Establish New Adult Care Home Payment Methodology

Session Law 2019-240, Section 1

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

North Carolina Medicaid and NC Health Choice and the Fiscal Research Division

by

North Carolina Department of Health and Human Services

June 10, 2022

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I. Introduction

In response to the legislation on Adult Care Homes and payment methodologies, NC Medicaid convened internal and external subject matter experts, collaborators and partnerships. The legislation is broad-based and allows a descriptive summary of what is currently provided for Adult Care Homes as well as prospective insights for NC Medicaid Direct (formerly known as fee-for-service) and the new Managed Care System. This report will provide information on the NC Medicaid Direct payment methodology for Adult Care Homes (ACH) and evaluate the reimbursement options under current authorities and future possibilities for managed care.

The initial goal was to provide an understanding of the ACH population, services, provider agencies and how the current payment structure works in North Carolina. Quality of care and the acuity of the population was also taken into consideration as we compiled information for this summary report.

The legislation requires NC Medicaid to convene a workgroup to share in the collaboration by providing expertise, real-life experiences, administrative oversight, provider perspectives and reimbursement considerations. After more than one year of population assessment, reviews, cross agency responsibilities, financial considerations, meetings and brainstorming sessions, NC Medicaid is providing the outcomes resulting from this effort. Our processes leading to the development of this report included:

- An internal NC Medicaid kick-off meeting of key staff representing various sections within NC Medicaid. This became the internal core team tasked to review and interpret the legislation and scope of work, identify current funding streams used to pay ACHs and the history of payment methodologies in North Carolina. This review also provided a baseline for what we know and need to know regarding funding streams. A timeline, meeting format and the composition of the workgroup were defined. Internal team assignments of responsibilities and discussion for clarifying questions. The NC Medicaid communications team was engaged at the onset of the legislation to assure consistent flow of information, timelines and access to broad stakeholder groups.
- An ACH webpage was developed to provide information, post meeting materials and list an email to field incoming inquiries. This webpage was also beneficial in administering a statewide ACH survey for stakeholders. The survey covered questions regarding evidenced-based and best practice models, quality health outcomes and performance measures for settings of care, and value-based purchasing input on how it could work for Adult Care Homes in North Carolina. In addition, the survey sought suggestions on how ACH/Alternative Family Living could transition from NC Medicaid Direct to managed care and input on what should be included in this report. A finance section included questions on the identification of other states utilizing cost report data to develop ACH rates, if current cost reporting documentation from North Carolina ACHs should be incorporated in rate development and input on whether the current rate structure should be revised to be provider-specific. Survey results are included in Attachment B.

- Research was done on Adult Care Homes in 10 states providing information on how services are administered and payment structures. The research provided general information on how other states administer their ACH programs and payment for services. Findings from the research were shared with the NC Medicaid provider reimbursement team to assist in their work on payment methodologies.
- Meetings with Division partners which included: Divisions of Health Services Regulation, Aging and Adult Services, Social Services, Mental Health, Developmental Disabilities and Substance Abuse Services. Each provided detailed guidance on their services, their relation to the adult care population, impacts on existing services such as federal requirements, waivers, crossover beneficiaries, targeted strategies, penalties, medical outcomes and touch points for enhanced collaboration. Division partnerships represented high-level leadership, managers and subject matter experts.
- Stakeholder meetings were convened shortly after the legislation was introduced. Many stakeholders provided representation from associations, provider agencies, Disability Rights North Carolina, caregivers, advocates, joint commission, consulting groups and the Prepaid Health Plans that were awarded contracts for NC Medicaid Managed Care. The stakeholders comprised the workgroup specified in the legislation to help inform and facilitate from the front-line perspective. See Stakeholder Workgroup Participants Attachment C.
- Twenty-four meetings were held both in person and later virtually due to COVID-19. Agenda topics included: Medicaid overview, payment methodologies, home- and community-based services final rule, care and quality strategies, regulatory oversight and identifying who else needs to be at the table for these discussions. These meetings provided valuable education to the workgroup and stakeholders on the many roles and responsibilities of the State and how each agency and/or program interfaces with the adult care home population and providers. Presentations from Stakeholder's Workgroup Meetings Attachment D.

  During one of the stakeholder meetings, the State posed a few questions to gauge input on what topics were needed to provide more information, identify outstanding questions, identify others who were not engaged and avenues to ensure input from those living the adult care home experience. A brief summary of the responses is included in the ACH Stakeholder Meeting Notes (Questions & Responses) document Attachment E. In addition to the stakeholder workgroup, NC Medicaid's core team participated from various levels including finance, managed care liaisons, LTSS staff, behavioral health, strategic development, care and quality, and value-based services.
- A data request was submitted from the stakeholder workgroup to NC Medicaid for additional information on the Adult Care Home population. The request consisted of 11 data elements covering a five-year time span by county, gender, age, and diagnosis. The stakeholder workgroup's expected outcomes were to help identify for the ACH population:
  - Level of illness in the population,
  - Number of activities of daily living (ADL) the beneficiaries need
  - Population demographics
  - Costs associated with certain diagnoses (paid amounts). The complete data set is included in Attachment F.

II. Data Analysis

In collaboration with NC Medicaid, Aging and Adult Services, and Health Services Regulation, the following information was compiled based on a data request by the North Carolina Senior Living Association and other workgroup stakeholders. The data request consisted of 11 queries to illustrate the population receiving ACH and Personal Care Services (PCS). Its framework was developed with several parameters to better illustrate the demographic, medical and payment sources of current Medicaid beneficiaries using ACH and PCS services. A summary of the findings is presented in this section of the legislative study. The stakeholder workgroup's data request is listed is in Attachment G.

Stakeholder data request variables:

Demographics

Population:	Medicaid and Medicare
Gender:	Male and Female
Age Groups:	Age 21+, 40 and under, 41-64 and 65+ (at the time of service)
Residential County	

Parameters

Paid Claims:	Managed Care (MC) Regions (by county)
Dates of Service:	State Fiscal Years (SFYs) (July 1, 2014 - June 30, 2019)
Data summarized:	Trial and full run
Procedure Code:	99509 (PCS)
Modifiers:	HC – ACH
	SC – Special Care Unit (Memory Care)

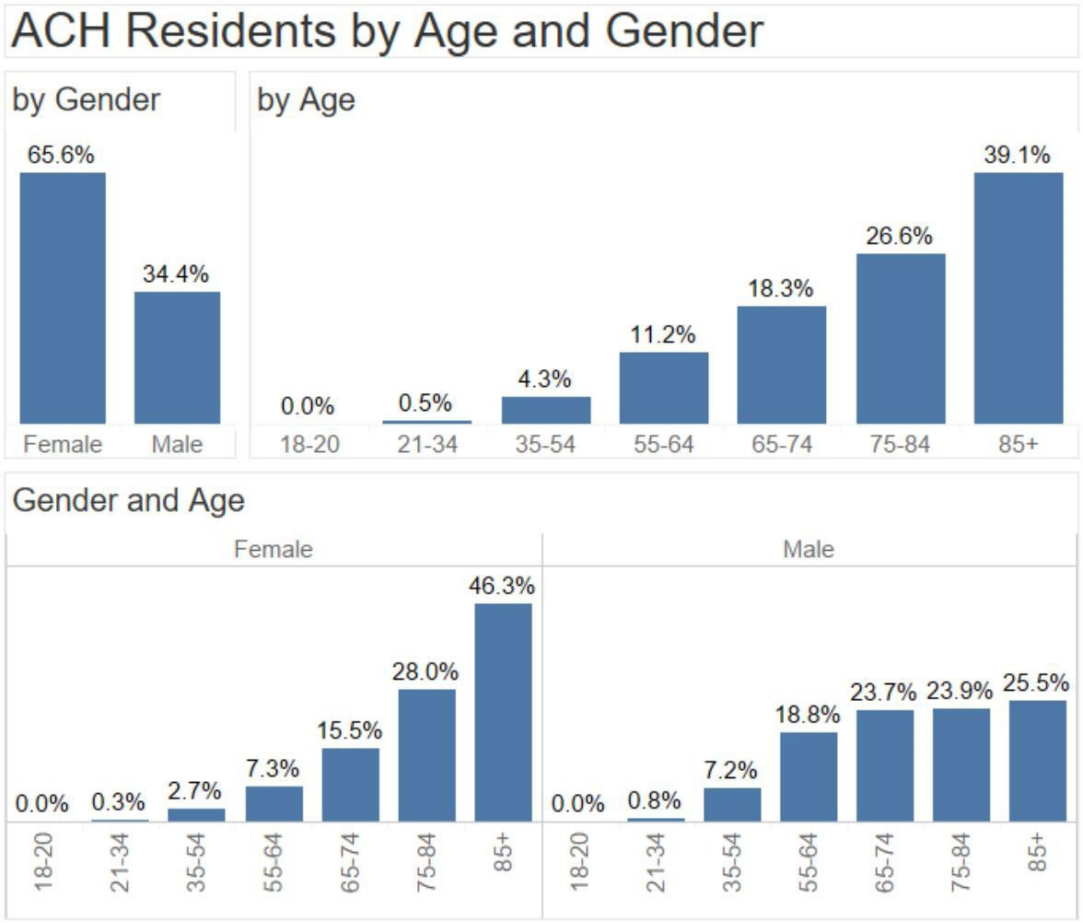
Levels of Care
Top Diagnosis Profiles

North Carolina'sAssisted Living Residences - Types

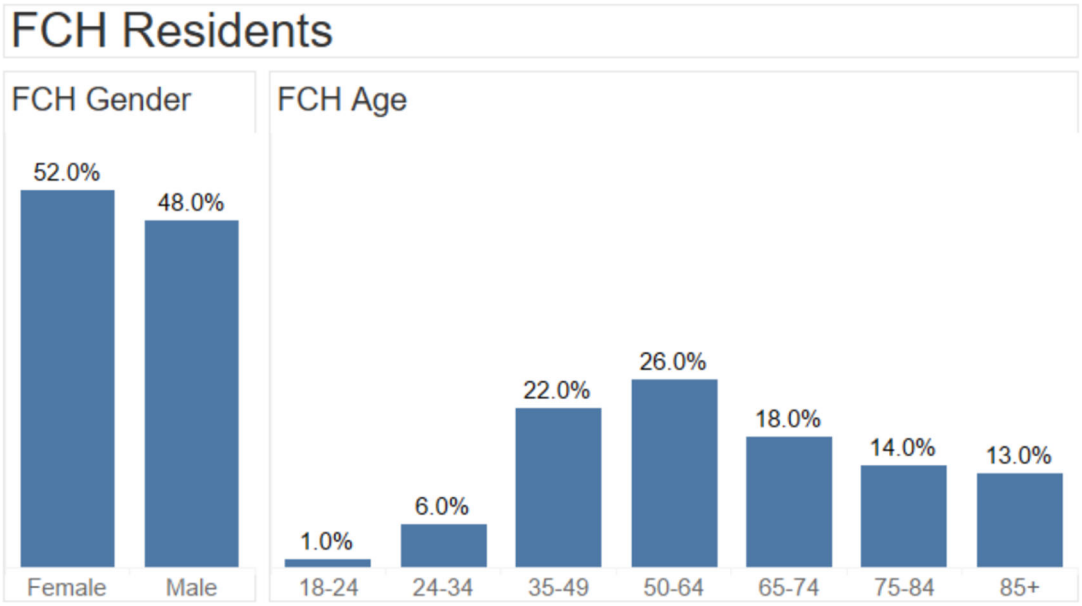
G.S. 131D-2 defines three types of assisted living settings:

1. Adult Care Homes
    - ACH with seven beds and up, 590 facilities with ~38,400 beds with ~26,000 occupied with 41% of residents with memory disorders
    - Family Care Homes (FCH) with two to six beds, 595 homes with ~3,400 beds with ~2,700 occupied
2. ACHs for the elderly (55 years and older)
3. Multi-unit assisted housing with services – unlicensed with minimal regulatory oversight by NCDHHS

Adult Care Home Characteristics SFY 2019



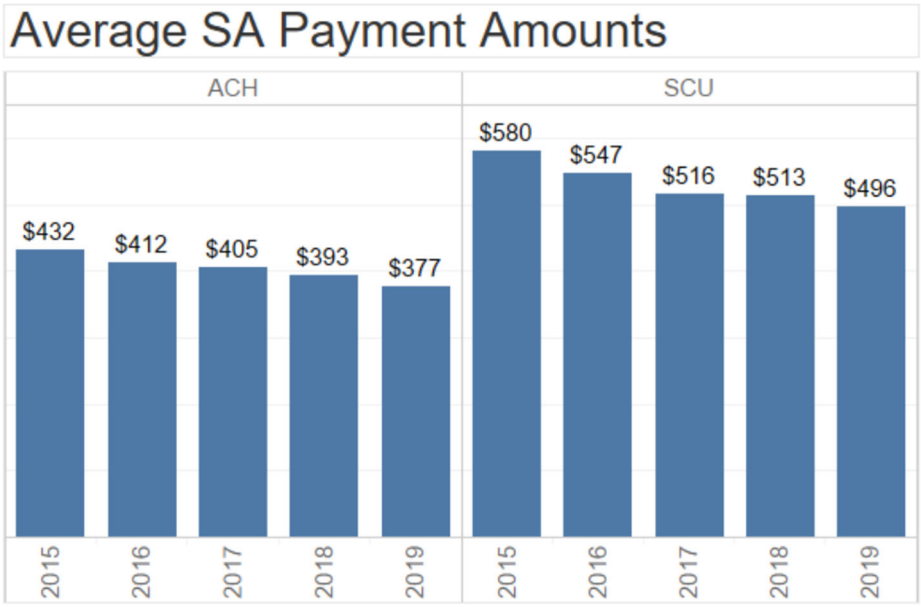
2019Family Care Home Characteristics



Adult Care Home Methodology

- DHHS data below shows analysis of claims for 8,889 unique residents of ACH facilities, totaling $109 million: $73 million of that is over 67% that went to support residents with an Alzheimer's Disease or dementia-related diagnosis.
- Among this cohort of 8,889 residents, 5,227 (58%) had an Alzheimer's or dementia-related diagnoses.
- In addition, there were 731 residents of these facilities with schizophrenia, major depression, or unspecified intellectual disabilities.

There are 11,011 PCS recipients who are residents in the facilities represented in the data. Of these, 7,902 (72%) are over 65 years of age, 2930 (27%) are between 41 and 64, and a few are 40 years of age or below. In addition, State/County Special Assistance (SA) pays for the room and board for many of these residents. SA is a combination of the resident's income and a 50/50 portion of state/county funds.



As illustrated above:

- The average SA payment for the residents in these facilities has gone down in unadjusted terms every year in the DHHS reporting data. This is the result of an increase in outside "countable income" such as Social Security, which is subtracted under State law from the maximum allowable SA.
- The maximum allowable SA has been essentially fixed at $1,182 per month for ACH residents ($1,515 for special care units - SCUs) for over ten years.
- The net effect is that PCS residents in these facilities, have had zero inflation adjustments to the room and board allowed. While the General Assembly had a program to pay $34 additional per month, that ceased when the budget authority ended June 30, 2019; a planned increase in that number to $70 was not implemented.

- A special one-time payment of $1,325 was authorized in Session Law 2020-4. But special or catch-up payments are not a solution to the obvious structural issue presented by our current system – which is that we have effectively frozen room and board reimbursement for over a decade.
- The data also reflects that a significant number of residents are at risk for termination from Medicaid in ACH facilities annually. This is due to outside income increases, such as Social Security which may push them slightly over an income threshold.

Additional observations from the data include:

- DAAS identified 280 such events for 2018 and 365 such events in 2019, indicating the issue is becoming more serious. Some, but certainly not all, were saved from losing Medicaid eligibility by the so-called pass-along provisions: the data showed post COLA drops of 84, 138 and 58, respectively, for the 2017 to 2019 Medicaid eligible populations.

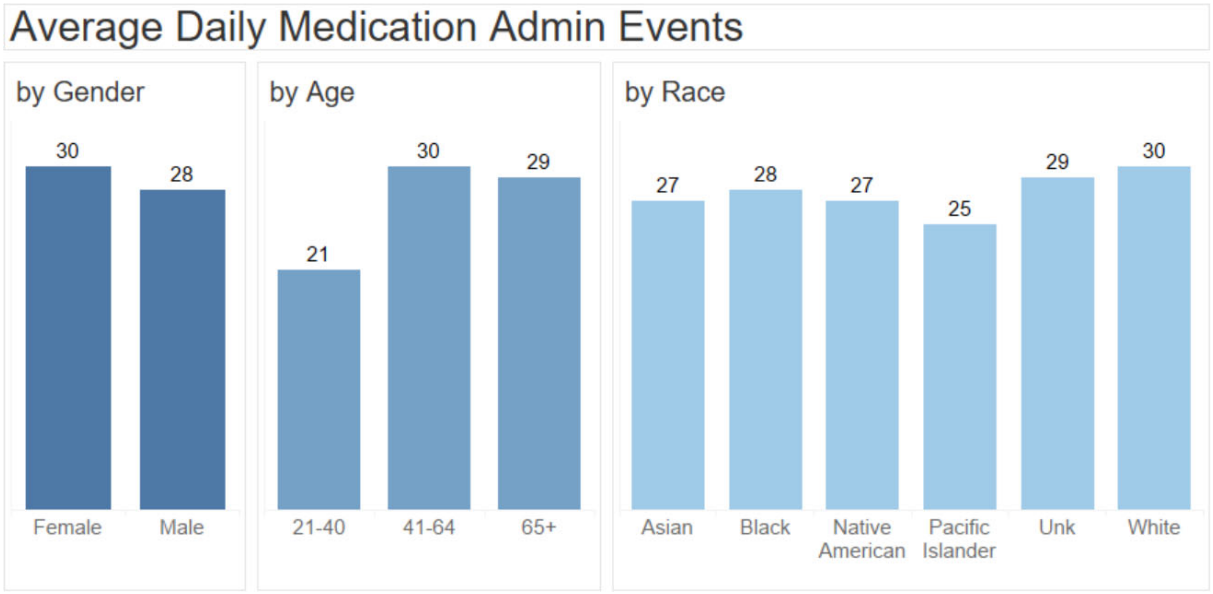
- Individuals in nursing facilities generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance, to the nursing facility. Medicaid pays the remainder of their cost of care.

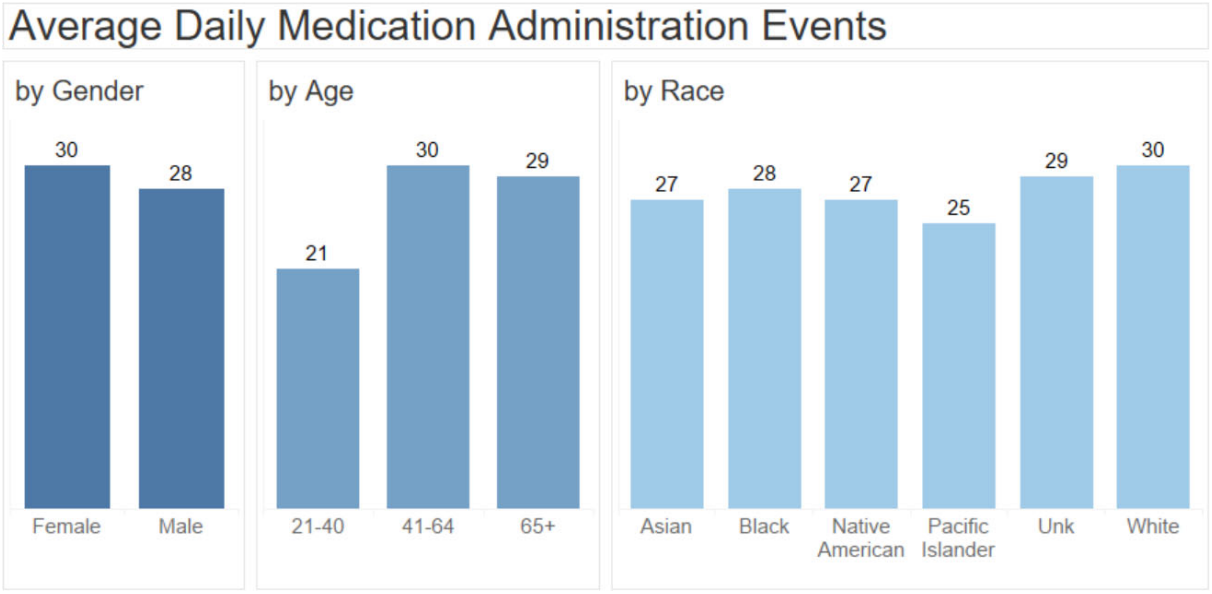
- In some cases, this results in residents electing to move to Skilled Nursing Facilities (SNF) to retain Medicaid reimbursement for their care, when they might otherwise choose to remain in their ACH community.

