group

Eliminating the SA eligibility group from the NC Medicaid State Plan requires a SPA to be submitted to CMS. If allowed, this would disenfranchise approximately 5,422 SA recipients from the Categorically Needy Medicaid Program as their incomes would be above 100% of the FPL ($1,005/month effective 2017). This change would further reduce the reimbursement to SA facilities as they would not be able to provide Medicaid PCS for these approximately 5,422 individuals. Grandfathering of current SA recipients would not be permitted as previously stated above.

Another 6,129 SA recipients fall below 100% of the FPL, but have incomes too high to qualify for SSI ($735/month effective 2017). These 6,129 would most likely be eligible for Medicaid, but would have to be evaluated under another Medicaid eligibility group.

If CMS were to approve a SPA eliminating the SA eligibility group, 11,551 overall would be impacted by such a change.

Addressing Capital Costs

Maintenance of the physical environment is an ongoing expense for facility owners and can be a significant expense as buildings age. Capital costs are typically defined as depreciation, amortization, mortgage interest expenses, building repairs and maintenance, and lease/rent.

Different methodologies exist as to how capital costs can be reimbursed and vary among the other states. Some states are gravitating to toward a Fair Rental Value model to address capital costs. More study of this approach could potentially identify a means to provide long-term sustainability to facility providers.

Continue Temporary Assistance Payments to Facilities

Temporary assistance payments to facilities licensed to accept SA residents enacted with Session Law 2016-94 were effective October 1, 2016. DHHS had a very short timeframe to implement the payment with no existing mechanisms and no time to test the process and procedures that were quickly developed. The reimbursement process is not fully automated. Long-term sustainability of this predominantly manual process by DHHS would be difficult. Changes are required in NC FAST to efficiently and correctly administer payments system.

Recommendations

Recommendation 1: The NC General Assembly should consider continuing the Temporary Assistance payments for facilities licensed to accept SA recipients as established in Session Law 2016-94 as a time-limited solution.

This recommendation is made as a time-limited solution because it is the only readily available option that would not increase the SA and Medicaid income limit, thereby expanding Medicaid. It is not recommended as a long-term solution because continuing payments made directly to providers freezes the current Basic (Non-SCU) and SCU SA income eligibility limits. This has a significantly negative effect by further reducing the number of individuals eligible for SA and consequently jeopardizes long-term sustainability for providers and the availability of publicly funded adult care facility and group home beds.

Should the General Assembly decide to continue these direct payments to facilities for a longer period, significant changes would have to be made to NC FAST to ensure an automated process that is timely and efficient. Current estimates for enhancements to NC FAST indicate a minimum of 18 months with the cost undetermined at this time.

Recommendation 2: The NC General Assembly should consider ~~a~~ process to incrementally adjust rates for SA based on cost reports and other economic factors. Any increase must also include both in-home and residential settings.

As described earlier in this plan, the maximum rate for Basic (Non-SCU) SA has remained unchanged since 2009. The maximum rate for SCUs has remained unchanged since 2005 when that rate was established by the NC General Assembly. Therefore, the income eligibility limits have remained constant since 2009 for Basic (Non-SCU) SA and since 2005 for SCU SA. Appendix 2 shows the trending decline in the SA caseload and SA expenditures. Without adequate funding for staffing, facility maintenance, and other essential costs for providing care, the availability of this level of residential care will continue to decline.

<u>Projected Cost Estimates</u>

DMA estimates for the number of new individuals qualifying for various SA rate increases and associated Medicaid costs are found in Appendix 7. Examples of SA rate increases of $50, 75, and $100 per month with projected total costs (State and county) for the current caseload and new potential eligibles and for the State's share of Medicaid for new potential eligibles are illustrated below. The DHHS cost modeling study findings for the SFY 2014-15 rate-setting cycle are also included [$213 per month increase for Basic (Non-SCU) and $190 per month increase for SCU].