- The data shows that the resident population in ACH facilities require a high level of assistance with ADLs such as bathing, dressing, toileting, eating and mobility. To receive Medicaid PCS reimbursement, the beneficiary must require assistance with two or more ADLs. As of SFY ’17, there were 11,011 Medicaid beneficiaries residing in ACH/SCU facilities, 4,531 (41%) require help with all five ADLs; 3,759 (34%) require assistance with four of the five ADLs.

- On average, these residents suffer from five to six exacerbating conditions. These conditions affect their livelihood abilities, as they include problems with balance, incontinence of bowel and bladder, shortness of breath, tremors, pain, amputations, and cognitive impairment.

- The medication regimens of these residents are extensive. The average resident has nine medications, requiring 27 to 30 administrations daily. In the counties of Alexander, Columbus, Dare, Iredell, Northampton, Person, Scotland and Wilkes, the average is 40 administrations per day, or higher.


Average Daily Medication Admin Events
by Gender
30
28
Female
Male
by Age
21
30
29
21-40
41-64
65+
by Race
27
28
27
25
29
30
Asian
Black
Native American
Pacific Islander
Unk
White


Average Daily Medication Administration Events
by Gender
30
28
Female
Male
by Age
21
30
29
21-40
41-64
65+
by Race
27
28
27
25
29
30
Asian
Black
Native American
Pacific Islander
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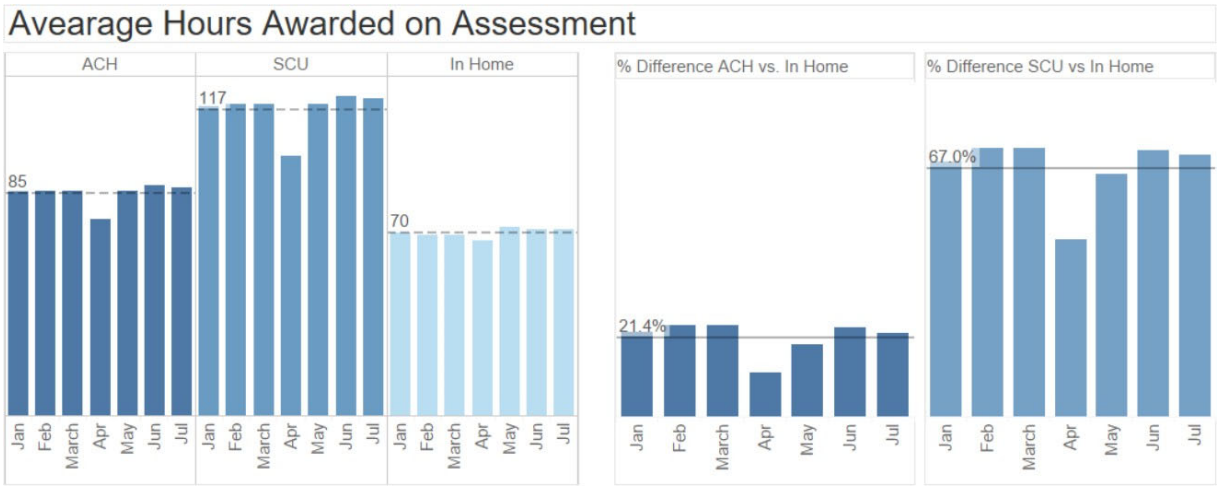


How is assisted living funded by Medicaid in other states?

- Washington state pays for Medicaid PCS as a Medicaid State Plan service in both the in-home setting as well as residential settings including assisted living facilities and "adult family homes," which are similar to North Carolina's family care homes.
- North Carolina pays for both in-home and residential PCS, based on approved hours and billed as units; Washington allows *payment for residential-based services at a daily rate or per diem.*
- Specifically, the Washington State Plan states: "Payment for agency and Individual provider *(personal care)* services are reimbursed at an hourly unit rate, and payment for residential-based services is reimbursed at a daily rate."

Summary

- North Carolina's ACHs take care of more complex PCS beneficiaries (including memory disorders) than other settings that provide PCS services.
- Whereas other settings are limited in terms of their contact with PCS beneficiaries, due to the nature of intermittent care (in-home PCS), ACHs are responsible for the beneficiary 24 hours/day, 7 days/week, which results in these facilities providing more care than is captured with the current PCS assessment and allocation of hours model.
- The current payment model does not capture all the care provided to Medicaid beneficiaries by ACHs.
- The PCS assessment accounts for additional hours due to the number of administered medications, as many as 30 hours per month, which is a significant amount. This is part of the reason ACH residents tend to get more hours than in-home care.
- However, individuals not requiring as many medication administration interactions receive considerably less on their assessed hours. The real expense to ACHs that is not covered by the current PCS model is care coordination, an area that is not reimbursed for its level of scrutiny.
- Previously, CMS stated that NC Medicaid PCS services in residential and in-home settings should be comparable; this eventually led to the current independent assessment and allocation of hours model. There is now precedent with Washington state's Medicaid State Plan that allows residential settings to be reimbursed with a daily or per diem payment under the same PCS program umbrella.

Provider stakeholder have stated that they believe a per diem rate for PCS in North Carolina's ACHs is the most reasonable way to pay for services; this is due to the fact that providers provide more care for Medicaid beneficiaries than they are being paid.

III. Provider Analysis

In North Carolina, there are approximately 1,128[1] facilities commonly known as "Assisted Living" throughout 97 of 100 counties. These facilities are licensed to provide assistance with ADLs, medication administration and supervision to residents based on assessed needs. The two types of licensed adult care facilities are differentiated by their size. Family care homes are small, residential facilities licensed to serve two to six residents. Adult care homes are licensed to serve seven or more residents. Under either of these types, the facility can be designated to serve only those with a diagnosis of dementia or the elderly, the latter being defined under statute as serving individuals 55 years or older. Additionally, adult care homes can choose to license all or part of their facility as a special care unit to serve those with Alzheimer's or other types of dementia. Approximately 42% of adult care homes have licensed special care units[2].

[1] 2020 Adult Care Homes data from Long Term Care Safety Initiative System
[2] Data from Adult Care Homes 2020 Facility License Renewal Applications

Currently, there are approximately 558 licensed family care homes and 570 licensed adult care homes in North Carolina, all privately owned. The type of ownership varies; however, the facilities are typically owned by corporations/legal liability corporations, partnerships, and proprietorships. Based on ACH 2020 Facility License Renewal Applications data submitted by providers, corporations and legal liability corporations are the legal operating entities for 75% of licensed adult care and family care facilities. Proprietorships make up 20% and partnerships are 5%.

Review of the number of facilities per county reveals 83 counties have less than 20 licensed adult care and family care homes,[3] and 37 of these counties have less than five licensed adult care and family care homes.[4] Approximately 25% of all North Carolina adult care facilities are located in Alamance, Buncombe, Mecklenburg and Wake counties.

Each adult care facility has a licensed capacity which represents the maximum number of residents that may live in the home. Currently, 14% of licensed adult care homes have a licensed capacity of 100 or more residents.[5] The facility with the highest capacity of 201 beds is in New Hanover county. Many licensed adult care facilities (47%) have a capacity between 60-99 residents; however, the total number of residents residing at the facility may actually be less than the capacity for various reasons.[6]

IV. Regulatory Analysis

Over the past three years, family care home closures ranged from 40 to 54 per year while adult care homes closures range from 3-9 per year.[7] Of these facilities, 70% provided notices of closure or chose not to renew their licenses,[8] while 30% of the facilities were closed by the Adult Care Licensure Section (ACLS) as a result of licensure action or license expiration.[9] Although closures have occurred, ACLS issued 123 initial licenses for family care homes and 11 adult care homes between 2017-2019.[10]

Data References

Ownership of Adult Care Homes[11]

Corporations and legal liability corporations	75%
Proprietorships	20%
Partnerships	5%

Adult Care Homes Capacity[12]

Capacity between 7-19 residents	12%
Capacity between 20-59 residents	27%
Capacity between 60-99 residents	47%
Capacity of 100 or more residents	14%

[3] *See* supra footnote 1
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Data from Adult Care Licensure Facility Files
[9] *See* supra footnote 1
[10] Ibid
[11] *See* supra footnote 2
[12] *See* supra footnote 1

Closures[13]

Number of Closures	Year
Adult Care= 6 Family Care= 54	2017
Adult Care= 9 Family Care= 40	2018
Adult Care= 3 Family Care= 52	2019

Initial Licenses[14]

Number of Initial Licenses Issued	Year
Adult Care= 4 Family Care = 50	2017
Adult Care= 5 Family Care = 30	2018
Adult Care= 3 Family Care = 43	2019

V. Special Assistance

This section should discuss how Special Assistance (SA) factors into the funding of ACHs, patterns and trends noted in the previous years.

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 a 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

[13] Ibid.
[14] Licensing data from Long Term Care Safety Initiative System

Security Act, 42 CFR.435.232.

Please see Attachment H: Plan for Long-term Solution for Adequate Reimbursement to Facilities Serving Recipients of State/County Special Assistance (tables 2-8) in the attached report completed April 1, 2017.

VI. Other States' Experiences

In federal law, states have the option to pay for personal care and other long-term care services in residential care settings such as adult care homes through the Medicaid state plan personal care option and the home- and community-based services (HCBS) 1915(c) waiver program.

Since 1975, states have had the option to offer personal care services under the Medicaid state plan in individuals' place of residence, whether in their own home or in a residential care setting such as an adult care home. Until 1993, the option was medically focused, and services had to be prescribed by a physician and delivered in accordance with a care plan. In 1993, Congress allowed states to authorize personal care service providers to oversee the provision of care. States have the authority to impose reasonable medical necessity criteria for eligibility to receive services but cannot restrict services to people who require nursing home level of care.

Because personal care is an optional Medicaid service, states have considerable flexibility in how the services are provided. While optional services must be offered statewide, states can set additional eligibility criteria for the receipt of services. As of 2018, 33 states and the District of Columbia have taken up the personal care service option, but three states (Delaware, New Mexico, and Rhode Island) do not have enrollment in the program.

An advantage of using the personal care state plan option to cover services in residential care settings is that the state can provide services to a less severely impaired population. However, providing services through the state option limits the eligibility standard to more limited income parameters than may be in place for waiver programs.

Since 1981, care in adult care homes can also be provided through the HCBS waiver program. This option is more flexible, and the provision of services focuses on current licensing and regulatory provisions for residential care settings. States can design their waivers to target specific populations or limit the number of people eligible for the program. States can either amend an existing waiver to add services provided in residential care settings or they can apply for a new separate waiver to cover services in residential care settings. The HCBS waivers are intended to be, by definition, cost-effective.

VII. NC Medicaid Quality Strategy

North Carolina's Quality Strategy is designed around a quality framework that builds an innovative, whole-person, well-coordinated system of care, which addresses both medical and

non-medical drivers of health and promotes health equity. NCDHHS contracted with the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics (NCIOM Task Force) to assemble a statewide group of providers, beneficiaries, quality experts and managed care representatives who recommended a set of Medicaid quality measures to be used to drive improvement in the health of Medicaid beneficiaries. The Quality Strategy for NC Medicaid is closely aligned with the measures the NCIOM task force put forth.

The aims, goals and objectives outlined in the Quality Framework align with the CMS National Quality Strategy, with the goals and objectives aimed at driving improved and sustained population health outcomes. The aims are: better care delivery, healthier people and communities, and smarter spending. The six goals to help reach those aims are: (1) ensure appropriate access to care, (2) drive patient-centered, whole-person care, (3) promote wellness and prevention, (4) improve chronic condition management, (5) work with communities to improve population health, and (6) pay for value. To meet those goals, the objectives are similarly aligned to ensure beneficiary access to services, particularly in the context of the State's transition to managed care.

In relation to the ACH population, the LTSS population is represented in the objective to maximize long-term services and supports (LTSS) populations' quality of life and community inclusion as well as in the following interventions: AMHs, value-based payment and accreditation. It is a requirement that the PHPs achieve NCQA Health Plan Accreditation with LTSS distinction by contract year three. For LTSS distinction, PHPs must meet core features with element documentation around comprehensive assessments, care plans, sharing information with the PCP and reassessment after discharge.

These features can also be reported as the following measures:

1. LTSS comprehensive assessment and update
2. LTSS comprehensive care plan and update
3. LTSS shared care plan with primary care provider (PCP)
4. LTSS re-assessment/care plan update after discharge

Examples of requirements the PHPs need to provide are as follows:

- The percentage of LTSS members who have documentation of an annual in-home comprehensive assessment
    - Documentation of nine core elements and at least 12 out of 19 supplemental elements
- The percentage of LTSS members who have documentation of an annual comprehensive LTSS care plan completed face-to-face
    - The percentage of LTSS members with a care plan for whom all or part of the care plan was transmitted to the PCP within 30 days of development or update
    - The percentage of inpatient discharges of LTSS members resulting in updates to the assessment and care plan within 30 days of discharge
        - Rate 1: re-assessment within 30 days
        - Rate 2: re-assessment and care plan update within 30 days

The LTSS objective was selected to allow DHHS to compare all quality measures with the outcomes of the LTSS population. DHHS will use information from the comprehensive

assessment to identify individuals with LTSS needs to ensure those individuals have access to care and that plans are made to, where possible, reduce disparities in treatment outcomes. These will be an integral part of ensuring the ACH population's quality of care is a priority for DHHS and we have improvements in place to positively move it forward.

VIII. Value-Based Purchasing

DHHS is dedicated to ensuring its NC Medicaid Managed Care program optimizes health and well-being for North Carolina's Medicaid members. Central to these efforts are payment models that reward providers for delivering high-quality, appropriate care and improved health outcomes.

DHHS has proposed a value-based purchasing (VBP) strategy[15] that will rapidly accelerate the adoption of payment models that reward high-value care. In driving increased use of VBP models, DHHS seeks to align incentives for improving health and offer providers greater flexibility to deliver the care that will be best suited to their patients' needs.

PHPs and providers that are ready to enter value-based arrangements should begin value-based contracting from the outset of NC Medicaid Managed Care and increase their value-based arrangements and risk-based contracts over time. Providers without VBP experience may experiment with incentive payments and steadily increase their use of value-based arrangements as they gain experience in the managed care environment. Over time, DHHS envisions that nearly all Medicaid Standard Plan payments will be made under VBP arrangements, and that most PHP and provider contracts will incorporate some level of shared savings and shared risk.

The strategy leaves broad flexibility for PHPs and providers to design their own innovative VBP arrangements and to build off and align with VBP models in use today with other payers. It does not require PHPs or providers to enter any specific VBP models.

In developing the VBP Strategy, DHHS sought to balance the following objectives:

- **Ensure NC Medicaid "purchases health" and is a good steward of state resources** – NC Medicaid is committed to "purchasing health" for its members, meaning that it aims to align financial incentives to better achieve whole-person health and well-being. This includes paying for improved health outcomes rather than for discrete services; paying for all elements that contribute to a person's health including medical (e.g., immunizations) and non-medical (e.g., food or housing) services; and paying to keep people healthy rather than primarily treating them when they are sick. Additionally, NC Medicaid aims to be a good steward of State resources and get the full value of the dollars it spends. A critical step to achieving these goals is moving from a fee-for-

[15] More details about DHHS' Proposed Value-Based Purchasing Strategy can be found in a policy paper published January 8, 2020. DHHS is in the process of reviewing this strategy to account for any changes in provider readiness because of the COVID-19 pandemic.

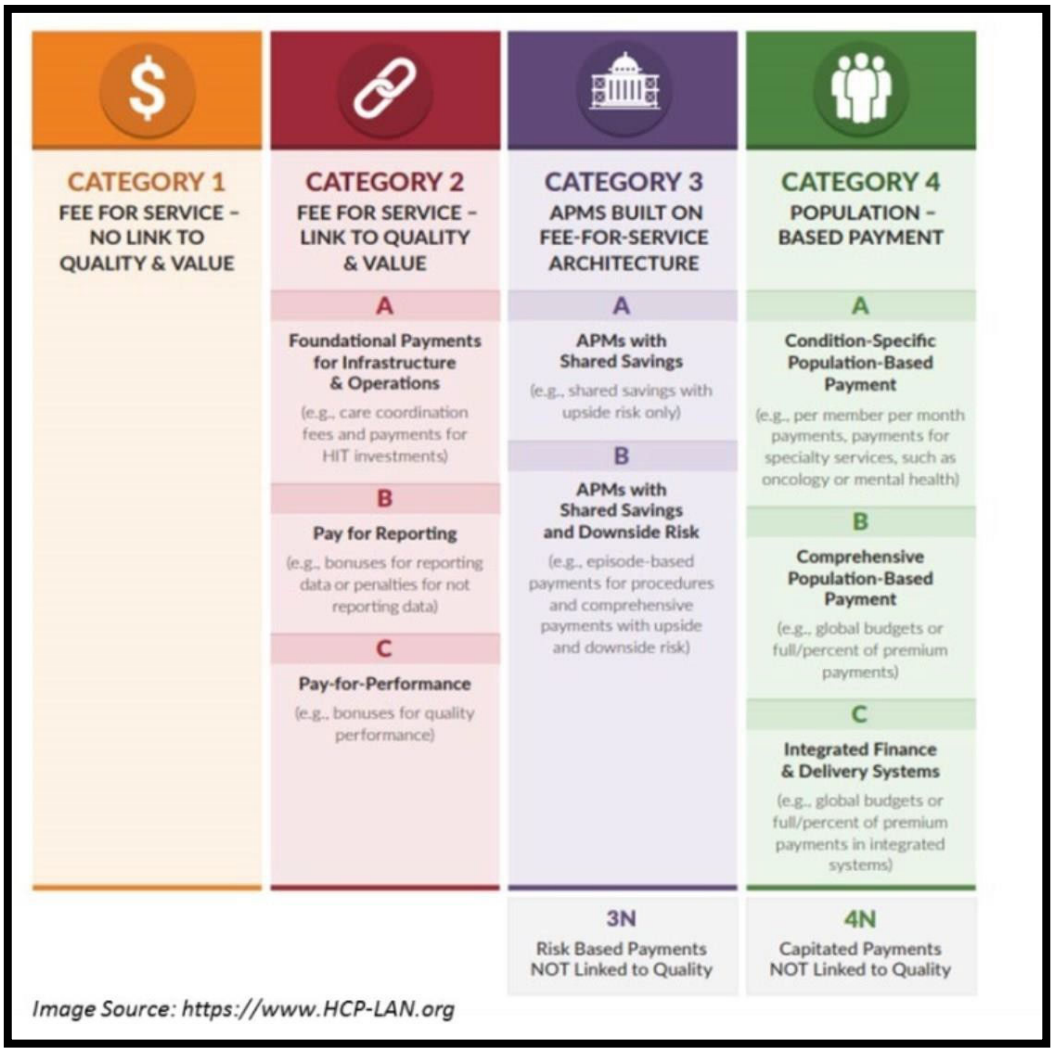
service payment system, which incentivizes the quantity of care provided, to a system that incentivizes high-quality care and improved whole-person health.