SA Monthly Rate Increase	$50	$75	$100	$213 Basic (Non-SCU only)	$190 SCU only
*Projected Total annual SA costs (state and county) for current and new potential eligibles	$16,611,600	$25,117,200	$33,909,600	$69,464,412	$8,634,360
**Projected State annual share of Medicaid cost increase for new eligibles	$5,566,913	$6,620,358	$8,423,028	$18,591,921	$2,622,288
Combined SA and Medicaid TOTAL	$22,178,513	$31,737,558	$42,332,628	$88,056,333	$11,256,648

*SA Basic (Non-SCU) and SCU caseload numbers and new eligibles from DMA, Appendix 7, Part 6. SA In-Home caseload numbers of 2,944 are from February 2017 NC FAST Caseload by Program Report. The number of SA In-Home recipients will not increase due to the SA rate increase.

**Overall Medicaid costs based on the PMPM, including PCS, pharmacy, physician costs, and other services covered by Medicaid. Projected increase Appendix 7, Part 9.

Decrease in Public Funding to Facilities

Appendix 8 illustrates the decrease in public funding to facilities since state fiscal year 2009. The total (state and county) decrease in SA funding is over $32 million. The total (state and federal) Medicaid PCS expenditures have decreased by almost $119.8 million. The State share of funding for Medicaid PCS and SA combined equates to a decrease of just under $56 million. The decrease in funding over an eight-year period offsets the cost of a $100 increase in the maximum rates for SA and the corresponding impact on Medicaid.

Recommendation 3: **The NC General Assembly should consider an increase in the personal needs allowance (PNA) for SA recipients**.

The current PNA rate has been $46 per month since 2003. Residents often end up with no spending money at all after paying for all essential personal items. Facilities often subsidize the costs of these items on behalf of SA residents. Further analysis is recommended to determine the amount of a PNA increase. The PNA is used by the residents for items including those listed below:

- Medicaid prescription drug co-pays,[2]
- Over-the-counter medications
- Incontinence supplies
- Haircuts
- Clothing, shoes
- Individual toiletries (shampoo, deodorant, tooth brushes, toothpaste, lotion, etc.)
- Snack foods
- Any other incidentals which are not covered by SA and Medicaid

[2] The Medicare Modernization Act became effective January 1, 2006. Medicare Part D, prescription drug coverage was a part of this Act. SA recipients who are also eligible for Medicare must have a Part D plan. Medicaid co-pays average over $17 per month per person per DMA 2016 data.

Recommendation 4: The NC Department of Health and Human Services should continue working with stakeholders to review cost-effective funding options that support residential and non-residential options for older adults and adults with disabilities who need state supported services. Options should consider support for capital costs, fundamental changes in the reimbursement structure for in-home and residential settings that focus on NC's unique needs, and providing the maximum choice for citizens

Capital costs continue to pose a significant expense for facility providers. Other states are moving toward a Fair Rental Value model as a more efficient and economical way to address these costs. Further study should be undertaken to evaluate the efficacy of a capital cost reimbursement plan, including Fair Rental Value to provide long-term sustainability to facility providers.

While this report addresses several solutions available to the NC General Assembly now, further consideration is needed to address fundamental changes in reimbursement structures for residential and in-home settings. Maximizing choice for citizens must be a driving factor in any ongoing discussion of options.

Summary

The SA program has been an important component in the continuum of care for older and adults and adults with disabilities in North Carolina for many years. Adult care and group home providers have undergone changes in the public funding reimbursement structure over the past decade and have seen many challenges in providing care and services for vulnerable adults in residential settings. The data examined by the work group and contained in this plan demonstrates that SA and Medicaid PCS reimbursement has been declining for a number of years. This has created uncertainty for providers and concerns about long-term sustainability for this setting of care.

The work group represented diverse areas of interest and expertise, but came together with the shared goal of finding a long-term solution to ensure adequate reimbursement to facilities serving SA recipients. As this plan describes, the options for a long-term solution without expanding Medicaid are very limited. The four recommendations provided represent consensus among work group members as the best options for adults living in adult care and group homes and for the providers who deliver care and services to these individuals.

While it was not part of the legislative mandate, it should be noted that the SA In-Home Program was codified in NC General Statute in 2007. This Program assists low-income adults who are at risk of placement in a licensed facility to reside in a private living setting. The SA monthly supplemental payment helps cover essential expenses and is intended to help maintain the individual's health and safety while residing in the community.

G.S 108A-47.1 sets forth that "the standard monthly payment to individuals enrolled in the Special Assistance In-Home Program shall be one hundred percent (100%) of the monthly

payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager." Since 2007, the Basic (Non-SCU) rate is the same individuals for residential and in-home settings. This is critical for the State's compliance with the Olmstead Act, to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

Appendix 1

SA Work Group Members

Name	Affiliation
Heather Burkhardt, Assistant Director	Division of Aging and Adult Services
Hugh Campbell, Owner / Operator Assisted Living and Skilled Nursing Communities	Hedgehog Healthcare Associates
Sam Clark, Government Liaison	NC Health Care Facilities Association
Curtis Crouch, Director of Accounting	DHHS Controller's Office
Tara Fields, Chief Operating Officer	Benchmarks
Stephanie Gilliam, Section Chief	Division of Health Service Regulation, Mental Health Licensure & Certification Section
Bob Hedrick	NC Providers Council
Bill Lamb, Executive Director	Friends of Residents in Long Term Care
Megan Lamphere, Section Chief, Adult Care Licensure Section	Division of Health Service Regulations
Clint Lewis, Director Carteret County Department of Social Services	NC Association of County Directors of Social Services
Carolyn McClanahan, Associate Director, Beneficiary Services	Division of Medicaid Assistance
Suzanne Merrill, Director	Division of Aging and Adult Services
Frances Messer, President and CEO	NC Assisted Living Association
Joyce Massey-Smith, Section Chief, Adult Services Section	Division of Aging and Adult Services
Dr. Peggy Terhune, President/CEO	Monarch
Chris Urso, Program Administrator, State/County Special Assistance	Division of Aging and Adult Services
Fred Waddle	Easter Seals UCP
Tyronda Whitaker, Lead Long-Term Care Ombudsman	Upper Coastal Plains Council of Governments
Herb Whitesell, CPA	Davidson, Holland, Whitesell & Co., PLLC
Lou Wilson, Director of Government Relations	North Carolina Association Long Term Care Facilities
Kevin Sheridan, Financial Analyst, DMA	Data Resource and Contributor