- **Establish ambitious, but achievable, VBP goals** – DHHS aims to rapidly accelerate the use of VBP through NC Medicaid Managed Care. This strategy reflects a strong commitment to measurable and significant progress on VBP adoption. The expectation is that nearly all PHP and provider contracts will contain a VBP component over time, though the nature of these VBP components may vary based on PHP and provider needs. At the same time, DHHS recognizes that PHPs and providers will need time to negotiate and implement value-based arrangements and has considered the provider landscape in North Carolina as well as PHP commitments related to VBP in their contracts with DHHS to ensure expectations for VBP adoption are achievable in the defined timeframes.
- **Recognize market readiness for VBP and align across payers when feasible** – The move towards VBP in NC Medicaid builds upon existing trends in the North Carolina healthcare landscape. Many large health systems in the state participate in Medicare Accountable Care Organizations (ACOs) or have entered into VBP contracts with commercial payers. Within Medicaid, nearly 1,500 practices have attested into AMH Tier 3, which uses a performance-based incentive payment model. All PHPs have begun developing alternative payment models that link provider payments to quality and accountability for total cost of care, and both PHPs and providers have entered into contracts with clinically integrated networks (CINs) or other partners to help their efforts to improve care. In the early years of managed care, DHHS hopes to build upon and align with existing VBP infrastructure while encouraging increased adoption in the Medicaid context. This alignment is important to reduce administrative burden for providers who may contract with multiple payers.
- **Allow PHPs and providers flexibility to tailor VBP models to their specific populations and needs**— Recognizing that PHPs and providers will have different needs when developing value-based arrangements, DHHS will permit PHPs and providers to develop and enter arrangements that best align with their readiness and infrastructure, and with their specific populations and services. DHHS expects larger, more mature health systems with greater VBP experience to move quickly into models that are linked to the total cost of care and quality and incorporate financial risk. However, smaller, independent practices with little VBP experience will have flexibility to build experience in incentive-based or, at their option, lower risk VBP models. Although the VBP strategy offers guidance for forming VBP arrangements and highlights several VBP initiatives, DHHS will not require providers to participate in any specific VBP models, allowing PHPs and providers broad flexibility to develop innovative VBP models that best suit their needs.
- **Build from and leverage state programs focused on improving high-value care—** Many North Carolina programs focus on delivering high-value care to Medicaid members, and these existing programs are foundational to the VBP strategy. The strategy aims to align with and build on these programs and initiatives, which include AMHs, Healthy Opportunities initiatives, the Medicaid quality strategy, and other

efforts that aim to increase provider capacity to deliver high-quality, coordinated, whole-person care.

The Department will define VBP using the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework (see Figure 1). Initially, the definition of VBP is intentionally broad, and includes any payment arrangements that fall into HCP-LAN Category 2 and above. Over time, PHPs are required to increase the percentage of payments in VBP arrangements overall as well as in higher level models.

Figure 1. HCP-LAN Alternative Payment Model Framework



IX. Financial Analysis

Payment History:

Prior to January 1, 2013 the basic fee for North Carolina Adult Care Homes (ACHs) was based on 1.1 hours of service per resident day and was computed by determining:

- Estimated salary
- Fringes
- Direct supervision
- Cost of medication administration
- Allowable overhead

Rates were calculated based on a cost reporting period selected by the State. Reimbursement did not include room and board. The basic fees in effect before consolidation were $16.62 for 1-30 facility beds and $18.21 for 31+ facility beds. For NC Medicaid eligible residents that

demonstrated a need for additional care, enhanced rates were billed in addition to the basic rate. These enhanced services included:

- Eating $10.26
- Toileting $ 3.67
- Ambulation/Locomotion $ 2.62
- Additional fee schedule rates included:
- Special Care Units (Alzheimer's) $44.44/$48.68
- Transportation – NEMT $0.57

Per North Carolina General Assembly Session 2011, House Bill 950, DHHS was required to implement a new consolidated PCS benefit. Effective May 1, 2012, CMS approved a North Carolina State Plan Amendment revising the scope and nature of PCS (formerly called In-Home Care). This approval extended the sunset deadline of IHC and ACH from April 30, 2012, to Dec. 31, 2012.

Current Fee for Service (FFS) Rates:

Effective Jan. 1, 2013, Medicaid PCS for recipients in all settings, including licensed adult care home facilities, would be provided under a consolidated PCS benefit.

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowa ble
99509	HA	ATTENDANT CARE SERVICES	Personal Care Services, Private Residences, Beneficiaries Under 21 Years	15 min.	$4.51
99509	HB	ATTENDANT CARE SERVICES	Personal Care Services, Private Residences, Beneficiaries 21 Years and Older	15 min.	$4.51
99509	HC	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes	15 min.	$4.51
99509	HH	ATTENDANT CARE SERVICES	Personal Care Services, Supervised Living Facilities, Adults With MI / SA	15 min.	$4.51
99509	HI	ATTENDANT CARE SERVICES	Personal Care Services, Supervised Living Facilities, Adults With MR / DD	15 min.	$4.51
99509	HQ	ATTENDANT CARE SERVICES	Personal Care Services, Family Care Homes	15 min.	$4.51
99509	SC	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes Special Care Units	15 min.	$4.51
99509	TT	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes Combination Homes	15 min.	$4.51

*Note: **All rates include 5% and 10% separately implemented COVID-19 rate increases to the $3.90 pre COVID-19 rate***

Rate Changes:

$4.51 effective April 1, 2020

$4.96 effective Jan. 10, 2021 (EVV increase included)

$5.96 effective Jan. 10, 2022 (PHE uniform increase included)

(COVID-19 Breakout rates are not depicted in rates)

FFS Rate Comparison of Surrounding States:

State	Service Description	Hourly Rate
North Carolina	Personal Care Services (All Settings)	 $15.60
South Carolina	Personal Care Services - Personal Care I (S5130) - Personal Care II (T1019)	 $14.00 $18.40
Georgia	Personal Support Service - T1019, <= 10 units (2.5hrs) - T1019 TF, >= 12 units - T1019 UC, consumer-directed	 $20.20 $17.96 $19.20
Virginia	Personal Care Services (T1019) Northern VA Rest of State	 $13.70 $16.13

Analysis of SFY Spending

North Carolina Adult Care Homes (only) Totals	# Recipients	Total PCS Annual Spending	Total Annual PCS Hours	Avg PCS Hours Per Recipient Per Month	Avg Cost Per Recipient Per Month
SFY 2019-20	143,348	216,088,814	13,066,561	91.15	$1,507.44
SFY 2018-19	145,277	202,486,241	13,053,675	89.85	$1,393.79
SFY 2017-18	145,225	197,597,664	13,043,120	89.81	$1,360.63
SFY 2016-17	148,284	179,677,812	13,007,055	87.72	$1,211.71

Rate Methodologies

States use a variety of methodologies to set rates for 1915(c) direct support services operated under managed care, with no “one-size-fits-all” prescription or approach. States with managed care 1915(c) waiver programs highlight the considerable amount of flexibility afforded to states to develop payment rates best appropriate for their respective program. Table 1 below outlines examples of the various types of payment methodologies for five of 16 states that offer services which include ACL provided in a residential or group setting and operate 1915(c) waiver programs with managed care delivery systems. As illustrated below, California and Kansas use a mix of fee-for-service and managed care with the State Medicaid Agency establishing a floor for waiver service rates. Conversely, Illinois uses a mix of negotiated market pricing and fee-for-service methodologies to establish payment rates for personal care, home health and adult day services.

Table 1: Examples of Payment Methodologies for States with Managed Care Delivery Systems

State (Waiver Programs)	Services Similar to North Carolina's Adult Care Home & Personal Care Services	Payment Methodology
California (CA.0141: Multiple Senior Services Program/MSSP)	Adult Day Care, Respite Care, Supplemental Personal Care	All services for California's Multiple Senior Services Program (MSSP) are offered under both fee-for-service and managed care rate settings. The MSSP coordinates care planning and service delivery with managed care plans for benefits covered by the managed care plans. An annual budget is established for the MSSP and monthly payment rates are determined by dividing the program's annual budget over a 12-month period.
Kansas (KS.0224: HCBS I/DD Waiver, KS.0303: HCBS for the Frail Elderly, KS.0304: Kansas Physical Disability Waiver, KS.0320: Serious Emotional Disturbance Waiver, KS.0476: Autism Waiver, KS.4164: HCBS Traumatic Brain Injury Waiver, KS.4165: Technology Assisted Waiver)	Adult Day Care, Attendant Care, Personal Care, Respite Care, Residential Supports, Sleep Cycle Supports	Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, that consider utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS. Under KanCare, the State sets the floor HCBS service rates which serve as the minimum MCOs are required to pay providers.

State (Waiver Programs)	Services Similar to North Carolina's Adult Care Home & Personal Care Services	Payment Methodology
Illinois (IL.0142: Persons with Disabilities, IL.0143: HCBS Waiver for Persons who are Elderly, IL.0202: HCBS Waiver for Persons with HIV or AIDS, IL.0329: HCBS Waiver for Persons with Brain Injury)	Personal Assistant, Adult Day Service, Home Health Aide	Illinois reimburses waiver services including adult day, home health aide and personal assistant services based on a fixed rate schedule for each service type. • Adult Day service rates were established through rate analysis of past claims and by conducting participant and provider focus groups. • Home health aide providers are reimbursed based on rates negotiated on an individual participant basis with prevailing wages for providers statewide. Home health rates include both direct care staff wages and administrative expenses. • Personal assistants are reimbursed based on periodic negotiated flat rates determined by the state's healthcare union and these rates exclude any direct or indirect administrative costs.
Iowa (IA.0213: HCBS AIDS/HIV, IA.0242: Intellectual Disabilities (ID) Waiver, IA.0299: Brain Injury (BI), IA.0345: Physical Disability Waiver Renewal, IA.0819: Children's Mental Health Waiver, IA.4111: Health and Disability Waiver, IA.4155: HCBS Elderly Waiver)	Self-Directed Personal Care, Adult Day Care, Consumer Directed Attendant Care, Home Health Aide Services	• Iowa reimburses self-directed personal care services based on the rate negotiated by the participant and the self-directed employee. • The State reimburses home health providers using a cost reconciliation rate methodology approach. The State establishes a prospective interim rate for home health providers based on projected costs. Providers are then required to submit cost reports on an annual basis with payments subject to a retrospective cost settlement.
Virginia (VA.0321: Commonwealth Coordinated Care Plus for Aged, Disabled and Technology Dependent)	Personal Assistance, Respite Care Services	Virginia employs a rate model framework that accounts for direct support professional wages, benefits, productivity and other direct care costs. Agency and program support costs are also considered and factored into the State's rate for personal assistance and respite care services.

State (Waiver Programs)	Services Similar to North Carolina's Adult Care Home & Personal Care Services	Payment Methodology
Washington State **WAC 388-845** **RCW 71A.10.020(5)** Developmental Disabilities Administration (DDA) provides services through five HCBS waivers: (1) Basic plus waiver **WA.0409.R03.05** (2) Core waiver WA.0410.R03.07 (3) Community protection (CP) waiver WA.0411.R03.06 (4) Children's intensive in-home behavioral support waiver (CIIBS) WA.40669.R02.04 (5) Individual and family services (IFS) waiver. WA.1186.R01.03	Personal Care Services	• The rate for personal care services provided by agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency. • The rate for personal care provided in assisted living facilities is based on a per day unit. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are based on components for provider staff, operations, and capital costs. • The rate paid to residential providers does not include room and board. The rate for personal care provided in an adult family home is based on a per day unit and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes.

The examples in Table 1 are not all-encompassing and reflect high level examples of the types of methodologies states use.

States operating 1915(c) managed care waiver programs retain the same flexibilities afforded to non-concurrent programs to select a rate methodology most appropriate for that respective waiver program. Nationally, states operating managed 1915(c) waiver programs use a range of methodologies including fee-for-service or fee schedule, cost reconciliation, negotiated market price, and capitated payment rates to pay for direct support services.

Summary:

Financial research findings indicate that establishing a new ACH payment methodology will require NC Medicaid to coordinate the clinical and quality internal policy objectives, external service objectives for Medicaid beneficiaries, along with the following cost considerations:

a) Leveraging existing service cost and utilization data

b) ACH provider assessment of the costs of rendering services and benchmarks such costs with the State's projected costs

c) A range of cost assumptions beginning with identifying a base direct support worker wage assumption for each waiver service.

Alignment of Payment Structures with Managed Long-Term Services and Supports Program Goals:

Payment to managed care plans should support the goals of the MLTSS program, including improving the health of populations, improving the beneficiary experience of care, and reducing costs. Tools may include capitation rates that support community integration or performance incentives/withholds tied to outcome measures and quality improvement.

X. NC Interim Strategy

Seek approval from CMS to amend the existing State Plan to incorporate a per diem payment for PCS delivered in a congregate care (ACH or FCH) setting.

Steps needed to implement a per diem payment for PCS in congregate setting.

- Establish a per diem rate methodology for ACH Congregate Care Services based on current assessment tool
- Draft changes to State Plan for PCS
- Submit proposed changes to key stakeholders for consensus and comment
- Upon CMS approval of the State Plan Amendment (SPA)
    - Amend Clinical Coverage Policy 3L (concurrent with SPA submission)
    - Submit FMR to GDIT to determine changes needed to payment system

XI. NC Long Term Strategy

Develop a new ACH Congregate Care Services (CCS) Program that aligns with the assistance and personal care support provided in Adult Care Home setting.

Steps needed to create an ACH Congregate Care Services (CCS) Program.

- Develop a service definition for Congregate Care Services and initiate a new State Plan Amendment to include Congregate Care Services (CCS)
- Establish a per diem rate methodology for ACH Congregate Care Services
- Develop a new clinical coverage policy for ACH Congregate Care Services
- Adopt a new independent assessment tool to align with the needs of the ACH setting of care.
- Remove ACH setting from current PCS SPA and Clinical Coverage Policy

ATTACHMENTS

A. Session Law 2019-240, Senate Bill 537, Part I.

B. Survey Results

C. Stakeholder Workgroup Participants

D. Presentations from Stakeholder Workgroup Meetings

E. ACH Stakeholder Meeting Notes (Questions & Responses)

F. Complete Data Set

G. Full Data ACH Study

H. Plan for Long-term Solution for Adequate Reimbursement to Facilities Serving Recipients of State/County Special Assistance (tables 2-8)

Attachment A. S.L. 2019-240

AN ACT TO EXAMINE AND ESTABLISH A NEW ADULT CARE HOME PAYMENT METHODOLOGY; TO AMEND THE LICENSED PROFESSIONAL COUNSELORS ACT; TO UPDATE AND REVISE THE SUBSTANCE ABUSE PROFESSIONAL PRACTICE ACT; TO AMEND THE SOCIAL WORKER CERTIFICATION AND LICENSURE ACT; TO AMEND DEPARTMENT OF HEALTH AND HUMAN SERVICES' STATUTES PERTAINING TO MEDICAID, SOCIAL SERVICES REFORM, CHILD SUPPORT, VOCATIONAL REHABILITATION, EMPLOYEE ASSISTANCE PROFESSIONALS, ADOPTIONS, CHILD ABUSE AND NEGLECT, JOINT SECURITY FORCES, SECURITY RECORDINGS, NC REACH PROGRAM, TRAUMATIC BRAIN INJURY, AND THE MEDICAL CARE COMMISSION MEMBERSHIP; TO POSTPONE DEPLOYMENT OF NC FAST CASE-MANAGEMENT FUNCTIONALITY FOR CHILD WELFARE SYSTEM/AGING AND ADULT SERVICES' PROGRAM, DEVELOP REQUESTS FOR INFORMATION, AND REQUIRE PROGRAM EVALUATION DIVISION TO STUDY THE ISSUE; TO IMPLEMENT CRIMINAL HISTORY RECORD CHECKS FOR CHILD CARE INSTITUTIONS; TO MAKE CHANGES TO INVOLUNTARY COMMITMENT; AND TO ESTABLISH THE RURAL HEALTH CARE STABILIZATION PROGRAM.

The General Assembly of North Carolina enacts:

PART I. ESTABLISH NEW ADULT CARE HOME PAYMENT METHODOLOGY

SECTION 1.(a) It is the intent of the General Assembly to provide funding to adult care homes in the State in a manner that recognizes the importance of a stable and reliable funding stream to ensure access, choice, and quality of care within the adult care home segment of the care continuum. In furtherance of this intent, and as the North Carolina Medicaid program transitions to a managed care delivery system, the Department of Health and Human Services is directed to establish and convene a workgroup to evaluate reimbursement options for services provided by adult care homes that take into account all funding streams and to develop a new service definition, or definitions, under Medicaid managed care for these services. The workgroup shall consist of adult care home industry representatives and other relevant stakeholders. In development of the new service definition, or definitions, the workgroup shall include all of the following components:

(1) Support for alternative payment models available under the State's 1115 Medicaid waiver for Medicaid transformation, including pay-for-performance initiatives.
(2) Best practices for long-term services and supports.
(3) Efficient payment methodologies.

SECTION 1.(b) No later than December 1, 2020, the Department of Health and Human Services shall submit a report on the new service definition, or definitions, developed by the workgroup, as required in subsection (a) of this section, to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. The Department shall not submit to the Centers for Medicare and Medicaid Services any amendments to the NC Medicaid State Plan necessary to implement the new service definition without prior approval from the General Assembly.

SECTION 1.(c) If House Bill 966, 2019 Regular Session, becomes law, then Section 9D.12B of that act is repealed.

Attachment B. Survey Results

ACH Stakeholder Survey Summary	
Date: 9/16/2020	
Total Respondents: 10	
Survey Duration: 8/4/2020 - 9/10/2020	
Adult Care Home Provider	**5 / 10 responses = 50%**
Community Advocate	**3 / 10 responses = 30%**
Adult Care Home Resident	**0 / 10 responses = 0%**
Adult Care Home Family Member	**1 / 10 responses = 10%**
Professional Association	**0 / 10 responses = 0%**
Other	**2 / 10 responses = 20%**
Question 1	
Share your comments about evidence-based or best practice models for delivering services and supports to individuals currently being served in NC Adult Care Homes.	
ACH Provider	**Response 1** - Resident acuity varies and should be compensated as such. **Response 2** - NOT A FAN OF IT! **Response 3** - Best practice is to allow the facilities to concentrate in providing the appropriate care to the residents versus book keeping. With the 15 minute billing and the documentation that follows is very cumbersome during normal times at best. **Response 4** - We are currently using the Plan Do Check Act as an evidenced-based utilizing the Integrated Care, Collaborative Care Model to individuals currently being served in our Adult Care Homes. **Response 5** - As a provider of Innovation waiver services as well the evidenced based practice and best practice model of person centered care has proven

	itself with the quality of life and service for the individuals served. If the person centered care system were used in adult care homes with a daily flat rate of services based on the level care needed for the individual the quality of life and delivery of services of the individuals served in adult care homes would be greatly improved.
Community Advocate	**Response 1** - Service model is dated. Compensation for operators to care of this population is very low. Staff should be paid a living wage. **Response 2** - Residents are engaged in group activities, meal planning and prep, social groups outside of the home. Neighborhoods are safe and support the facility. **Response 3** - Best practice and evidence-based care precludes the existence of Adult Care Homes. In other words, they all need to be shut down. NC funnels significant resources into ACHs, which routinely provide substandard care to older adults and/or adults with disabilities. Suspicious deaths, abuse and neglect are rampant. The State's enforcement mechanism (DHSR) is feckless, and ACHs routinely prevail in court actions to thwart licensure enforcement. ACHs have a powerful lobby and continue to receive more and more money, yet provide absolutely no improved quality of care.
ACH Resident	**N/A**
ACH Family Member	**Response 1** - The individual needs fully integrated healthcare with an emphasis on prevention, supported recovery, and training to learn skills of daily living.
Professional Association	**N/A**

Other	**Response 1** - N/A **Response 2** - I do not feel the homes follow any EBP care. It is the provider in the home that outlines the care for that resident/patient. Depending on the ACH, staff may not even be aware of what evidence based care or practice models are. Most providers in this arena are not monitored for EBP's or pathway type care. On top of this, guardians also need to be educated on EBP and what should be expected around well care, episodic care and care management for chronic conditions.
Question 2	
Identify quality health outcomes and performance measures for this setting of care and how they should be measured. Reference: Quality Management and Improvement webpage.	
ACH Provider	**Response 1** - Resident acuity varies and should be compensated as such. **Response 2** - This will not work for ACH's. **Response 3** - Facilities should continue their Quality Assurance programs with completion of the assessments by the residents. **Response 4** - Improved Care, Improved Access to Care and Ensuring Timely Access to Care are quality health outcomes and performance measures for this setting. We are currently using Power BI within our EHR to produce improved timely and improved access to care. The Collaborative Care Model has a Patient Tracking Spreadsheet that documents each contact, along with the PHQ9 and GAD 7 for Improved Care. **Response 5** - Person centered plans with the individual's input on how their day goes and what their short and long terms goals are in regards to their mental and physical health. Nutrition, exercise, weight loss, hygiene, etc.