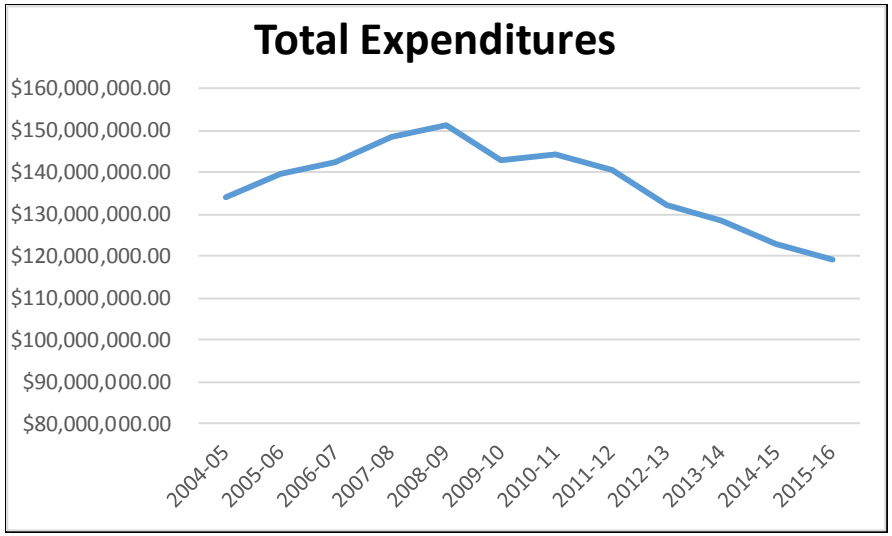
Appendix 2

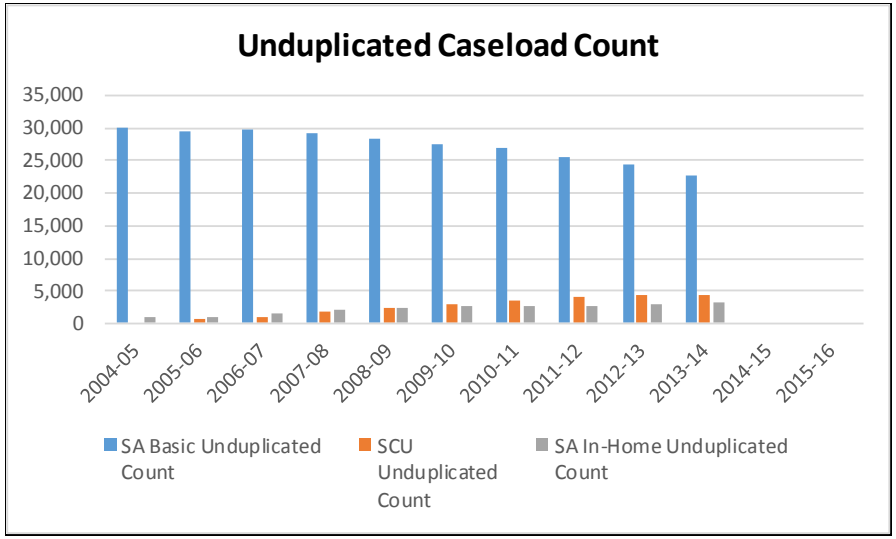
Special Assistance Ten Year Data

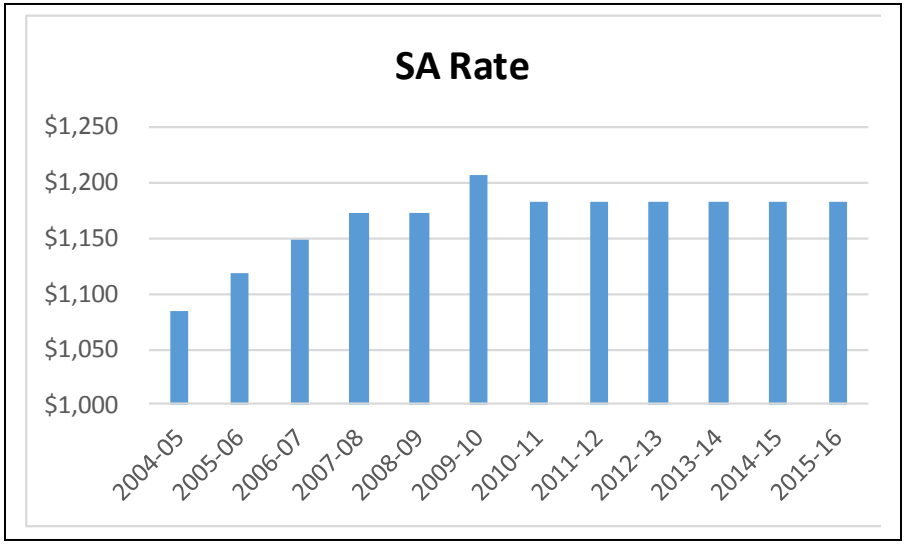
State Fiscal Year	Certified Budget	Total Expenditures	SA Basic Unduplicated Count	SCU Unduplicated Count	SA In-Home Unduplicated Count	SA Rate-Basic	SA Rate-SCU	Personal Needs Allowance
2005-06	$135,823,005.00	$139,486,915.00	29,467	629	1,040	$1,118	$1,515	$46
2006-07	$140,830,676.00	$142,412,950.00	29,664	1,110	1,503	$1,148	$1,515	$46
2007-08	$151,818,466.00	$148,392,234.00	29,214	1,724	2,027	$1,173	$1,515	$46
2008-09	$153,775,738.00	$151,366,306.00	28,297	2,429	2,429	$1,207 (1/2009-10/2009) $1,182 (10/2009)	$1,515	$46
2009-10	$148,487,201.00	$142,881,801.00	27,467	2,942	2,567	$1,182	$1,515	$46
2010-11	$137,351,085.00	$144,129,226.00	26,810	3,568	2,774	$1,182	$1,515	$46
2011-12	$140,427,088.00	$140,427,088.00	25,524	3,944	2,755	$1,182	$1,515	$46
2012-13	$140,427,088.00	$131,996,004.00	24,476	4,357	3,057	$1,182	$1,515	$46
2013-14	$136,424,388.00	$128,438,636.00	22,802	4,340	3,343	$1,182	$1,515	$46
2014-15	$120,157,232.00	$122,742,341.00	*	*	*	$1,182	$1,515	$46
2015-16	$120,157,232.00	$119,351,930.00	26,439**	**	3,555	$1,182	$1,515	$46

* All cases converted to NC FAST 12/14 and one-third back to Legacy System until 3/15 -reliable numbers unavailable
** Combined Basic and SCU (used available NC FAST reports)

Appendix 2 (Continued)







All cases converted to NC FAST 12/14 and one-third back to Legacy System until 3/15 -reliable numbers unavailable
Combined Basic and SCU (used available NC FAST reports

Appendix 3

Occupancy Percentage by License Type and Size

	Size Categories				
	<7 beds	7 - 30 beds	31 - 60 beds	61 - 90 beds	91+ beds
MHL	93.80%	90.69%			
Non-SCU		82.34%	79.16%	73.89%	71.13%
SCU		78.19%	83.74%	77.47%	76.48%

	# of Homes per Size Categories				
	<7 beds	7 - 30 beds	31 - 60 beds	61 - 90 beds	91+ beds
MHL	703	15			
Non-SCU		87	97	68	26
SCU		9	44	75	67

Appendix 4 Direct & Indirect Cost by License Type & Size for SFY 2014-15[3]

Non-SCU				
	# of Homes	Total Direct Cost per Resident Month	Total Indirect Cost per Resident Month	Total SA Cost per Month
7 to 30 beds	87	$503	$716	1,219
31 to 60 beds	97	$426	$873	1,300
61 to 90 beds	68	$492	$1,080	1,572
91+ beds	26	$430	$927	1,357
Average	278	$459	$936	1,395

SCU				
	# of Homes	Total Direct Cost per Resident Month	Total Indirect Cost per Resident Month	Total SA Cost per Month
7 to 30 beds	9	$456	$1,048	1,504
31 to 60 beds	44	$501	$1,256	1,757
61 to 90 beds	75	$531	$1,382	1,913
91+ beds	67	$527	$1,533	2,060
Average	195	$523	$1,426	1,949

MHL				
	# of Homes	Total Direct Cost per Resident Month	Total Indirect Cost per Resident Month	Total SA Cost per Month
Less than 7 beds	674	$594	$906	1,499
More than 7 beds	15	$417	$887	1,304
Average	689	$587	$905	1,492

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[3] The rates listed above are based upon raw cost report data and do not reflect the cost model results

Appendix 5

Profit and Loss without PCS by Size and License Type

SFY 2014-2015

			Non-SCU without PCS				
	% SA Days to Res. Days		Net Revenue Without PCS	Net Expenses Without PCS	Net Profit (Loss) Without PCS	Facilities Reporting a Profit	Facilities Reporting a Loss
7 to 30 beds	74.07%		$22,959,004	$41,351,156	($18,392,152)	37	50
31 to 60 beds	70.24%		$70,762,852	$85,462,041	($14,699,189)	43	54
61 to 90 beds	58.31%		$91,358,522	$95,298,324	($3,939,802)	30	38
91+ beds	70.19%		$39,263,909	$41,526,836	($2,262,927)	14	12

			SCU without PCS				
	% SA Days to Res. Days		Net Revenue Without PCS	Net Expenses Without PCS	Net Profit (Loss) Without PCS	Facilities Reporting a Profit	Facilities Reporting a Loss
7 to 30 beds	65.19%		$4,290,431	$3,385,478	$904,953	7	2
31 to 60 beds	59.13%		$61,383,161	$50,476,115	$10,907,046	28	16
61 to 90 beds	46.01%		$150,048,141	$121,823,797	$28,224,344	53	22
91+ beds	46.42%		$195,460,488	$149,994,245	$45,466,243	55	12

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Appendix 6

Profit & Loss Including PCS by Size and License Type

SFY 2014-2015

			Non-SCU including PCS				
	% SA Days to Res. Days		Total Income/ Revenue	Total Expenses Reported	Total Net Profit (Loss)	Facilities Reporting a Profit	Facilities Reporting a Loss
7 to 30 beds	74.07%		$30,710,096	$51,487,518	($20,777,422)	33	54
31 to 60 beds	70.24%		$94,035,353	$113,852,362	($19,817,009)	40	57
61 to 90 beds	58.31%		$112,084,421	$128,487,721	($16,403,300)	24	44
91+ beds	70.19%		$51,959,950	$57,093,316	($5,133,366)	13	13