Community Advocate	**Response 1** - If you continue with present model, you can expect more deaths because most patients are being warehoused until they expire. The department has shown over the past twenty five years little or no concern for the welfare and safety of the residents. More money for facilities upgrades and staff training on a monthly basis. **Response 2** - Decreased hospitalizations, increased independence, social interaction and participation - Facilities should be penalized when individuals relapse as soon as they are released. Compensate institutions to keep an ill individual until they are stabilized. **Response 3** - Smarter spending -- This branch says NC will pay for value and ensure high quality care. We are not paying for value. We are paying for a powerful lobbying and donation bloc, at the expense of the people receiving substandard care in these facilities. The taxpayers who fund ACHs are getting no value for their money, never mind fair value.
ACH Resident	**No responses**
ACH Family Member	**No response**
Professional Association	**No response**
Other	**Response 1** - There should be a better way other than adding more responsibility to the companies. **Response 2** - It depends on the resident, diagnoses, medications and how acute their conditions are. HEDIS metrics would be a place to start, pharmacology reviews for duplicate classes of medications, chronic measures for adults like CHF, DM care, etc. should also be looked at. Readmissions, number of incidents or adverse events, etc.
Question 3	
NC Medicaid, along with other states, is continuing to explore value-based purchasing (VBP). What are your ideas on how value-based purchasing could work for ACHs in North Carolina? Please be specific, and if you have examples of where this is happening in other states, please provide the state and payment arrangement. Reference: NC Value-Based Payment Strategy	

ACH Provider	**Response 1** - No examples **Response 2** - It will not work for ACH's because there will be no continuity in how this will be achieved. **Response 3** - I do not have experience with VBP **Response 4** - The Value Based Payment models that we are currently using in a residential environment is the bundled capitated rate with an upfront incentive pay and quarterly bonuses based on performance for the duration of the contract. Value Based Payment models are unique and can structured based on the needs of the consumer. This models improves financial stability for the provider, residential stability for the client and job security for the direct support professional. **Response 5** - With a VBP rate in place for NC ACHs would improve the quality of care/life per individual by being able to hire more qualified staff, more person centered day less institutionalized day. Gives individual a sense of still being in control of their day to day life. With a flat rate based on the level of need the ACH will be able to hire more qualified staff at a higher rate of pay, be able to purchase computer systems compatible with the EHR mandate, food service quality will improve and be individualized based on person centered goals. ACH's will be able to work more closely with doctor's and other outside caregivers as a team to better serve the individual.
Community Advocate	**Response 1** - Will not work with this population due to the age of many facilities and not a level playing field. Will favor the more well finance homes rather that the average facility. **Response 2** - Suggest you look at CMS and how Medicare is managed. Providers that can not show measurable improvement in patient/ client outcomes or at least keep and individual stable should not continue to be paid. PCP should be undated and reviewed quarterly. More dollars for preventative services and all individuals to participate in multiple programs at the same time. **Response 3** - Managed Care and the MCOs have been a total disaster for behavioral health services. I have no confidence in the ability of this system to adapt and encompass ACHs. Therefore, the only way VBP could work for ACHs in NC is if VBP provides higher rates for in-home or in-community options of care, and actively seeks to shut down ACHs.

ACH Resident	**No response**
ACH Family Member	**No response**
Professional Association	**No response**
Other	**Response 1** - There has to be a better way **Response 2** - I am not confident that this could work. It would depend on the home, how they have their care model structured, diagnoses of their clients/acuity and the receptiveness of the provider over the home or the provider group. I could potentially see maybe a PMPM based model.
Question 4	
Beginning July 2021, NC Medicaid will transition from fee-for-service to a Managed Care Payment system. Within 4 years of managed care implementation, the Department plans to enroll LTSS beneficiaries into managed care in three phases. Share your suggestions or examples of how NC ACH/AFLs should transition from fee-for-service to managed care. Reference: North Carolina's Vision for Long-term Services and Supports under Managed Care	
ACH Provider	**Response 1** - Have active participants in adult care homes make suggestions, not "people" sitting in offices **Response 2** - ALL THIS WILL DO IS ADD ANOTHER LAYER OF RED TAPE TO THE PROCESS FOR OPERATORS OF ACH'S. WE ALREADY HAVE TO DEAL WITH OUSTIDE SOURCES THAT CAN COME IN AND LEGALLY POACH OUR RESIDENT POPULATION. THERE IS NO OTHER MEDICAID PROVIDER THAT HAS TO DEAL WITH THIS. **Response 3** - I believe this is a lofty goal in light of our current pandemic. **Response 4** - ACH's are totally different from AFL's. Currently Fee-For-Service is not available for ACH's. ACH's should be managed by the MCO who will assist the Provider in developing a Value Base Reimbursement model that is Provider based. NC CARES 360 can be continue to be the referral source to identify the clients specific needs. The United Providers of Health, LLC, located in Raleigh, NC is a state wide organization comprised of small behavior and primary care providers who assist with solidifying Value Based Reimbursement models, who can be utilized as a liaison for the Provider in developing a VBP based on the Provider Service Array and also as a liaison for the MCO to assist in operationalizing the VBP.

	Response 5 - The VBP rates should meet the level of care required. meetings with ach owners to understand the costs involved to operate a ACH on the amount of reimbursement for the fee for service rate to understand how levels should be set. a standardized assessment to assess the level of care needed. these rates and assessments should be modeled and mirrored after the residential rates and determination required under the Innovations waiver. The rates may not be the same as Innovations but the determination process should be the same.
Community Advocate	**Response 1** - This is a failing model. Great goal but no readiness . State must make investment into structural aspects of this program. **Response 2** - I do not see this plan as a solution for individuals with chronic and persistent mental illness. Living in recovery is not the same as being cured or made well. These are long tern illness, many with progressive symptoms. **Response 3** - See #4. NC Medicaid should use these four years to focus on building high-quality community-based services and obviating the market for ACHs. Community-based services should receive a higher reimbursement rate than ACHs and other congregate settings, in order to phase out ACHs entirely by the end of year 4. All remaining ACHs should be required to break into smaller family care homes (6 beds or less).
ACH Resident	**N/A**
ACH Family Member	**N/A**
Professional Association	**N/A**

Other	**Response 1** - N/A **Response 2** - I would start with the low acuity LTSS beneficiaries and save the highest acuity LTSS beneficiaries as the last phase.
Question 5	
Please share with this workgroup any other information or recommendations that should be considered in developing this report.	
ACH Provider	**Response 1** - See above **Response 2** - THIS PROGRAM SHOULD NOT BE PURSUED IN ANY FORM. THIS IS THE SAME PROGRAM THE STATE TRIED 20 YEARS AGO, THAT WAS A DISASTER!! THE NAME IS ONLY DIFFERENT. IT WAS CALLED HMO's THEN! **Response 3** - I don't know **Response 4** - Transitioning ACH's to managed care utilizing a VBP will improve the 60% turnover workforce rate for direct support professionals. VBP will incentivize Providers to invest in professional development and training which will result in better outcomes for the individuals currently being served. Extending the transition past 2 years will discourage providers and may cause distrust of DHHS, the process and the hope of changing to a better system of care. Access to Care and Timely Access to Care are key measurement that can be shared by the Provider as well as DHHS during the transition. **Response 5** - Keep in mind the quality of care you would require/ expect for your family member or yourself. keep in mind you get what you pay for low rates equal low quality of services. advisory groups from different facilities in regards to size and population serve.

Community Advocate	**Response 1** - Each member of this workgroup should spend at 24 hours a day in at least five different facilities prior to making any suggestions for changes. **Response 2** - Rate of pay for group homes is too low, but leaves very little of the residents income ($66)to pay for personal items/ clothing/ and entertainment. Current ACH rate make is difficult for the basis like food and staffing to be covered. May homes do not provide enough food, especially healthy meals, and depend of day programs to help feed and care for the residents. There is little oversite of current group homes especially in Alamance County. **Response 3** - This survey needs to be rewritten so that lay people, such as those who have loved ones in ACHs, can participate. As currently composed, this survey is clearly geared towards ACH industry members and professionals.
ACH Resident	**N/A**
ACH Family Member	**N/A**
Professional Association	**N/A**
Other	**Response 1** - N/A **Response 2** - ACH's need to be treated as a HC entity and should be required to be accredited within 3 years of opening their doors. They need to learn how to work with insurance companies and care management programs outside of their organizations and be held to regulation no different than a provider or hospital system around care. They also need to better case manage their residents between physical and BH conditions.
Finance Questions	
Question 1	
Are you aware of any states currently using cost report data in the development of ACH rates? If so, please list the state.	
ACH Provider	**Response 1** - No **Response 2** - No **Response 3** - No **Response 4** - I am not aware of any states using cost report data **Response 5** - N/A

Community Advocate	**Response 1** - N/A **Response 2** - No **Response 3** - No
ACH Resident	**N/A**
ACH Family Member	**N/A**
Professional Association	**N/A**
Other	**Response 1** - No I'm not currently aware of any other states. **Response 2** - No
Question 2	
Should the current cost reporting documentation compiled by NC ACHs be incorporated into rate development? Why or why not?	
ACH Provider	**Response 1** - For fairness **Response 2** - Yes, it should and more consideration should be given to higher fixed costs that are incurred by ACH's. Utility, Insurance, (Property & Health) Food Costs,, have steadily increased over the last decade. **Response 3** - Sure **Response 4** - No. It does not include intangibles such as care, love, respect, nor tenderness. **Response 5** - Yes because the state requires us to do it and it is a large expense on our part and it is the raw figures and those numbers should give a baseline to rate development.
Community Advocate	**Response 1** - N/A **Response 2** - Cost have continued to rise while the home rate has been the same for years. An analysis of operating cost needs to be done and reviewed before setting new rates. Rental rates for property, salaries, and other operating cost vary widely across the state. **Response 3** - No, because it is clearly in the ACH industry's self-interest to push for greater funding without providing better care. An independent, neutral body should compile any time of cost report or rate development recommendations.
ACH Resident	**N/A**
ACH Family Member	**N/A**
Professional Association	**N/A**

Other	**Response 1** - No, not with the way it is now. More work need to be more pay. It's already hard enough to keep staff with the current pay rate. There's no pay for mileage and that's already an issue. **Response 2** - Yes. They need to learn to manage their clients or residents and not overutilize resources like ER's or other organizations. Their providers need to be accountable for holistic care and medical and BH management no different than an inpatient acute BH unit or hospital. They need to be accredited.
Question 3	
Should the current rate structure be revised to be provider-specific? Please explain.	
ACH Provider	**Response 1** - Yes. Resident acuity varies **Response 2** - No, we do not need another change to this program, It has changed three times since 2011. The change from EDS to NC Tracks was a nightmare for all providers at best. **Response 3** - ACHs are hanging on by a thread since March 2020. The extra one time payment did help to elevate a small portion of the cost burden of purchasing tens of thousands of dollars in PPE. Businesses can not depend on Emergency Management to relieve the burden of procuring adequate quantities of PPE for staff and residents. When was the last time there was an increase in the Medicaid rate for ACHs and how much has the cost of living surpassed that amount? We are charged with providing a safe and secure environment for our most vulnerable people in NC but the current payment does not reflect that responsibility. For example: facility specific payroll is half of what we net each year. **Response 4** - The rate structure should be revised to be provider specific based on the provider service array. Subcontracting should be encouraged to increase gender and cultural diversity. **Response 5** - Yes some providers offer better accommodations and services and this should be reflected in the rate they receive for the care provided. some providers cater to a special population of individuals and this should be reflected in their rate.

Community Advocate	**Response 1** - N/A **Response 2** - Yes, the rates should be provider specific so homes that provide more services and staffing can be compensated at a higher rate. I would like to see a fee for service model where services are documented and compliance standards are implemented. Rents vary by area as do labor cost. **Response 3** - Yes. Bad providers should be penalized, in order to push them to improve or shut down.
ACH Resident	**N/A**
ACH Family Member	Response 1 - Cost of providing service in ACH or FCH are more similar to assisted living facilities when residents have SPMI.
Professional Association	**N/A**
Other	**Response 1** - Yes it should be revised due to having to do more and teach staff. You would need more to hire someone just to do the system by itself. **Response 2** - It could be either provider specific on a PMPM basis or by group, no different than that a PCMH or PCP structure and should include Case Management structures.

Attachment C. Stakeholder Workgroup Participants

Name	ACH Role
Sabrena Lea	LTC Operations Manager
Linda Rascoe	Sr. Policy Analyst
Reginald Little	Associate Director/Provider Reimbursement (FFS)
Amanda Van Vleet	Senior Program Analyst, Quality and Population Health
Cassandra McFadden	Programs Operations Manager for Community Programs
LaCosta Parker	IDD Clinical Consultant
Emma Sandoe	Associate Director, Srategy and Planning
Patricia Farnham	Senior Policy Analyst, Quality and Population Health
Katrina Brown	Financial Analyst
Darcel Harris	Financial Analyst II
Mya Lewis	Section Chief for IDD
Susan Bryan	Senior Program Analyst
Jaimica Wilkins	Senior Program Manager

Name	ACH Role
Samuel B Clark, CPA	VP of Finance
Polly Welsh, RN-BC, MPH	Executive VP
Jeff Horton*	Executive Director
Frances Messer	President & CEO
Corye Dunn	Director of Public Policy
Victor Orija	State Long-Term Care Ombudsman
Megan Lamphere	Adult Care Licensure Section Chief
Libby Kinsey	Adult Care Licensure Section Assistant Chief (Division of Health Service Regulation)
Sarajane Melton	Aging Administrator
Joyce Massey-Smith	NC Department of Aging & Adult Services
Bill Lamb	Sabrena's referral LTC
Lauren Zingraff	Bill Lambs colleague
Allison Costanzo	NC Coalition on Aging
Kimberly Clawson	Senior Associate Director, Payor Relations The Joint Commission
Nikkia Wallace	Manager, Payor Relations, Division of Business Development, Government and External Relations
Mary Bethel	Board Member

Adult Care Home Legislation Stakeholders Meeting[7]
Agenda - Kirby Building Conference Rm. 297 9:00 - 12:00 noon
NC Medicaid | Prepared by Linda Rascoe
January 24, 2020

AGENDA

Welcome & Introductions 9:00 – 9:10	Linda Rascoe Sr. Policy Analyst, Long Term Services & Supports Division of Health Benefits
Review of Legislation (10 min) 9:10 – 9:20	Sandra Terrell, Director of Medicaid Benefits and Services Division of Health Benefits
Medicaid Overview (10 min) 9:20 – 9:30	Sabrena Lea Associate Director, Long Term Services & Supports Division of Health Benefits
Payment Methodology (20 min) 9:30 – 9:50	Reginald Little Associate Director, Provider Reimbursement Division of Health Benefits
Break (10 min) 9:50 – 10:00	
Home and Community Based Services Final Rule (20 min) 10:00 – 10:20	Mya Lewis Section Chief, IDD & TBI Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DHB Care & Quality Strategy (25 min) 10:20 – 10:45	Jaimica Wilkins Senior Program Manager Division of Health Benefits
Break (10 min) 10:45 – 10:55	
Regulatory Overview (20 min) 10:55 – 11:15	Megan Lamphere Chief, Adult Care Licensure Section Division of Health Service Regulation
Small Group Discussion (25 min) 11:15 – 11:40	Workgroup Participants
Report Out and Next Steps	Linda Rascoe, Sr. Policy Analyst, Long Term Services & Supports Division of Health Benefits

[7] Presentation Slides Available on Request.

Adult Care Home Legislation Stakeholders Meeting[8]
August 19, 2020
1:00 - 2:30 pm

AGENDA

Welcome & Introductions 1:00 – 1:10	Linda Rascoe Sr. Policy Analyst Long Term Services & Supports Division of Health Benefits
NC Medicaid Perspectives 1:10 -1:25	Dave Richard Deputy Secretary Division of Health Benefits
Value-Based Purchasing 1:25 – 1:40	Julia Lerche Chief Strategy Officer & Chief Actuary Division of Health Benefits
Stakeholder Presentation: Data Summary 1:40 – 2:10	Jeff Horton Executive Director North Carolina Senior Living Association
Stakeholder Presentation: The Joint Commission 2:10 – 2:20	Kimberly Clawson Senior Associate Director Payor Relations The Joint Commission
Cost Report/Rate Structure 2:20 – 2:30	Reggie Little Associate Director Provider Reimbursement (FFS) Division of Health Benefits
Report Out & Next Steps	Linda Rascoe Sr. Policy Analyst Long Term Services & Supports Division of Health Benefits

ACH Stakeholder Survey:
https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/adult-care-homes/ach-stakeholder-survey
ACH Webpage:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/adult-care-homes

8 Presentation Slides Available on Request

Attachment E. ACH Stakeholder Meeting Notes (Questions and Responses)

Adult Care Homes Stakeholder Meeting Notes

Questions & Responses

NC Medicaid | Prepared by Linda Rascoe 1/24/2020

1. What other information is there that was NOT presented today to inform our thoughts and ideas?

- 1115 Waiver process
- Special assistance
  - If modifications are needed to the current 1115 waiver
  - Other definitions we can use under 1115
  - Rate development (agenda item for future meeting)
  - Value-based purchasing (Presentation in March 2020 meeting)
- Adult Care Home requirements now vs. a different model or requirements
- Request information on acuity levels based on settings of care (agenda item for future meeting)
  - Quality of care
  - Health Professionals
  - Staffing ratios
  - What's needed now to take care of the people in ACH
- Look at the whole industry today
- Regulatory Report - DHSR monitoring processes and reports
- How to integrate Adult Care Home payments with Managed Care
- Overview of Independent Assessments Processes
- Statutory Rule Making Process
- Services required to be provided under licensure rules vs. reimbursement (SCSA & PCS only for low income population)

2. Based on what you have heard today, what questions are raised?

- Quality: data, collection, funding for technology
  - Long-term solutions
  - Data technology/Electronic Health Records –if quality is important then discussion needs to occur on this issue.
  - Real-time data measures or information on the patients
  - Electronic reporting including the cost report.
  - Need funding for the Industry
- Consider options to separate Personal Care Services based on setting of care (Adult Care Home and In-Home)

3. Anyone else we need at the table to help inform this decision?

- PHP representation
- DAAS staff (Joyce Massey-Smith or Designee)
- NC HIE- to hear the thoughts of the group on what is needed for this industry.
- Coalition on Aging Meeting
- Go to other places for meetings like "Friends of Residents in Long-term care and Adult Care Homes"

Adult Care Homes Stakeholder Meeting Notes

4. What can we do to ensure that in this process, we have the opportunity to hear from Medicaid beneficiaries who are living this experience?

- Conduct a meeting with the facility
- Include Associations partnering on a tour of Adult Care Homes Or Partner with Associations touring Adult Care Homes

Attachment F. Complete Data Set

Data request for Adult Care Home Legislative Study - Updated 5.18.2020

DATA	SOURCE	CONTACTS	COMMENTS & Requested Date
1. Average number of medications per resident (counted on Liberty assessment)	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
2. Average number of medication administration events daily (totaled on Liberty Assessment)	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	Not always required may be limited. Will pull what's available **Completed 4/1/2020**
3. Number of residents whose medication administration is labeled as complex	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
4. Average age by setting - Also recommend classifying by groups (i.e. 21+, 40 and under, 41 – 64, 65+)	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
5. Diagnosis profile by setting only	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
6. List of frequently used Diagnosis codes billed for SA recipients via SAS query-Claims	NC Tracks	Lakeisha Jordan	**Reframed 3/17/2020 Completed**
7. Current PCS hours by setting, i.e. ACH and ACH memory care	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
8. Number of Qualifying ADL's by setting; 2-5 totals	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
9. Number of exacerbating conditions by setting listed in most to least	QiReport	Emonique Wooten-Whitfield & Kevin Goddard	**Completed 4/1/2020**
10. Average SA payment amount by type (regular SA and special care unit SA) - NC FAST	DAAS	Angie Phillips, Hank Bowers & Karey Perez NC FAST	**Completed 4/1/2020**
11. Estimated number of individuals losing eligibility for SA and SA In-Home for each of the past ~~5~~ 3 years due to Social Security and SSI Cost of Living Adjustments (COLAS). (Note: Only an estimate can be provided based on Pre-and Post-COLA Case	DAAS	Angie Phillips, Hank Bowers & Karey Perez; Sonja McLeod & Matt Lawlor NC FAST if needed	**Reframed 3/16/2020 Completed**

Counts, which may include termination of benefits for other reasons.)			

Attachment G. Full Data ACH Study

ADULT CARE HOME PAYMENT METHODOLOGY STUDY

PURPOSE:

Adult Care Homes (ACH) provide room and board, and supervision to those requiring assistance with Activities of Daily Living (ADL). In order to examine the current, and establish a new, payment methodology; the NC General Assembly issued a Senate Bill. DHHS has convened a workgroup, relevant stakeholders, and a data team (from which this data is summarized).