			SCU including PCS				
	% SA Days to Res. Days		Total Income/ Revenue	Total Expenses Reported	Total Net Profit (Loss)	Facilities Reporting a Profit	Facilities Reporting a Loss
7 to 30 beds	65.19%		$5,367,730	$5,035,921	$331,809	6	3
31 to 60 beds	59.13%		$79,487,405	$77,203,761	$2,283,644	25	18
61 to 90 beds	46.01%		$175,727,270	$175,591,313	$135,957	36	39
91+ beds	46.42%		$227,406,304	$221,880,391	$5,525,913	35	32

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Appendix 7

					SA recomm.	$1,395	$1,705
Part 1: Official Incomes					SA current	$1,182	$1,515
	BASE	$30	$50	$75	$100	$213	$190
ACH	$14,736	$15,096	$15,336	$15,636	$15,936	$17,292	$17,016
SCU	$18,732	$19,092	$19,332	$19,632	$19,932	$21,288	$21,012
Part 2: Relative % change between US income and NC income							
http://statisticalatlas.com/state/North-Carolina/Household-Income							
	US	NC					
95	$196	$169	116%				
80	$107	$92	115%				
60	$67	$58	115%				
median	$53	$46	114%				
40	$42	$36	114%				
20	$22	$19	112%				
Part 3: Convert NC income to equivalent US income							
	BASE	$30	$50	$75	$100	$213	$190
ACH	16,483	16,886	17,154	17,490	17,825	19,342	
SCU	20,953	21,355	21,624	21,960	22,295		23,503
Part 4: Estimate % of NC households under enrollment limit							
PULLLED NUMBERS from website							
https://dqydj.com/archived-income-percentile-calculator-for-2015-data/							
	BASE	$30	$50	$75	$100	$213	$190
ACH	19.2	19.5	20.2	20.4	20.6	23.0	
SCU	26.5	27.2	27.4	27.5	28.6		30.0
Part 5: Estimate increase in population eligible (from base scenario)							
	BASE	$30	$50	$75	$100	$213	$190
ACH	0.0%	1.6%	5.2%	6.3%	7.3%	19.8%	

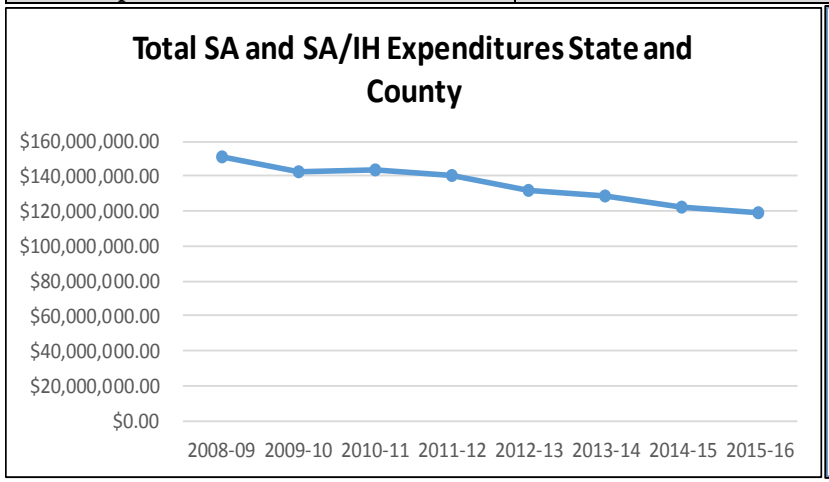
Appendix 7 (continued)							
SCU	0.0%	2.6%	3.4%	3.8%	7.9%		13.2%
Part 6: Estimate total enrollment							
	BASE	$30	$50	$75	$100	$213	$190
ACH	20,229	20,545	21,283	21,493	21,704	24,233	
SCU	3,345	3,433	3,459	3,471	3,610		3787
Part 7: Estimated Enrollment increase (from base scenario)							
	BASE	**$30**	**$50**	**$75**	**$100**	**$213**	**$190**
ACH	0	316	1,054	1,264	1,475	4,004	
SCU	0	88	114	126	265		442
Part 8: Per Member- Per Month Cost							
ACH	$1,161						
SCU	$1,484						
Part 9: Estimated Cost Increase (month)							
	BASE	**$30**	**$50**	**$75**	**$100**	**$213**	**$190**
ACH	$0	$366,946	$1,223,153	$1,467,783	$1,712,414	$4,647,980	
SCU	$0	$131,114	$168,576	$187,306	$393,343		$655,572
Total	$0	$498,060	$1,391,728	$1,655,090	$2,105,757	$4,647,980	$655,572
Final: Estimated Cost Increase (Year)							
	BASE	**$30**	**$50**	**$75**	**$100**	**$213**	**$190**
ACH		$4,403,350	$14,677,832	$17,613,399	$20,548,965	$55,775,763	$0
SCU		$1,573,373	$2,022,908	$2,247,675	$4,720,119	$0	$7,866,864
Total		$5,976,723	$16,700,740	$19,861,074	$25,269,084	$55,775,763	$7,866,864
Quick Estimation of NC		$1,992,241	$5,566,913	$6,620,358	$8,423,028	$18,591,921	$2,622,288
NOTE: AT the level of precision available to DMA finance, there is no discernable difference between $30 and $34.						$21,214,209	
						TOTAL ACH and SCU, cost modeling recommendation	