High-Level Parameters Requested:

SFY15 to SFY19

ACH & SCU Residents

Summarized by Gender, Race, Age Ranges, & Diagnosis

KEY WORDS & ACRONYMS

Resident:	*PCS beneficiary residing in either an ACH or SCU.*
Age Ranges:	*21-40, 41-64, 65+*
PCS Hours:	*4 units of 15 minutes per hour*
Setting/Type:	*Adult Care Home (ACH) or Special Care Unit (SCU); data uses the modifiers HC and SC.*
Activities of Daily Living:	*(ADLs) Bathing, Dressing, Mobility, Toileting, & Eating (Eligibility: min. 2/5).*
Exacerbating Conditions:	*A number of conditions identified in Session Law 2013-306; allowing for additional units.*
Special Assistance:	*(SA) Cash Assistance provided to low-income residents of certain facilities.*
Social Security Income:	*(SSI)*
Cost of Living Adjustment:	*(COLA)*

Service Level Determinations

1. Time is authorized for each day of unmet need for assistance with qualifying ADLs from the Daily Minutes table as follows:

Daily Minutes for Qualifying ADLs and Medication Assistance

	Beneficiary's Overall Self-Performance Capacity		
ADL	**Limited Assistance**	**Extensive Assistance**	**Full Dependence**
Bathing	35 minutes per day	50 minutes per day	60 minutes per day
Dressing	20 minutes per day	35 minutes per day	40 minutes per day
Mobility	10 minutes per day	20 minutes per day	20 minutes per day
Toileting	25 minutes per day	30 minutes per day	35 minutes per day
Eating	30 minutes per day	45 minutes per day	50 minutes per day
Medication Assistance			
Reminders/ Set-Up/Supervision	**Routine Administration, 8 or Fewer**	**Routine Administration Plus PRN**	**Poly pharmacy and/or Complex**
10 minutes per day	20 minutes per day	40 minutes per day	60 minutes per day

Beneficiary's Self-Performance Rating	Description
0 – Totally able	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and without monitoring or assistance setting up supplies and environment
1 – Needs verbal cueing or monitoring only	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires, monitoring, or assistance retrieving or setting up supplies or equipment
2 – Can do with limited hands-on assistance	Beneficiary is able to self-perform more than 50 percent of activity and requires hands-on assistance to complete remainder of activity
3 – Can do with extensive hands-on assistance	Beneficiary is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity
4 – Cannot do at all (full dependence)	Beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity

Item #:	QIREPORT: VIEBRIDGE *PAs approved for ACH/SCU during SFY15 & 19.*
1	Average number of medications per resident
2	Average number of medication administration events daily
3	Residents with complex medication administration
4	Average age by setting - Classified by age Range
5	Diagnosis profile by setting only
7	Current PCS hours by setting
8	Number of Qualifying ADL's by setting; 2-5 totals
9	Number of exacerbating conditions by category
9.1	Number of exacerbating conditions by setting

Item #:	BTRM / BIA *Paid claims, DOS: SFY15 & 19, Aid Program Code: S, & eligibility codes: SAABN, SAACN, SAACY, SAAQN, SAAQY, SADBN, SADCN, SADCY, SADQN, SADQY.*
6	Frequently billed Diagnosis codes on SA recipients SAS query-Claims

**Based on Claims Data*

Item #:	DAAS / NC FAST *SA Types: Regular (Basic/In-Home) & SCU SA.*
10	Average payment amount by SA type.
11	Recipient SA applications ineligible due to exceeding income limit.
12	Recipients no longer SA eligible due to SSI COLAS.

Item 1: Average Number of Medications per Resident

**Data collected during Liberty Assessment and provided by QiRePort.*

Average # of Medications Prescribed per ACH/SCU Resident

SFY	GENDER		AGE RANGE			RACE					
	Male	Female	21-40	41-64	65+	Black	White	Native American	Pacific Islander	Asian	Unk
15	12	12	10	13	12	11	12	13	13	12	11
16	10	10	9	11	10	9	10	11	12	8	9
17	9	9	8	10	9	9	9	10	11	7	9
18	9	9	8	10	9	9	9	9	7	8	8
19	9	9	7	10	9	8	9	10	7	8	8

COUNTY					
SFY:	15	16	17	18	19
Alamance	12	9	8	9	9
Alexander	11	10	9	7	8
Alleghany	0	0	0	0	0
Anson	15	11	11	11	10
Ashe	13	10	8	9	10
Avery	12	10	9	9	9
Beaufort	12	9	9	9	10
Bertie	13	10	9	9	9
Bladen	11	11	10	9	10
Brunswick	16	12	11	10	9
Buncombe	13	9	9	9	8
Burke	13	12	10	9	9
Cabarrus	11	10	10	9	9
Caldwell	10	10	8	8	7
Camden	14	13	6	5	7
Carteret	11	11	7	9	8
Caswell	10	8	7	7	8
Catawba	12	11	9	9	9
Chatham	10	8	8	8	8
Cherokee	9	8	7	8	8
Chowan	11	8	7	7	8
Clay	13	8	8	8	7
Cleveland	13	10	10	9	9
Columbus	12	12	11	10	12
Craven	10	9	9	9	9
Cumberland	15	12	10	9	9
Currituck	14	7	6	8	7
Dare	13	11	10	9	8
Davidson	11	10	9	9	9
Davie	11	10	9	9	8
Duplin	13	11	8	8	9
Durham	11	9	9	8	8
Edgecombe	13	10	10	9	9
Forsyth	12	10	9	9	9
Franklin	13	11	7	7	7
Gaston	13	10	9	9	9
Gates	17	9	7	7	7
Graham	0	0	0	0	0
Granville	10	7	7	8	8
Greene	11	8	9	8	8
Guilford	11	10	9	9	8
Halifax	13	10	10	8	9
Harnett	13	11	10	10	10
Haywood	11	9	8	8	8
Henderson	12	9	8	8	8
Hertford	12	10	10	9	9
Hoke	14	11	10	8	8
Hyde	0	0	0	0	0
Iredell	12	11	11	10	10
Jackson	11	10	9	9	10
Johnston	13	11	10	9	9
Jones	9	15	12	0	4
Lee	11	10	9	9	9
Lenoir	11	10	9	10	10
Lincoln	13	9	8	8	8
Macon	13	9	9	9	10
Madison	14	0	0	0	5
Martin	14	10	9	9	8
Mcdowell	13	11	10	10	10
Mecklenburg	13	10	9	8	8
Mitchell	11	8	8	7	8
Montgomery	10	9	9	9	8
Moore	11	9	9	9	9
Nash	13	11	9	10	10

New Hanover	16	12	10	9	9
Northampton	13	10	9	9	8
Onslow	11	10	10	9	9
Orange	10	9	9	8	9
Pamlico	8	7	8	9	10
Pasquotank	12	9	9	8	9
Pender	12	8	7	8	8
Perquimans	20	11	13	10	10
Person	10	9	9	8	8
Pitt	10	10	9	9	10
Polk	10	7	6	7	6
Randolph	12	11	11	10	10
Richmond	12	11	10	10	9
Robeson	13	11	10	9	9
Rockingham	11	9	8	9	9
Rowan	10	10	10	9	9
Rutherford	13	10	9	9	9
Sampson	12	10	9	9	8
Scotland	14	11	10	9	10
Stanly	10	9	9	8	8
Stokes	9	9	8	7	8
Surry	13	11	9	9	9
Swain	9	8	8	10	10
Transylvania	11	8	8	8	8
Tyrrell	11	10	9	9	8
Union	13	9	8	9	9
Vance	16	14	8	8	0
Wake	12	9	8	8	8
Warren	10	9	8	10	10
Washington	13	10	9	10	11
Watauga	10	9	8	8	9
Wayne	13	11	11	10	10
Wilkes	11	9	9	9	9
Wilson	14	12	10	10	11
Yadkin	12	9	9	9	8
Yancey					

Item 2: Average Number of Medication Administration Events Daily

**Data collected during Liberty Assessment and provided by QiRePort.*

Average # of Medication Administrations Performed Daily, per ACH/SCU Resident

Not always required, data may be limited.

SFY	GENDER		AGE RANGE			RACE					
	Male	Female	21-40	41-64	65+	Black	White	Native American	Pacific Islander	Asian	Unk
15	26	29	25	29	27	26	29	29	20	29	28
16	27	30	24	29	24	27	29	29	26	24	29
17	27	30	24	29	29	27	29	32	28	25	27
18	28	31	22	30	30	28	30	28	22	30	30
19	28	30	21	30	29	28	30	27	25	27	29

COUNTY					
SFY:	15	16	17	18	19
Alamance	24	25	23	23	26
Alexander	45	50	47	49	49
Alleghany	0	0	0	0	0
Anson	31	24	27	30	34
Ashe	30	35	27	38	42
Avery	25	20	26	23	24
Beaufort	28	26	25	28	27
Bertie	35	38	35	40	39
Bladen	24	26	26	24	25
Brunswick	35	35	36	44	40
Buncombe	25	22	22	23	20
Burke	33	28	25	21	21
Cabarrus	36	35	31	31	28
Caldwell	28	25	22	23	21
Camden	34	36	22	35	41
Carteret	26	27	24	25	22
Caswell	22	20	20	20	31
Catawba	39	38	38	41	38
Chatham	20	24	25	28	31
Cherokee	12	13	12	13	13
Chowan	32	32	34	32	38
Clay	20	21	22	33	29
Cleveland	21	25	31	30	29
Columbus	37	46	44	53	57
Craven	23	26	28	28	26
Cumberland	29	27	28	28	27
Currituck	31	28	33	36	37
Dare	36	39	40	38	35
Davidson	28	27	28	29	28
Davie	30	35	29	32	29
Duplin	27	28	20	20	26
Durham	20	24	23	21	21
Edgecombe	27	29	32	31	34
Forsyth	29	30	29	30	30
Franklin	26	25	19	20	20
Gaston	25	27	29	28	26
Gates	40	38	32	34	35
Graham	0	0	0	0	0
Granville	18	19	18	21	27
Greene	23	21	24	25	31
Guilford	29	30	30	29	27
Halifax	32	27	27	27	30
Harnett	27	26	26	28	25
Haywood	19	21	19	22	20
Henderson	22	22	21	19	21
Hertford	28	29	28	27	32
Hoke	28	28	30	23	21
Hyde	0	0	0	0	0
Iredell	42	42	45	49	43
Jackson	19	21	19	27	29
Johnston	28	32	34	37	33
Jones	34	51	23	0	21
Lee	24	23	37	38	39
Lenoir	28	30	28	31	32
Lincoln	25	22	20	27	28
Macon	22	21	20	29	30
Madison	21	0	0	0	15
Martin	29	30	32	33	31
Mcdowell	25	23	22	23	21
Mecklenburg	34	33	31	31	30
Mitchell	19	19	19	18	18
Montgomery	30	30	37	43	42
Moore	33	36	37	36	34
Nash	26	28	30	30	32

New Hanover	36	38	39	39	36
Northampton	40	40	40	41	35
Onslow	32	34	39	33	31
Orange	18	25	27	23	26
Pamlico	26	24	23	25	30
Pasquotank	22	23	23	21	27
Pender	33	30	30	30	29
Perquimans	40	37	34	27	31
Person	29	40	42	47	43
Pitt	20	25	27	27	27
Polk	16	20	19	16	33
Randolph	29	33	35	36	33
Richmond	27	31	31	27	26
Robeson	29	30	27	32	29
Rockingham	23	24	25	26	26
Rowan	29	29	31	30	28
Rutherford	23	23	23	21	22
Sampson	29	30	28	32	30
Scotland	33	30	44	28	26
Stanly	41	37	38	33	31
Stokes	29	31	29	31	29
Surry	29	26	27	28	27
Swain	17	18	19	35	29
Transylvania	20	26	24	27	26
Tyrrell	29	35	36	35	30
Union	29	28	27	27	27
Vance	33	30	18	34	0
Wake	24	27	27	30	30
Warren	21	21	19	30	33
Washington	26	25	25	26	28
Watauga	18	16	14	19	20
Wayne	23	23	21	20	25
Wilkes	27	30	40	37	37
Wilson	24	30	29	33	32
Yadkin	33	35	32	37	34
Yancey	23	20	22	23	18

Item 3: Number of Residents with Complex Medication Administrations

***Small Cell Suppression (<11) applied and indicated with # below.*

Total # of ACH/SCU Beneficiaries with Medication Assistance level: Complex

Complex Medication Assistance is identified as more than 8 routine administrations daily and is alotted 60 minutes to the total approved per day.

SFY	GENDER		AGE RANGE			RACE					
	Male	Female	21-40	41-64	65+	Black	White	Native American	Pacific Islander	Asian	Unk
15	1015	1662	68	854	1755	776	1812	32	#	#	47
16	983	1642	48	843	1734	814	1732	30	#	#	42
17	959	1597	57	826	1673	796	1667	30	#	#	55
18	975	1471	47	830	1569	802	1550	41	#	#	48
19	863	1273	49	738	1349	694	1357	35	#	#	45

COUNTY					
SFY:	15	16	17	18	19
Alamance	31	24	35	42	30
Alexander	18	#	#	#	#
Alleghany	#	#	#	#	#
Anson	#	14	16	16	#
Ashe	21	22	19	#	#
Avery	20	19	16	14	#
Beaufort	#	#	#	#	#
Bertie	#	#	13	#	14
Bladen	15	12	18	23	23
Brunswick	54	31	25	31	15
Buncombe	55	54	49	47	50
Burke	47	36	30	28	25
Cabarrus	64	58	53	50	43
Caldwell	26	14	19	15	14
Camden	#	#	#	#	#
Carteret	12	#	#	#	#
Caswell	#	#	11	11	#
Catawba	83	63	61	50	41
Chatham	#	11	#	#	#
Cherokee	#	#	#	#	#
Chowan	#	#	#	#	#
Clay	#	#	#	#	#
Cleveland	56	52	72	46	39
Columbus	42	25	12	11	#
Craven	15	15	31	26	17
Cumberland	40	46	29	31	37
Currituck	#	#	#	#	#
Dare	#	#	#	#	#
Davidson	34	29	32	28	18
Davie	14	13	12	12	#
Duplin	43	51	62	51	59
Durham	34	39	45	44	46
Edgecombe	40	44	38	38	40
Forsyth	109	113	107	109	103
Franklin	13	11	#	#	14
Gaston	76	72	85	72	63
Gates	#	#	#	#	#
Graham	#	#	#	#	#
Granville	#	#	#	#	13
Greene	#	#	#	12	#
Guilford	49	57	64	57	46
Halifax	#	#	#	#	# 45
Harnett	46	49	55	50	
Haywood	13	21	19	12	11
Henderson	31	30	12	17	16
Hertford	26	33	34	38	43
Hoke	13	15	12	12	#
Hyde	#	#	#	#	# 73
Iredell	62	52	58	41	# #
Jackson	#	#	#		
Johnston	38	33	47	49	43
Jones	#	#	#	#	#
Lee	20	26	26	24	19
Lenoir	46	51	43	52	39
Lincoln	40	38	34	34	26
Macon	#	19	11	#	#
Madison	#	#	#	#	#
Martin	17	26	24	24	13
Mcdowell	50	43	46	37	39
Mecklenburg	136	112	104	103	85
Mitchell	#	#	#	#	#
Montgomery	19	22	28	24	22
Moore	26	27	34	51	40
Nash	25	32	24	30	21

New Hanover	50	49	29	21	20
Northampton	18	26	25	26	19
Onslow	15	21	35	28	21
Orange	17	19	18	17	#
Pamlico	#	#	#	#	#
Pasquotank	23	23	16	14	16
Pender	#	13	19	16	#
Perquimans	#	#	#	#	0
Person	13	20	27	24	21
Pitt	41	34	39	35	31
Polk	#	#	#	#	#
Randolph	26	29	34	24	22
Richmond	19	25	27	23	21
Robeson	94	85	96	117	112
Rockingham	32	20	21	#	38
Rowan	36	33	39	32	30
Rutherford	53	52	38	37	33
Sampson	34	24	27	49	37
Scotland	20	21	17	12	#
Stanly	12	15	16	11	16
Stokes	21	23	20	13	11
Surry	68	81	71	42	30
Swain	#	#	#	#	#
Transylvania	#	#	#	#	#
Tyrrell	#	#	#	#	#
Union	62	49	34	35	24
Vance	#	#	#	#	81
Wake	92	60	68	56	#
Warren	#	#	#	25	14
Washington	#	#	#	#	#
Watauga	53	49	55	46	54
Wayne	19	31	25	28	16
Wilkes	56	63	44	33	26
Wilson	19	16	18	13	#
Yadkin	21	12	#	#	#
Yancey					

Item 4: Average Resident Age

***Small Cell Suppression (<11) applied and indicated with # below.*

Average Age of an ACH/SCU Resident

SFY	GENDER		SETTING		RACE					
	Male	Female	ACH	SCU	Black	White	Native American	Pacific Islander	Asian	Unk
15	67	76	70	79	71	73	68	68	72	77
16	67	75	70	79	71	73	69	75	75	76
17	67	75	69	78	71	72	68	81	74	76
18	67	75	69	78	71	72	68	79	74	76
19	67	75	69	78	70	72	66	89	75	77

Total # of ACH/SCU Residents by Age Range

AGE RANGE		
21-40	41-64	65+
191	3120	8277
155	2917	7769
179	2930	7902
156	3081	7918
172	2749	7109

COUNTY					
SFY:	15	16	17	18	19
Alamance	76	75	74	73	73
Alexander	#	70	72	71	71
Alleghany	#	#	#	#	#
Anson	70	66	71	72	72
Ashe	82	83	82	84	80
Avery	68	67	69	68	69
Beaufort	68	68	67	68	69
Bertie	74	74	74	45	73
Bladen	70	72	73	73	70
Brunswick	73	74	73	75	78
Buncombe	63	64	61	32	60
Burke	66	66	67	64	65
Cabarrus	72	74	70	70	70
Caldwell	75	74	74	47	74
Camden	75	78	83	78	79
Carteret	73	74	78	75	68
Caswell	72	71	71	72	72
Catawba	70	71	71	71	70
Chatham	84	83	82	80	83
Cherokee	62	64	63	61	64
Chowan	73	75	72	75	75
Clay	76	78	76	81	77
Cleveland	73	73	75	72	72
Columbus	62	64	65	66	63
Craven	67	69	71	71	74
Cumberland	72	71	72	72	72
Currituck	76	73	74	76	78
Dare	81	81	80	83	77
Davidson	75	75	76	75	75
Davie	76	76	74	74	74
Duplin	69	68	70	69	69
Durham	74	72	73	73	72
Edgecombe	65	68	66	66	67
Forsyth	72	72	71	71	70
Franklin	68	72	70	74	72
Gaston	73	72	71	72	72
Gates	71	74	76	73	74 #
Graham	#	#	#	# 73	74
Granville	72	71	73		
Greene	77	73	73	76	75
Guilford	77	77	77	75	76
Halifax	74	74	70	73	73
Harnett	73	72	72	72	72
Haywood	72	73	71	72	73
Henderson	73	73	71	70	69
Hertford	70	70	72	70	71
Hoke	77	77	77	78	78
Hyde	#	#	#	#	#
Iredell	73	73	72	71	70
Jackson	75	74	71	71	71
Johnston	72	72	72	73	72
Jones	70	69	70	#	87
Lee	71	71	68	68	67
Lenoir	72	72	73	72	72
Lincoln	70	72	72	70	70
Macon	76	78	77	78	75
Madison	86	#	#	#	60
Martin	72	71	71	70	70
Mcdowell	62	61	60	62	62
Mecklenburg	72	72	72	72	72
Mitchell	81	79	80	79	79

Montgomery	76	75	74	74	74
Moore	75	74	73	73	73
Nash	76	76	77	76	74
New Hanover	75	74	76	75	76
Northampton	75	76	77	74	74
Onslow	69	69	68	68	67
Orange	75	75	76	76	76
Pamlico	77	78	77	74	74
Pasquotank	73	71	72	71	71
Pender	76	77	80	79	81
Perquimans	60	65	57	59	71
Person	73	73	72	72	72
Pitt	72	72	71	73	74
Polk	81	71	78	75	73
Randolph	73	74	73	73	70
Richmond	68	69	67	67	68
Robeson	70	70	70	69	69
Rockingham	75	75	77	75	75
Rowan	72	71	68	70	70
Rutherford	64	65	65	66	66
Sampson	73	73	72	72	73
Scotland	76	75	77	75	71
Stanly	79	79	77	75	76
Stokes	77	77	77	78	76
Surry	75	74	72	73	73
Swain	72	72	74	71	70
Transylvania	78	75	75	76	76
Tyrrell	72	69	69	71	70
Union	76	76	76	77	77
Vance	86	96	61	81	#
Wake	77	78	78	77	77
Warren	70	72	70	69	68
Washington	61	58	61	60	61
Watauga	73	72	68	67	70
Wayne	68	68	70	68	69
Wilkes	80	81	80	80	80
Wilson	76	77	75	74	73
Yadkin	57	60	60	59	59
Yancey	72	75	75	72	71

Item 5: Diagnosis Profile by Setting Type (Top 20 Codes per SFY)

Totalled # of instances a dx code appears on assessments; residents with active PA's.

Diagnosis Code by SFY:		2015		2016		2017		2018		2019	
ICD-10	Description	ACH	SCU	ACH	SCU	ACH	SCU	ACH	SCU	ACH	SCU
M81.0	Age-Related Osteoporosis W/O Current Pathological	0	0	259	164	0	0	362	0	0	0
331	Alzheimers Disease	0	230	0	0	0	0	0	0	0	0
G30.1	Alzheimers Disease With Late Onset	0	0	0	0	0	0	0	154	0	0
G30.9	Alzheimers Disease, Unspecified	0	1301	0	1577	319	1432	0	1264	0	984
D64.9	Anemia, Unspecified	540	234	592	261	530	240	528	213	448	198
F41.9	Anxiety Disorder, Unspecified	486	224	654	354	735	327	724	362	744	302
I25.10	Athscl Heart Disease Of Native Coronary Artery W/O	261	130	398	204	353	0	380	175	378	153
F31.9	Bipolar Disorder, Unspecified	0	0	278	0	0	0	306	0	332	0
I63.9	Cerebral Infarction, Unspecified	0	0	0	0	0	0	306	0	301	0
J44.9	Chronic Obstructive Pulmonary Disease, Unspecified	1050	321	1186	377	1241	367	1312	362	1198	300
F02.81	Dementia In Oth Diseases Classd Elswhr W Behaviora	0	183	0	228	0	199	0	187	0	180
F02.80	Dementia In Oth Diseases Classd Elswhr W/O Behavrl	289	307	297	304	0	242	0	200	0	142
530.81	Esophageal Reflux	263	0	0	0	0	0	0	0	0	0
I10	Essential (Primary) Hypertension	3765	1609	4105	1863	3912	1677	3676	1552	3113	1263
K21.9	Gastro-Esophageal Reflux Disease Without Esophagit	1438	443	1467	535	1387	473	1303	432	1157	350
F41.1	Generalized Anxiety Disorder	241	0	305	0	0	0	297	0	266	0
Z91.81	History Of Falling	0	129	0	157	0	0	0	144	0	0
272.4	Hyperlipidemia Nec/Nos	249	136	0	0	0	0	0	0	0	0
E78.5	Hyperlipidemia, Unspecified	607	311	961	513	1062	561	1136	501	1080	442
401.9	Hypertension Nos	567	290	0	0	0	0	0	0	0	0
E03.9	Hypothyroidism, Unspecified	825	395	895	427	895	378	756	355	661	279
G47.00	Insomnia, Unspecified	319	141	325	190	307	189	290	167	289	152
F33.9	Major Depressive Disorder, Recurrent, Unspecified	0	0	0	0	0	0	0	0	284	140
F32.9	Major Depressive Disorder, Single Episode, Unspeci	472	261	571	363	547	308	509	277	457	207
E78.2	Mixed Hyperlipidemia	503	190	467	198	401	0	360	0	284	0
M62.81	Muscle Weakness (Generalized)	441	187	607	300	704	330	791	344	671	273
F20.0	Paranoid Schizophrenia	245	0	301	0	328	0	307	0	284	0
E78.0	Pure Hypercholesterolemia	237	0	274	0	0	0	0	0	0	0
F25.9	Schizoaffective Disorder, Unspecified	272	0	272	0	0	0	296	0	255	0
F20.9	Schizophrenia, Unspecified	275	0	432	0	508	0	608	142	601	127
E11.9	Type 2 Diabetes Mellitus Without Complications	812	332	1194	479	1352	511	1422	510	1313	473
R56.9	Unspecified Convulsions	314	0	338	0	330	0	307	0	0	0
F03.91	Unspecified Dementia With Behavioral Disturbance	0	0	0	211	0	282	0	304	0	291
F03.90	Unspecified Dementia Without Behavioral Disturbanc	905	702	1199	909	1172	1041	1153	1147	1019	1173
F79	Unspecified Intellectual Disabilities	0	0	0	0	0	0	304	0	294	0
M19.90	Unspecified Osteoarthritis, Unspecified Site	360	182	495	278	527	239	516	241	445	204
R32	Unspecified Urinary Incontinence	0	0	0	0	0	0	329	0	290	143
F01.51	Vascular Dementia With Behavioral Disturbance	0	0	0	156	0	0	0	152	0	130
F01.50	Vascular Dementia Without Behavioral Disturbance	0	302	0	488	0	445	0	454	0	358
E55.9	Vitamin D Deficiency, Unspecified	355	202	391	240	384	216	304	204	300	158

Item 6: Frequently Billed Diagnosis Codes on SA Residents SAS query-Claims

Top 20 Diagnosis Codes per SFY & the Unduplicated # of those Residents

Total Amount Paid: Paid SA Claims by dx code.

***Diagnoses are grouped together to show the transition of residents and funds from the ICD-9 Code to the ICD-10 Code.*

Grp	Dx Vers.	ICD-10	Description	Unduplicated # of Residents 2015	2016	2017	2018	2019	Total Amount Paid 2015	2016	2017	2018	2019
	ICD-9	3310	Alzheimers Disease	2664	1796	0	0	0	$29,078,391.0	$7,311,119.5	$0.0	$0.0	$0.0
1	ICD-10	G300	Alzheimer'S Disease With Early Onset	0	0	107	128	113	$0.0	$0.0	$1,046,798.6	$1,406,652.9	$1,488,064.8
	ICD-10	G301	Alzheimer'S Disease With Late Onset	0	0	0	121	122	$0.0	$0.0	$0.0	$1,437,258.7	$1,550,598.9
	ICD-10	G309	Alzheimer'S Disease, Unspecified	0	2334	2331	2027	1736	$0.0	$24,272,743.1	$29,832,660.9	$31,017,382.1	$26,799,654.0
	ICD-9	4011	Benign Hypertension	200	0	107	128	113	$1,681,207.8	$0.0	$1,046,798.6	$1,406,652.9	$1,486,115.8
2	ICD-9	401	Essential Hypetension	207	0	0	0	0	$1,796,612.9	$0.0	$0.0	$0.0	$0.0
	ICD-9	4019	Hypertension Nos	847	578	0	0	0	$6,625,678.6	$1,586,101.8	$0.0	$0.0	$0.0
	ICD-10	I10	Essential (Primary) Hypertension	0	1090	1412	1550	1571	$0.0	$7,338,535.1	$11,077,863.4	$14,470,110.5	$16,017,091.7
3	ICD-9	496	Chronic Airway Obstruction Not Elsewhere Classified	329	0	0	113	121	$2,527,661.8	$0.0	$0.0	$1,437,258.7	$1,549,627.8
	ICD-10	J449	Chronic Obstructive Pulmonary Disease, Unspecified	0	370	422	465	522	$0.0	$2,296,027.6	$3,203,469.0	$4,099,531.3	$4,540,384.3
4	ICD-9	29410	Dementia Conditions Classified Elsewhere W/O Behavioral Dist	659	428	0	0	0	$8,083,707.4	$1,657,347.6	$0.0	$0.0	$0.0
	ICD-10	F0280	Dementia In Other Diseases Classified Elsewhere Without Behavioral Disturbance	0	506	419	317	248	$0.0	$4,984,542.7	$5,022,282.0	$4,167,572.4	$3,305,805.9
5	ICD-9	29420	Dementia Unspecified Without Behavioral Disturbance	459	0	0	0	0	$3,895,954.8	$0.0	$0.0	$0.0	$0.0
	ICD-10	F0281	Dementia In Other Diseases Classified Elsewhere With Behavioral Disturbance	0	137	133	108	121	$0.0	$1,156,294.3	$1,261,633.5	$1,188,238.1	$1,355,054.7
	ICD-9	290	Dementias	440	301	0	0	0	$4,583,641.8	$1,097,707.1	$0.0	$0.0	$0.0
	ICD-9	331	Oth Cerebral Degenerations	453	271	0	0	0	$5,233,235.2	$1,121,458.5	$0.0	$0.0	$0.0
6	ICD-9	29020	Senile Delusion	1066	854	0	0	0	$9,739,318.7	$2,482,142.5	$0.0	$0.0	$0.0
	ICD-9	2900	Senile Dementia Uncomp	271	0	0	0	0	$2,097,598.7	$0.0	$0.0	$0.0	$0.0
	ICD-10	F0390	Unspecified Dementia Without Behavioral Disturbance	0	1801	1977	1982	2065	$0.0	$14,721,629.6	$20,988,867.2	$25,148,181.1	$27,599,236.0
	ICD-9	250	Diabetes Mellitus	404	0	0	0	0	$3,239,286.7	$0.0	$0.0	$0.0	$0.0
7	ICD-9	2500	Diabetes Mellitus Uncomp	188	0	0	0	0	$1,378,451.0	$0.0	$0.0	$0.0	$0.0
	ICD-9	25000	Diabetes Uncompl Adult	393	337	0	0	0	$3,162,748.5	$874,647.6	$0.0	$0.0	$0.0
	ICD-10	E119	Type 2 Diabetes Mellitus Without Complications	0	598	581	503	502	$0.0	$4,170,418.0	$4,769,365.7	$4,935,809.8	$5,147,208.1
				168	0	0	0	0	$1,337,787.4	$0.0	$0.0	$0.0	$0.0
8	ICD-9	317	Mild Intellectual Disabilities	0	0	154	117	0	$0.0	$0.0	$1,199,821.3	$874,498.4	$0.0
	ICD-10	F70	Mild Intellectual Disabilities	133					$1,075,346.9	$0.0	$0.0	$0.0	$0.0
	ICD-9	294	Persistent Mental Disorders Due to Conditions Classified	247	0	0	0	0	$1,335,581.5	$0.0	$0.0	$0.0	$0.0
	ICD-9	295	Schizophrenic Disorders	0	0	120	0	0	$0.0	$0.0	$873,768.3	$0.0	$0.0
	ICD-10	F2089	Other Schizophrenia	0	0	114	118	133	$0.0	$0.0	$831,642.5	$1,007,656.0	$1,142,628.3
9	ICD-10	F200	Paranoid Schizophrenia	0	0	143	139	141	$0.0	$0.0	$1,210,856.0	$1,370,318.0	$1,320,379.8
	ICD-10	F259	Schizoaffective Disorder, Unspecified	0	237	259	243	262	$0.0	$1,393,519.3	$1,905,692.6	$2,169,092.4	$2,460,387.9
	ICD-10	F209	Schizophrenia, Unspecified	225	0	0	0	0	$1,649,595.6	$0.0	$0.0	$0.0	$0.0
10	ICD-9	319	Unspecified Intellectual Disabilites	0	148	129	111	101	$0.0	$1,082,455.9	$1,185,059.6	$1,203,327.1	$1,166,692.3
	ICD-10	F79	Unspecified Intellectual Disabilities	308	0	0	0	0	$2,746,995.9	$0.0	$0.0	$0.0	$0.0
11	ICD-9	29040	Vascular Dementia Uncomplicated	0	391	445	420	434	$0.0	$3,226,667.3	$5,141,239.4	$5,732,134.5	$6,003,888.7
	ICD-10	F0150	Vascular Dementia Without Behavioral Disturbance	138	0	0	0	0	$1,307,739.6	$0.0	$0.0	$0.0	$0.0

N/A	ICD-9	2948	Other Persistent Mental Disorders Due To Conditions Classifi	0	0	113	0	0	$0.0	$0.0	$905,569.1	$0.0	$0.0
N/A	ICD-10	I509	Heart Failure, Unspecified	0	0	0	112	130	$0.0	$0.0	$0.0	$1,026,055.7	$1,316,678.0
N/A	ICD-10	E785	Hyperlipidemia, Unspecified	0	0	0	0	91	$0.0	$0.0	$0.0	$0.0	$894,980.2
N/A	ICD-10	E039	Hypothyroidism, Unspecified	0	0	0	91	94	$0.0	$0.0	$0.0	$916,814.7	$873,592.3
N/A	ICD-10	F329	Major Depressive Disorder, Single Episode, Unspecified	0	0	0	0	118	$0.0	$0.0	$0.0	$0.0	$1,021,347.5
N/A	ICD-10	M6281	Muscle Weakness (Generalized)	0	0	97	99	89	$0.0	$0.0	$909,322.7	$1,074,266.8	$983,855.5
N/A	ICD-10	G20	Parkinson'S Disease	0	0	130	197	275	$0.0	$0.0	$1,315,456.4	$2,448,798.2	$3,351,058.8
N/A	ICD-10	F0391	Unspecified Dementia With Behavioral Disturbance	0	0	115	119	122	$0.0	$0.0	$1,162,574.5	$1,455,920.5	$1,711,955.8
N/A	ICD-10	F0151	Vascular Dementia With Behavioral Disturbance										

Item 7: Current PCS Hours

Average # of PCS Hours Approved per ACH/SCU Resident

SFY	GENDER		AGE RANGE			SETTING		RACE					
	Male	Female	21-40	41-64	65+	ACH	SCU	Black	White	Native American	Pacific Islander	Asian	Unk
15	90	96	79	85	98	84	117	95	93	103	97	107	95
16	92	98	80	86	100	86	119	96	96	102	94	101	98
17	92	99	80	86	101	86	120	96	96	102	110	102	100
18	93	99	80	87	101	86	120	97	96	105	112	101	100
19	93	99	79	87	101	86	120	97	96	101	122	102	103

COUNTY					
SFY:	15	16	17	18	19
Alamance	96	93	94	97	94
Alexander	105	106	106	112	110
Alleghany	0	0	0	0	0
Anson	89	85	88	92	88
Ashe	100	104	114	109	106
Avery	104	104	109	110	106
Beaufort	81	82	81	81	81
Bertie	114	117	120	123	122
Bladen	88	95	95	98	98
Brunswick	93	98	93	94	104
Buncombe	86	87	86	88	89
Burke	80	84	84	85	87
Cabarrus	91	94	93	91	92
Caldwell	95	93	95	96	98
Camden	80	80	80	79	80
Carteret	82	87	103	93	84
Caswell	98	103	98	98	95
Catawba	95	98	97	98	99
Chatham	100	97	100	100	99
Cherokee	80	80	80	80	80
Chowan	90	99	94	102	99
Clay	129	127	127	128	128
Cleveland	97	99	97	94	94
Columbus	85	88	88	89	86
Craven	88	88	95	99	100
Cumberland	100	98	104	106	109
Currituck	102	104	104	104	107
Dare	92	87	87	88	85
Davidson	93	95	97	94	95
Davie	92	98	90	93	92
Duplin	88	87	87	86	86
Durham	101	102	105	106	103
Edgecombe	81	81	80	82	81
Forsyth	92	95	95	93	92
Franklin	84	90	92	91	93
Gaston	90	91	91	91	91
Gates	100	112	115	112	111
Graham	0	0	0	0	0
Granville	84	83	94	92	92
Greene	111	101	97	94	91
Guilford	93	96	97	98	104
Halifax	84	83	85	93	92
Harnett	88	89	91	98	98
Haywood	92	98	99	102	101
Henderson	93	98	97	93	90
Hertford	107	108	109	104	111
Hoke	97	102	108	114	106
Hyde	0	0	0	0	0
Iredell	95	96	94	91	90
Jackson	106	106	99	106	109
Johnston	93	95	99	98	99
Jones	80	80	80	0	80
Lee	95	98	100	99	102
Lenoir	93	96	99	97	96
Lincoln	86	87	90	87	90
Macon	112	110	112	114	109
Madison	130	0	0	0	62
Martin	95	99	99	96	94
Mcdowell	83	83	83	92	91
Mecklenburg	97	97	99	97	98
Mitchell	112	115	114	107	111
Montgomery	115	112	114	115	117
Moore	99	104	103	103	104
Nash	83	84	83	86	85
New Hanover	104	107	108	107	106
Northampton	108	110	106	105	406
Onslow	94	94	94	93	90
Orange	95	96	97	97	96
Pamlico	99	98	95	99	96
Pasquotank	94	95	93	91	86
Pender	116	120	120	121	119
Perquimans	87	80	80	80	80
Person	82	83	85	86	83

Pitt	85	87	85	86	86
Polk	80	80	97	91	80
Randolph	90	88	90	89	92
Richmond	91	94	94	93	92
Robeson	97	98	97	101	100
Rockingham	87	95	97	97	96
Rowan	82	85	85	84	85
Rutherford	82	86	88	87	91
Sampson	96	98	100	100	98
Scotland	80	81	83	83	85
Stanly	103	106	105	106	110
Stokes	100	100	106	110	106
Surry	98	102	100	101	97
Swain	96	85	86	86	83
Transylvania	112	108	109	112	109
Tyrrell	11	95	95	96	101
Union	94	95	93	95	95
Vance	80	77	80	105	0
Wake	102	106	105	105	106
Warren	102	96	100	100	96
Washington	80	80	79	80	80
Watauga	87	85	84	81	91
Wayne	91	93	93	92	92
Wilkes	91	92	93	91	90
Wilson	97	101	101	99	98
Yadkin	79	83	84	87	86
Yancey	94	104	97	94	93

Item 8: Number of Qualifying ADLs

Average # of Qualifying ADLs per ACH/SCU Resident

SFY	GENDER		AGE RANGE			SETTING		RACE					
	Male	Female	21-40	41-64	65+	ACH	SCU	Black	White	Native American	Pacific Islander	Asian	Unk
15	4	4	3	4	4	4	4	4	4	4	4	4	4
16	4	4	3	3	4	4	4	4	4	4	3	3	4
17	4	4	3	3	4	4	4	4	4	4	4	4	4
18	4	4	3	3	4	4	4	4	4	4	4	4	4
19	4	4	3	3	4	4	4	4	4	4	4	3	4

Total # of Residents by # of Qualifying ADLs Identified

SFY	# OF ADLS			
	2	3	4	5
15	82	2122	3915	5469
16	132	2420	3877	4412
17	78	2643	3759	4531
18	62	2804	3828	4461
19	48	2488	3554	3940

COUNTY					
SFY:	15	16	17	18	19
Alamance	4	4	3	3	3
Alexander	4	4	4	4	4
Alleghany	0	0	0	0	0
Anson	4	4	3	3	3
Ashe	4	4	4	4	4
Avery	4	4	4	4	4
Beaufort	4	3	4	4	4
Bertie	4	4	4	4	4
Bladen	4	4	4	4	4
Brunswick	4	4	3	3	4
Buncombe	4	4	3	3	3
Burke	4	4	4	4	4
Cabarrus	4	4	4	4	4
Caldwell	4	4	4	4	4
Camden	4	4	4	4	4
Carteret	4	4	4	3	3
Caswell	4	4	3	3	4
Catawba	4	4	4	4	4
Chatham	4	4	4	4	4
Cherokee	4	4	4	4	4
Chowan	3	4	3	4	4
Clay	4	4	4	4	4
Cleveland	4	4	3	3	4
Columbus	3	3	3	3	3
Craven	4	4	4	4	4
Cumberland	4	4	4	4	4
Currituck	4	4	4	4	4
Dare	4	4	4	4	4
Davidson	4	4	4	4	4
Davie	4	3	4	4	4
Duplin	4	4	4	4	4
Durham	4	4	3	4	4
Edgecombe	4	3	3	3	4
Forsyth	4	3	4	3	3
Franklin	4	3	4	4	3
Gaston	4	4	4	3	4
Gates	4	4	4	4	4
Graham	0	0	0	0	0
Granville	4	4	3	3	3
Greene	4	4	3	4	4
Guilford	4	3	3	4	4
Halifax	4	4	4	4	4
Harnett	4	4	4	4	4
Haywood	4	4	4	3	3
Henderson	4	4	3	3	3
Hertford	4	4	4	4	4
Hoke	4	4	4	4	4
Hyde	0	0	0	0	0
Iredell	4	4	4	4	4
Jackson	4	4	4	4	3
Johnston	4	4	4	4	4
Jones	4	3	3	4	4
Lee	4	4	4	4	4
Lenoir	4	4	4	4	4
Lincoln	4	4	4	3	4
Macon	4	4	4	4	4
Madison	0	0	0	0	0
Martin	4	4	4	4	4
Mcdowell	4	3	3	3	3
Mecklenburg	4	4	4	3	4
Mitchell	4	4	4	3	3
Montgomery	4	4	4	4	4
Moore	4	4	4	4	4
Nash	4	4	4	4	4
New Hanover	4	4	4	4	3
Northampton	4	4	4	4	4
Onslow	4	4	4	4	4
Orange	4	4	3	4	3
Pamlico	4	4	4	4	4
Pasquotank	4	4	4	3	3
Pender	4	4	4	4	4
Perquimans	4	4	3	4	4
Person	3	3	3	3	3