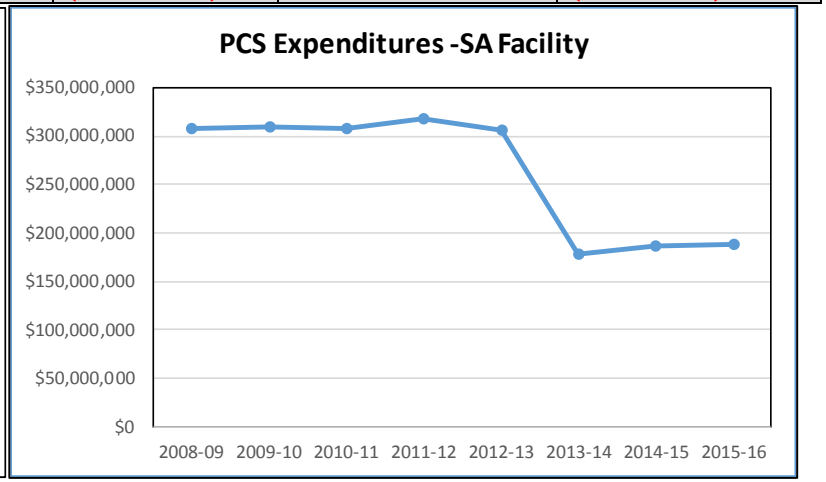
Division of Medicaid Assistance, February, 2017

Appendix 8

Decrease in Public Funding to SA Facilities

State Fiscal Year	Total SA (State/County Expenditures)	Loss/Increase	PCS Expenditures (State/Federal) SA Residential setting	Loss/Increase
2008-09	$151,366,306.00		$307,477,427	
2009-10	$142,881,801.00	($8,484,505)	$309,513,531	$2,036,105
2010-11	$144,129,226.00	$1,247,425	$308,292,190	($1,221,341)
2011-12	$140,427,088.00	($3,702,138)	$317,746,047	$9,453,857
2012-13	$131,996,004.00	($8,431,084)	$306,317,965	($11,428,083)
2013-14	$128,438,636.00	($3,557,368)	$178,528,223	($127,789,742)
2014-15	$122,742,341.34	($5,696,295)	$186,834,049	$8,305,826
2015-16	$119,351,930.51	($3,390,411)	$187,707,595	$873,546
Total Expenditure Decrease		**($32,014,375)**		**($119,769,831)**
Total Expenditure Decrease State Share		**($16,007,187)**		**($39,923,277)**





DHHS Office of the Controller (SA expenditures); Division of Medicaid Assistance, (PCS), February, 2017;