Pitt	4	3	4	4	4
Polk	4	4	4	3	4
Randolph	4	4	4	4	4
Richmond	4	4	4	4	4
Robeson	4	4	4	4	4
Rockingham	4	4	4	4	4
Rowan	4	3	4	4	4
Rutherford	4	4	3	3	4
Sampson	4	4	4	4	4
Scotland	4	3	3	4	4
Stanly	4	4	4	4	4
Stokes	4	4	4	4	4
Surry	4	4	4	4	4
Swain	5	4	4	4	3
Transylvania	4	4	3	3	4
Tyrrell	4	4	4	4	3
Union	4	4	4	3	3
Vance	3	3	3	3	4
Wake	4	4	4	4	4
Warren	4	4	4	4	4
Washington	4	3	3	3	3
Watauga	4	4	4	3	4
Wayne	4	4	4	4	4
Wilkes	4	4	4	4	4
Wilson	4	4	4	4	4
Yadkin	3	3	3	3	3
Yancey	4	4	4	3	3

Item 9: Number of Exacerbating Conditions

Average # of Exacerbating Conditions per ACH/SCU Resident

SFY	GENDER		AGE RANGE			SETTING		RACE					
	Male	Female	21-40	41-64	65+	ACH	SCU	Black	White	Native American	Pacific Islander	Asian	Unk
15	4	5	4	4	5	5	5	5	5	5	5	4	5
16	5	5	4	5	5	5	6	5	5	6	6	4	6
17	5	6	4	5	6	5	6	5	5	5	7	4	6
18	5	5	4	5	5	5	6	5	5	5	4	5	6
19	5	5	4	5	5	5	5	5	5	6	5	5	6

COUNTY					
SFY:	15	16	17	18	19
Alamance	3	4	4	4	4
Alexander	4	6	7	7	7
Alleghany	0	0	0	0	0
Anson	6	5	5	5	6
Ashe	5	5	6	8	8
Avery	4	5	6	5	5
Beaufort	4	5	6	4	5
Bertie	5	5	6	6	6
Bladen	5	6	6	5	6
Brunswick	4	5	5	4	4
Buncombe	6	5	5	5	5
Burke	4	6	6	5	5
Cabarrus	7	6	5	5	5
Caldwell	4	6	6	6	7
Camden	2	6	5	4	4
Carteret	4	5	7	3	4
Caswell	4	4	4	4	4
Catawba	4	6	7	7	6
Chatham	4	4	4	5	4
Cherokee	8	8	6	7	8
Chowan	4	5	5	5	5
Clay	7	7	6	6	5
Cleveland	3	6	6	5	5
Columbus	4	5	6	6	5
Craven	4	4	4	4	4
Cumberland	5	6	6	6	6
Currituck	4	6	4	4	3
Dare	6	6	7	5	4
Davidson	3	5	6	7	5
Davie	5	5	6	6	5
Duplin	4	5	5	6	5
Durham	5	5	5	6	5
Edgecombe	5	5	5	4	5
Forsyth	4	5	5	4	4
Franklin	6	6	5	5	5
Gaston	3	5	5	4	5
Gates	5	4	5	5	5
Graham	0	0	0	0	0
Granville	5	7	6	5	5
Greene	4	5	4	5	5
Guilford	4	5	4	4	5
Halifax	5	6	5	5	5
Harnett	5	5	6	7	6
Haywood	7	6	5	5	5
Henderson	6	6	5	5	5
Hertford	5	6	6	6	6
Hoke	7	7	8	8	6
Hyde	0	0	0	0	0
Iredell	4	6	7	7	6
Jackson	7	6	5	6	6
Johnston	4	6	6	6	6
Jones	7	3	2	0	6
Lee	6	6	5	5	7
Lenoir	4	5	5	5	5
Lincoln	3	4	4	4	5
Macon	8	6	6	6	5
Madison	8	0	0	0	7
Martin	5	5	6	5	6
Mcdowell	5	5	5	5	5
Mecklenburg	5	5	5	5	5
Mitchell	6	5	5	5	5
Montgomery	7	6	9	9	8
Moore	7	6	7	7	7
Nash	5	6	5	5	5
New Hanover	4	5	5	4	4
Northampton	5	6	5	5	5
Onslow	4	5	6	5	5
Orange	4	5	5	6	5
Pamlico	4	4	4	4	5
Pasquotank	4	5	4	4	4
Pender	4	5	6	4	5
Perquimans	3	5	6	7	6
Person	4	4	4	4	3

Pitt	4	4	4	4	4
Polk	5	7	5	5	4
Randolph	3	4	4	4	4
Richmond	7	6	5	7	6
Robeson	5	6	6	6	6
Rockingham	4	5	6	5	5
Rowan	4	5	6	7	5
Rutherford	4	6	6	6	5
Sampson	5	6	5	5	5
Scotland	7	6	6	5	5
Stanly	5	5	5	5	5
Stokes	4	5	5	4	4
Surry	5	6	6	4	5
Swain	10	5	6	5	5
Transylvania	7	6	5	5	5
Tyrrell	4	6	6	5	5
Union	6	4	5	5	5
Vance	5	5	6	7	0
Wake	5	5	5	6	6
Warren	5	7	7	8	7
Washington	4	5	4	5	4
Watauga	4	4	5	5	7
Wayne	5	6	6	5	6
Wilkes	4	6	7	8	8
Wilson	5	7	6	5	5
Yadkin	4	5	5	3	4
Yancey	7	5	5	5	4

Item 9: Number of Exacerbating Conditions

***Small Cell Suppression (<11) applied and indicated with # below.*

Total # of Exacerbating Conditions Identified by Setting Typ & SFY

ACH - Conditions	2015	2016	2017	2018	2019
Abusive	623	587	461	419	320
Acute healing fracture	44	67	61	56	60
Adult Seizure Disorder	682	471	388	402	361
Amputations	145	153	172	168	153
Balance	5396	5931	6265	6440	5912
Bed bound	51	46	55	66	70
Bowel ostomy	42	39	32	52	39
Chair bound	1417	1486	1597	1665	1531
Child Seizure Disorder	#	#	#	#	#
Cognitive impairment	5001	4829	4909	5127	4467
Combative	308	399	287	193	165
Dyspnea	82	78	25	#	20
Dyspnea / shortness of breath	1757	1617	1700	1818	1598
Edema or self-reported weight gain	715	616	626	631	483
Gait abnormality	2422	2623	2433	1916	1706
Hearing	475	378	338	346	241
Hyperactivity	64	43	95	72	43
Impaired endurance	2594	2816	3376	3729	3157
Incontinence urine	5101	5267	5425	5528	5075
Incontinent bowel	2530	2843	2812	2835	2606
Injurious to others	117	118	82	69	43
Injurious to self	129	109	60	33	29
Late effects CVA / Hemiparesis / Aphasia	944	822	875	876	765
Late effects of fractures	235	172	148	124	136
Obesity	1749	1490	#	1753	1498
Orthopnea	16	#	#	#	#
Other	195	861	921	1008	882
Other condition	967	2353	2584	2635	2464
Pain	3448	3502	3654	3680	3447
Paralysis / TBI / CP / muscle dystonia	130	127	100	79	79
Skin condition	488	309	249	253	181
Speech	570	429	408	371	297
Tremors / parkinsonism	827	970	986	967	952
Urinary ostomy	26	19	25	14	12
Use of oxygen	523	479	451	458	380
Vision	716	617	#	605	496
Wanders	223	424	408	414	350

SCU - Conditions	2015	2016	2017	2018	2019
Abusive	469	496	483	399	279
Acute healing fracture	23	24	25	25	30
Adult Seizure Disorder	169	115	101	115	93
Amputations	24	19	26	25	22
Balance	2437	2678	2787	2797	2564
Bed bound	41	45	45	71	53
Bowel ostomy	#	#	#	#	#
Chair bound	664	694	736	813	752
Cognitive impairment	3374	3316	3308	3292	2929
Combative	453	580	516	383	289
Dyspnea	16	31	#	#	#
Dyspnea / shortness of breath	347	337	327	324	292
Edema or self-reported weight gain	218	188	201	209	141
Gait abnormality	975	1094	1099	866	750
Hearing	235	151	164	133	95
Hyperactivity	17	24	26	15	15
Impaired endurance	719	872	1092	1190	1006
Incontinence urine	2915	2947	3001	2951	2627
Incontinent bowel	2118	2304	2308	2248	2001
Injurious to others	167	159	149	126	59
Injurious to self	96	48	43	40	#
Late effects CVA / Hem iparesi s / Aphasia	167	143	146	146	160
Late effects of fractu res	68	35	42	54	39
Obesity	351	287	296	323	254
Orthopnea	#	#	#	#	#
Other	56	270	281	324	276
Other condition	294	897	841	868	834
Pain	860	872	824	810	750
Paralysis / TBI / CP / muscle dystonia	28	27	57	46	18
Skin condition	164	116	97	103	56
Speech	218	211	216	263	197
Tremors / parkinsonism	262	308	308	316	266
Urinary ostomy	#	#	#	#	#
Use of oxygen	109	99	97	106	69
Vision	176	156	150	133	131
Wanders	789	986	1028	1025	845

Item 10: Average SA Payment Amount by Setting Type

Avg SA Amt by SFY		
June	**ACH**	**SCU**
2015	$432	$580
2016	$412	$547
2017	$405	$516
2018	$393	$513
2019	$377	$496

Avg SA Amt - SFY18 Q4		
Age Range	**ACH**	**SCU**
21-40	$452.6	n/a
41-64	$406.4	$640.0
65+	$364.5	$502.0
Unk	$394.0	$515.0

Avg SA Amt by Quarter		
SFY18	**ACH**	**SCU**
Q1	$404.9	$518.5
Q2	$404.4	$519.7
Q3	$395.1	$513.9
Q4	$405.3	$372.7

Average SA Payment Amount by County

Data reflects SFY2018

County	Qtr 1		Qtr 2		Qtr 3		Qtr 4							
	ACH	SCU	ACH	SCU	ACH	SCU	ACH				SCU			
							AGE RANGE:	21 - 40	41 - 64	65 +	Unk	21 - 40	41 - 64	65+	Unk
Alamance		$392.2	$411.4	$402.7	$718.5	$393.5		$407.1	$402.8	$396.4	$409.5	$412.4	$569.2	$442.8
Alexander		$388.0		$497.2		$396.4			$494.5	$385.4		$504.9	$535.6	$441.3
Alleghany		$462.9		$330.3		$448.2			$425.7	$451.9		$463.0	$480.5	$501.0
Anson		$420.1		$581.0		$410.6			$603.2	$402.1		$625.4	$610.6	$489.1
Ashe		$371.9		$585.6		$369.8			$557.0	$395.2		$543.1	$561.3	$480.5
Avery		$413.2		$444.0		$422.6			$408.7	$412.9		$377.0	$425.4	$510.4
Beaufort		$409.9		$749.0		$418.5			$744.0	$400.5		$713.4	$525.4	$441.5
Bertie		$458.2		$651.8		$449.7			$673.5	$448.6		$646.4	$521.8	$475.2
Bladen		$418.0		$589.0		$418.5			$582.0	$399.7		$601.8	$492.0	$478.0
Brunswick		$427.1		$536.3		$433.6			$517.6	$409.8		$566.2	$462.1	$456.4
Buncombe		$418.4		$495.1		$412.6			$519.6	$399.9		$477.8	$503.1	$396.4
Burke		$380.2		$486.0		$384.9			$498.3	$365.4		$462.1	$528.0	$458.9
Cabarrus		$375.8		$355.4		$370.0			$397.4	$357.6		$413.5	$525.4	$414.4
Caldwell		$374.6		$549.3		$379.6			$530.6	$362.9		$530.5	$431.5	$476.1
Camden		$435.9		$675.2		$433.7			$674.5	$418.0		$656.0	$493.8	$432.0
Carteret		$379.2		$641.0		$374.6			$620.3	$375.4		$587.2	$544.2	$479.2
Caswell		$418.1		$250.1		$418.2			$429.0	$398.6		$330.7	$641.4	$490.2
Catawba		$358.0		$321.8		$362.1			$337.0	$354.7		$358.4	$641.0	$461.5
Chatham		$385.3		$553.6		$380.8			$517.0	$361.3		$486.9	$594.8	$439.4
Cherokee		$436.4		$483.0		$433.5			$603.8	$421.8		$477.1	$503.9	$465.7
Chowan		$456.0		$413.3		$446.2			$519.9	$441.9		$462.8	$623.1	$498.0
Clay		$451.0		$648.0		$442.1			$498.2	$430.2		$462.1	$628.8	$463.0
Cleveland		$403.3		$423.9		$395.6			$397.3	$388.7		$386.6	$474.5	$433.8
Columbus		$425.2		$616.4		$419.8			$530.7	$407.7		$530.5	$431.5	$474.7
Craven		$415.6		$429.6		$416.7			$674.5	$399.2		$656.0	$493.8	$474.5
Cumberland		$438.5		$574.1		$434.0			$620.3	$428.9		$587.2	$544.2	$452.4
Currituck		$402.5		$456.0		$407.8			$429.0	$393.9		$330.7	$641.4	$483.7
Dare		$409.6		$511.1		$415.7			$337.0	$394.0		$358.4	$641.0	$466.5
Davidson		$358.9		$442.7		$363.9			$517.0	$358.2		$358.0	$594.8	$425.6
Davie		$383.0		$502.0		$370.6			$603.8	$358.0		$408.1	$623.1	$479.2
Duplin		$430.7		$487.5		$428.3			$519.9	$417.0		$422.4	$503.9	$465.6
Durham		$426.4		$577.1		$428.1			$498.2	$404.1		$398.4	$462.1	$476.4
Edgecombe		$443.0		$524.7		$434.2			$397.3	$362.0		$454.9	$628.8	$454.9
Forsyth		$407.2		$522.6		$409.3			$530.7	$370.6		$422.5	$463.0	$477.1
Franklin		$432.4		$574.5		$417.8			$674.5	$416.5		$384.7	$623.1	$477.4
Gaston		$372.7		$423.2		$369.3			$620.3	$384.7		$418.3	$503.9	$455.8
Gates		$476.1		$627.6		$483.4			$429.0	$378.9		$388.2	$462.1	$478.0
Graham		$368.6		$842.5		$379.0			$337.0	$388.2		$377.6	$628.8	$488.5
Granville		$428.1		$576.2		$433.6			$517.0	$421.2		$442.6	$503.9	$482.8
Greene		$427.6		$697.4		$426.3			$603.8	$442.6		$378.8	$623.1	$426.9
Guilford		$390.4		$444.5		$393.6			$519.9	$378.8		$364.8	$462.1	$445.2
Halifax		$421.4		$548.5		$427.9			$498.2	$430.9		$422.5	$503.9	$467.2
Harnett		$387.7		$594.4		$386.3			$397.3	$391.8		$416.5	$463.0	$444.5
Haywood		$393.0		$515.3		$383.3			$530.7	$411.4		$384.7	$628.8	$472.0
Henderson		$389.1		$475.4		$388.7			$674.5	$385.7		$418.3	$503.9	$418.9
Hertford		$430.1		$723.4		$419.0			$620.3	$405.3		$378.9	$462.1	$478.2
Hoke		$449.2		$680.8		$461.4			$429.0	$378.2		$388.2	$628.8	$476.1
Hyde		$386.2		$826.0		$390.1			$337.0	$413.3		$377.6	$503.9	$0.0
Iredell		$371.3		$471.1		$371.3			$517.0	$448.4		$421.2	$462.1	$438.8
Jackson		$426.6		$669.8		$431.8			$603.8	$435.5		$442.6	$628.8	$402.1
Johnston		$398.4		$542.5		$397.4			$519.9	$410.4		$378.8	$503.9	$461.4
Jones		$408.0		$572.0		$391.9			$498.2	$398.9		$364.8	$462.1	$437.6
Lee		$401.5		$673.1		$387.1			$397.3	$436.9		$430.9	$628.8	$495.7
Lenoir		$421.9		$575.0		$418.3			$530.7	$400.2		$391.8	$503.9	$416.8
Lincoln		$385.0		$459.3		$382.2			$674.5	$399.5		$411.4	$462.1	$432.8
Macon		$431.6		$586.0		$397.9			$620.3	$398.7		$385.7	$628.8	$344.6
Madison		$462.9		$566.1		$460.6			$429.0	$402.5		$405.3	$503.9	$474.2
Martin		$437.0		$467.6		$430.5			$337.0	$384.4		$378.2	$462.1	$431.0
McDowell		$407.7		$430.1		$412.1			$517.0	$393.2		$413.3	$628.8	$482.4
Mecklenburg		$411.8		$498.8		$411.0			$603.8	$399.2		$448.4	$503.9	$453.2
Mitchell		$436.1		$634.9		$427.1			$519.9	$410.3		$435.5	$462.1	$488.5
Montgomery		$385.8		$609.7		$399.0			$498.2	$426.4		$410.4	$628.8	$477.6
Moore		$410.0		$451.4		$405.2			$397.3	$401.7		$398.9	$503.9	$464.9
Nash		$407.3		$499.3		$406.3			$530.7	$396.4		$436.9	$462.1	$456.5
New Hanover		$423.4		$532.1		$417.9			$674.5	$368.9		$400.2	$628.8	$433.6
Northampton		$397.3		$665.8		$397.2			$620.3	$421.3		$399.5	$503.9	$486.8
Onslow		$414.3		$494.3		$414.2			$429.0	$339.2		$398.7	$462.1	$447.3
Orange		$422.6		$465.5		$413.5			$337.0	$360.1		$402.5	$628.8	$429.7
Pamlico		$387.8		$219.3		$397.6			$517.0	$402.3		$384.4	$503.9	$468.5
Pasquotank		$430.4		$595.2		$434.3			$603.8	$421.9		$393.2	$462.1	$453.8
Pender		$417.3		$604.2		$418.0			$519.9	$387.2		$399.2	$628.8	$441.5
Perquimans		$394.0		$624.1		$403.1			$498.2	$365.4		$410.3	$462.1	$441.0
Person		$383.6		$579.9		$381.9			$397.3	$394.4		$426.4	$503.9	$412.2
Pitt		$429.8		$613.6		$430.5			$530.7	$413.6		$401.7	$462.1	$463.1
Polk		$353.7		$451.3		$340.5			$674.5	$404.4		$396.4	$628.8	$389.7
Randolph		$371.9		$562.1		$368.8			$620.3	$349.3		$368.9	$503.9	$430.8
Richmond		$424.0		$478.3		$424.6			$429.0	$396.2		$421.3	$462.1	$489.4
Robeson		$427.7		$546.9		$431.7			$337.0	$376.4		$339.2	$628.8	$482.3
Rockingham		$393.4		$376.5		$400.9			$517.0	$431.8		$360.1	$503.9	$437.6
Rowan		$368.6		$447.6		$369.3			$603.8	$359.5		$402.3	$462.1	$436.9
Rutherford		$400.6		$306.0		$404.3			$519.9	$405.6		$421.9	$628.8	$478.1
Sampson		$424.9		$623.8		$423.1			$498.2	$368.5		$387.2	$503.9	$480.5
Scotland		$407.9		$623.7		$407.5			$397.3	$402.8		$365.4	$462.1	$471.9
Stanly		$358.5		$520.7		$363.1			$530.7	$401.9		$394.4	$628.8	$448.9
Stokes		$399.4		$569.5		$414.8			$674.5	$453.6		$413.6	$503.9	$448.5
Surry		$376.8		$482.6		$378.4			$620.3			$404.4	$462.1	$461.3
Swain		$442.0		$74.0		$443.9			$429.0			$349.3	$628.8	$503.0
Transylvania		$378.5		$316.5		$368.3			$337.0			$396.2	$503.9	$376.8
Tyrrell		$391.4		$515.2		$380.7			$517.0			$376.4	$462.1	$373.0
Union		$381.4		$389.4		$386.2			$603.8			$431.8	$628.8	$405.1
Vance		$411.2		$541.3		$404.5			$519.9			$359.5	$503.9	$430.2
Wake		$410.0		$472.9		$410.1			$498.2			$405.6	$462.1	$459.4
Warren		$463.0		$641.2		$471.5			$397.3			$368.5	$628.8	$498.5

$680.5	$395.0	$441.0	$370.5	$395.8	$0.0	$665.3	$402.7	$417.9
	$405.3	$445.1	$360.6	$397.4	$0.0	$587.3	$486.9	$510.4
	$429.2	$456.5	$475.8	$461.0	$0.0	$147.0	$552.4	$462.0
	$384.1	$385.3	$360.6	$382.3	$0.0	$811.0	$614.5	$629.2
	$419.1	$406.5	$343.3	$378.8	$0.0	$0.0	$574.5	$562.1
	$388.3	$503.5	$398.0	$413.7	$0.0	$0.0	$382.3	$375.2
	$407.5	$382.7	$374.3	$400.7	$0.0	$801.3	$472.0	$665.8
	$444.2	$413.5	$418.2	$445.1	$0.0	$821.5	$647.1	$651.1
	$391.5	$439.2	$407.3	$401.8	$0.0	$722.0	$584.3	$600.0
	$435.9	$409.2	$340.0	$397.3	$0.0	$870.2	$446.4	$549.9
	$414.2	$416.4	$378.4	$399.7	$0.0	$468.5	$466.0	$477.0
	$396.4	$414.6	$309.5	$367.6	$0.0	$806.7	$442.1	$462.4
	$387.2	$379.4	$322.5	$358.9	$0.0	$331.0	$445.4	$470.2
	$380.8	$403.1	$336.6	$361.5	$0.0	$593.8	$511.3	$507.8
	$416.2	$447.5	$406.7	$417.5	$0.0	$0.0	$695.0	$695.0
	$424.5	$394.6	$352.8	$383.5	$0.0	$831.0	$553.8	$648.9
	$407.1	$339.7	$403.6	$406.1	$0.0	$0.0	$314.0	$314.0
	$385.0	$396.1	$317.9	$360.3	$0.0	$458.2	$373.9	$370.6
	$366.2	$417.0	$319.8	$359.8	$0.0	$0.0	$453.1	$500.6
	$441.3	$285.6	$342.4	$413.9	$0.0	$771.0	$548.4	$597.8
	$461.7	$380.3	$437.3	$442.4	$0.0	$0.0	$572.3	$527.0
	$379.3	$432.3	$483.2	$429.2	$0.0	$496.0	$612.3	$586.6
	$412.4	$434.7	$344.6	$380.4	$0.0	$821.0	$506.1	$528.1
	$388.7	$416.5	$390.4	$398.6	$0.0	$0.0	$681.8	$677.0
	$396.5	$359.2	$363.7	$402.9	$0.0	$577.8	$450.4	$447.1
	$433.1	$412.4	$408.0	$426.4	$0.0	$666.3	$539.9	$569.6
	$362.6	$436.2	$381.2	$393.6	$0.0	$0.0	$514.8	$486.5
	$437.0	$411.9	$339.8	$399.9	$0.0	$0.0	$343.1	$360.0
	$381.7	$330.9	$309.3	$351.9	$0.0	$776.3	$407.8	$440.1
	$349.4	$417.8	$310.1	$342.6	$0.0	$0.0	$502.5	$508.3
	$419.0	$372.9	$389.3	$400.5	$0.0	$0.0	$600.8	$593.5
	$421.9	$436.7	$378.8	$418.7	$0.0	$742.1	$576.6	$599.4
	$423.1	$381.6	$401.2	$424.8	$0.0	$7.0	$401.9	$430.5
	$418.5	$482.3	$355.4	$397.1	$0.0	$756.1	$492.4	$530.6
	$407.7	$399.6	$384.0	$398.3	$0.0	$831.0	$546.1	$576.4
	$377.3	$409.0	$336.2	$364.9	$0.0	$266.0	$389.7	$365.5
	$421.1	$405.8	$538.3	$465.4	$0.0	$468.0	$596.8	$560.0
	$319.6	$414.3	$338.0	$361.5	$0.0	$0.0	$831.5	$832.0
	$439.3	$385.9	$387.2	$420.2	$0.0	$0.0	$662.0	$639.0
	$468.8		$389.1	$425.7	$0.0	$831.0	$569.3	$561.2
	$385.8		$360.6	$383.3	$0.0	$506.5	$440.8	$445.6
	$459.5		$397.4	$422.9	$0.0	$681.1	$499.4	$514.8
	$388.0		$342.9	$379.0	$0.0	$759.3	$629.4	$658.7
	$419.3		$337.5	$389.0	$0.0	$0.0	$432.3	$435.0
	$382.4		$354.7	$375.7	$0.0	$0.0	$435.0	$396.4
	$408.4		$412.7	$426.2	$0.0	$693.3	$644.8	$677.5
	$370.5		$461.1	$446.4	$0.0	$811.0	$716.2	$726.8
	$366.0		$376.5	$378.8	$0.0	$0.0	$811.0	$811.0
	$402.4		$325.8	$362.3	$0.0	$0.0	$442.5	$455.5
	$437.5		$419.2	$430.3	$0.0	$831.0	$557.3	$622.5
	$410.7		$355.5	$396.1	$0.0	$468.7	$543.5	$539.9
	$0.0		$388.6	$376.9	$0.0	$614.0	$528.0	$560.7
	$380.9		$353.3	$387.9	$0.0	$775.9	$600.4	$623.5
	$426.7		$394.7	$414.7	$0.0	$573.7	$579.3	$567.0
	$365.		$322.8	$362.8	$0.0	$0.0	$438.2	$435.8
			$386.6	$399.8	$832.0	$425.3	$513.3	$518.2
			$411.7	$433.6	$0.0	$0.0	$519.0	$519.0
			$423.1	$432.9	$0.0	$0.0	$402.3	$437.9
			$431.7	$413.1	$0.0	$0.0	$386.8	$374.8
			$373.1	$396.3	$0.0	$608.0	$508.9	$501.7
			$357.8	$429.3	$0.0	$802.0	$593.7	$617.2
			$390.2	$401.4	$0.0	$831.5	$536.3	$619.1
			$356.5	$397.8	$0.0	$511.8	$432.9	$442.7
			$368.6	$402.6	$0.0	$644.0	$459.2	$493.0
			$374.0	$398.9	$0.0	$754.0	$536.4	$551.9
			$334.0	$387.0	$0.0	$0.0	$593.0	$635.9
			$339.6	$385.1	$0.0	$129.0	$460.8	$445.1
			$388.7	$401.1	$0.0	$626.8	$492.2	$490.6
			$370.5	$401.3	$0.0	$0.0	$512.8	$308.0
			$390.8	$423.3	$0.0	$609.3	$539.4	$574.8
			$368.6	$397.4	$0.0	$822.0	$643.4	$613.8
			$433.2	$413.3	$0.0	$0.0	$615.6	$621.8
			$350.2	$362.9	$0.0	$510.5	$588.9	$528.7
			$409.2	$420.6	$0.0	$804.5	$572.6	$619.6
			$316.5	$319.4	$0.0	$0.0	$480.0	$473.6
			$327.4	$367.2	$0.0	$634.7	$532.2	$513.1
			$355.6	$392.0	$0.0	$726.5	$503.5	$520.0
			$411.1	$423.8	$0.0	$633.2	$558.4	$587.4
			$357.4	$388.6	$0.0	$0.0	$405.2	$389.5
			$333.8	$362.2	$0.0	$815.0	$380.5	$444.1
			$339.8	$385.6	$0.0	$0.0	$424.8	$420.0
			$380.1	$412.4	$0.0	$608.0	$598.8	$558.5
			$374.2	$392.5	$0.0	$707.0	$566.2	$616.5
			$326.9	$352.4	$0.0	$0.0	$513.8	$493.3
			$385.3	$406.6	$0.0	$821.0	$538.8	$565.9
			$360.6	$374.7	$0.0	$477.0	$455.5	$453.3
			$337.0	$417.4	$0.0	$0.0	$799.0	$799.0
			$362.1	$372.3	$0.0	$279.5	$337.5	$326.6
			$209.5	$373.1	$0.0	$0.0	$565.1	$437.0
			$337.0	$366.2	$0.0	$151.0	$385.5	$382.2
			$405.5	$403.9	$0.0	$524.0	$643.7	$715.9
			$373.3	$402.1	$0.0	$549.2	$438.9	$448.4
			$501.8	$450.5	$0.0	$0.0	$698.3	$670.3
			$375.2	$411.4	$0.0	$831.0	$733.6	$857.3

Watauga	$385.4	$498.0	$388.2	$457.2	$371.0	$475.4	$428.7	$367.2	$371.9	$384.2	$0.0	$560.0	$575.5	$545.1
Wayne	$424.3	$591.8	$425.2	$592.0	$421.4	$553.4	$460.1	$429.5	$366.5	$406.9	$0.0	$795.5	$532.2	$544.3
Wilkes	$407.6	$530.5	$401.5	$520.6	$394.3	$515.6	$412.2	$426.6	$348.0	$390.2	$0.0	$316.0	$496.5	$502.3
Wilson	$420.7	$600.3	$419.3	$609.1	$408.0	$606.9	$477.5	$449.3	$375.5	$416.2	$0.0	$459.3	$599.5	$584.3
Yadkin	$378.1	$469.0	$389.4	$468.7	$376.9	$460.8	$498.8	$405.7	$350.0	$388.6	$0.0	$372.0	$506.5	$507.4
Yancey	$385.0	$539.2	$388.6	$499.6	$405.3	$513.3	$0.0	$433.0	$406.1	$429.8	$0.0	$0.0	$500.4	$507.6

Item 11: SA Applications Ineligible Due to Exceeding Income Limit

Note: Data for SFY 2015 and 2016 are not available due to transition from EIS to NC FAST between July 2014 and Oct 2015.

Total # of SA Applications due to Exceeding Income by SFY Quarter

Note: Only counties with SA Applicants shown per SFY

County	2017				County	2018				County	2019			
	Qtr 1	Qtr 2	Qtr 3	Qtr 4		Qtr 1	Qtr 2	Qtr 3	Qtr 4		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Alamance	4				Alamance	1	1			Alamanc	1			
Avery	1	1			Alexande				1	Ash		1		
Bladen			1		Beaufor				1	Buncombe	1	1		1
Brunswick			1		Bertie			1	1	Cabarrus	1		2	1
Buncombe	1		1		Blade		1			Chowan			1	1
Cabarrus	1	1			Cabarru				1	Clevelanc	3			
Catawba				1	Catawb	2	2	1		Columbu	1			
Chowan		1			Chathan	1		1		Craver		1		
Clevelanc		1	1	1	Clevelanc	1	2	1	1	Cumberlanc		2		2
Cumberlanc			2	2	Columbus				1	Dar				1
Davidson		1			Cumberlanc	2			1	Davidson				2
Duplin		1	1		Dare	1	1			Davi			1	
Durham	1	2	1		Davidson				1	Duplin			1	
Edgecombe				1	Duplin			2		Durhan			1	
Forsyth	2	2	1		Durham	2	1	1	2	Edgecombe			1	
Gaston		1			Edgecombe				1	Forsyth		1	4	1
Harnett	1				Forsyth	1	3		1	Gaston		1	1	
Iredell	2	1			Frankli			1		Green				1
Johnston	3	2	1	1	Gaston				1	Guilford		1	1	
Lincoln	1		1		Greene		1			Halifa			1	
Martin		1			Guilford	3	2	5	3	Harnet				4
Mecklenburg		3	1		Halifax		1			Henderson				1
Moore	1			1	Harnet		1			Iredell		1	1	1
New Hanover				3	Henderson		2	1	1	Macon		1		
Onslow		1			Jackson			1		Mecklenburg			3	2
Orange	1				Johnston		1		1	Mitchell	2			
Person			1		Macon		1			Moore		1		
Pitt		4	1		Martin			3		New Hanover			1	1
Polk	1				McDowell			2	1	Orange		1		
Richmond				1	Mecklenburg	2	2	1	1	Pasquotank	1	2		
Robeson		1			Mitchell	1				Pende				1
Rockingham			2		Montgomery			1		Perquiman				1
Rowan	2			1	Moore	2				Person	1			2
Stokes			1		Nash			1		Pitt	3			
Surry	1	2			Northampton	1				Randolph			1	
Transylvania			1		Onslow			1		Robeson	2			
Union	1				Pitt	1			2	Rowan			2	
Wake	12	5	4	2	Randolph		1			Rutherford			1	
Watauga	3			1	Robeson	3			2	Stoke			1	
Wilson		1		1	Rowan	3	3			Surry				1
					Sampson			1		Vance	2	1		
					Surry			3		Wake	5	3	8	15
					Transylvania		2			Watauga	2			
					Union	2		1		Wilson		1		
					Vance				1					
					Wake	1	1	3	1					
					Warren	1								
					Washington	1								
					Watauga			3						
					Wilson		1							

SFY	GENDER		AGE RANGE			RACE				
	Male	Female	21-40	41-64	65+	AI	A	B	Un	W
17	44	65	5	20	84			36	2	71
18	48	75	4	23	96	3	1	33	1	4
19	47	68	4	32	79	1	1	25	2	86

 # Race Definitions:

AI - American Indian or Alaskan Native
A - Asian
B - Black
Un - Unreported
W - White

Item 12: Estimated Number of Residents that lost SA Eligibility due to Social Security and SSI Cost of Living Adjustments (COLAS).

***Estimate based on Pre- & Post-COLAS #s; data may include caseload changes, and or termination of benefits, not due to COLA implementation.*

Year	COLA Date	SA Impact	Potential Terminations***	Pre-COLA Case Count	Post-COLA Case Count	Difference (Post-Pre)	% of Pre-COLA Count
2019	April	In-Home	n/a	3,493	n/a	n/a	n/a
	January	ACH	365	17,118	17,060	-58.0	0.3%
2018	April	In-Home	no report	3,164	3,237	73.0	2.3%
	January	ACH	280	18,068	17,930	-138.0	0.8%
2017	April	In-Home	no report	2,928	2,956	28.0	1.0%
	January	ACH	no report	20,027	19,943	-84.0	0.4%

****Potential Terminations: Estimate based on Post-COLA eligibility limit, less prior month Countable Income, plus COLA; shows end-of-month resident count.*

The December 2016 (Pre-COLA, ACH) and January 2017 (Post-COLA, ACH) counts were pulled from Client Services Data Warehouse (CSDW); while the other counts were pulled from the NC FAST SA Summary Detail Report. CSDW stores NC FAST program data that can be queried for program evaluation and management. The CSDW counts include cases that are in "Pending Closure" status; resulting in a higher count than the corresponding NC FAST counts.

Attachment H. Plan for Long-term Solution for Adequate Reimbursement to Facilities Serving Recipients of State/ County Special Assistance (tables 2-8)

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

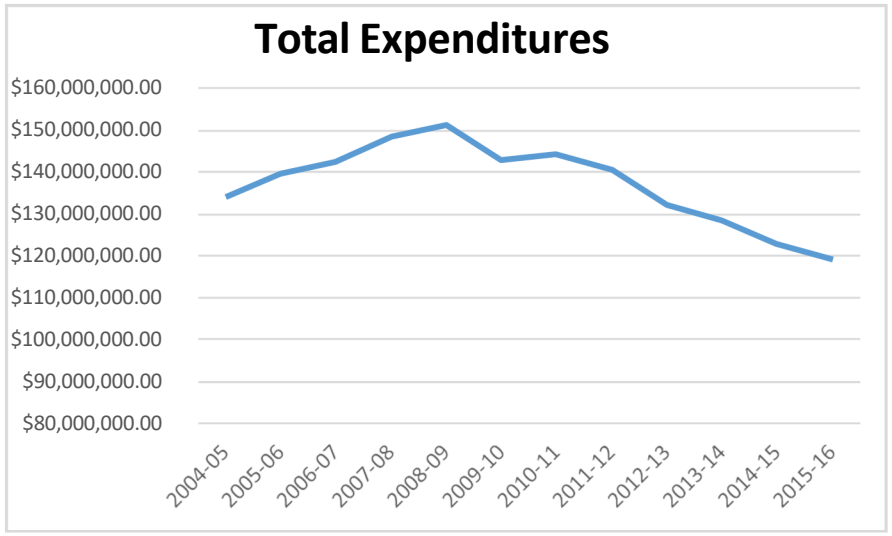
Appendix 2

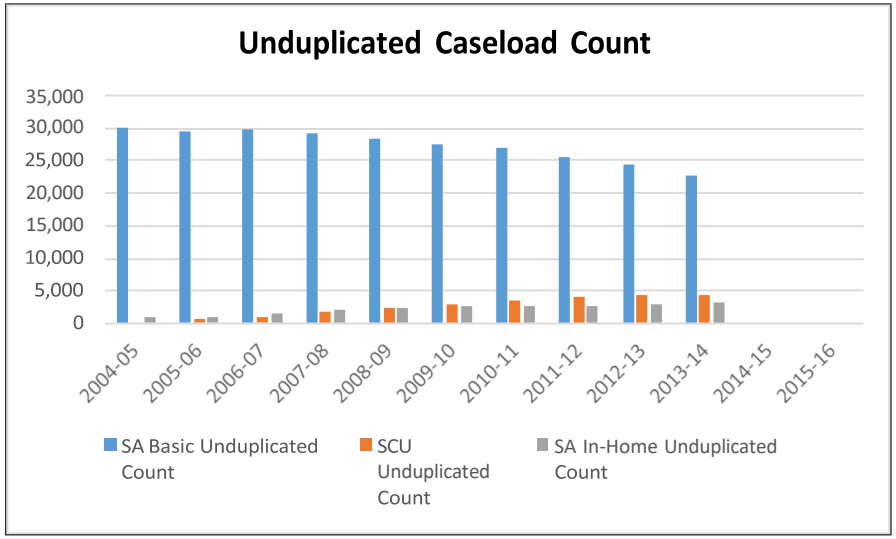
Special Assistance Ten Year Data

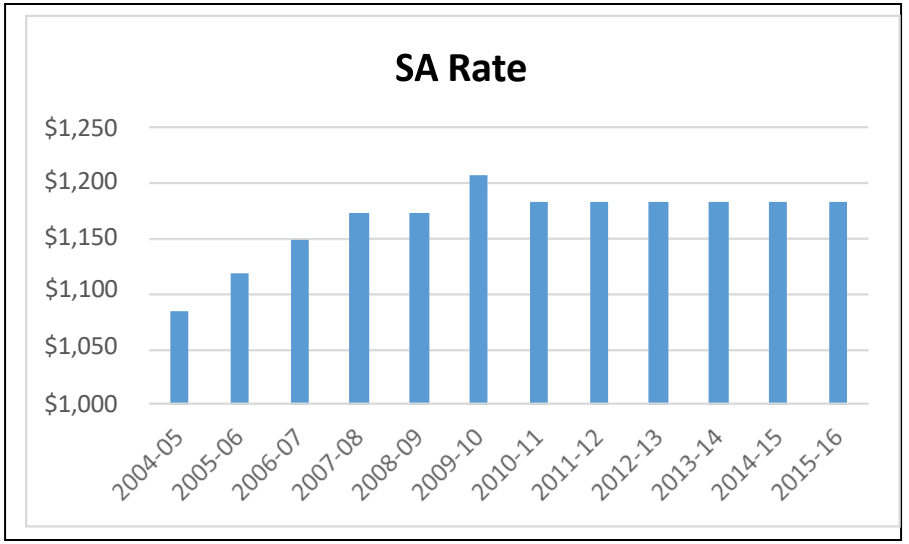
State Fiscal Year	Certified Budget	Total Expenditures	SA Basic Unduplicated Count	SCU Unduplicated Count	SA In-Home Unduplicated Count	SA Rate-Basic	SA Rate-SCU	Personal Needs Allowance
2005-06	$135,823,005.00	$139,486,915.00	29,467	629	1,040	$1,118	$1,515	$46
2006-07	$140,830,676.00	$142,412,950.00	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
MH L	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
MH L	703	15			
Non-SCU		87	97	68	26
SCU		9	44	75	67

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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%	

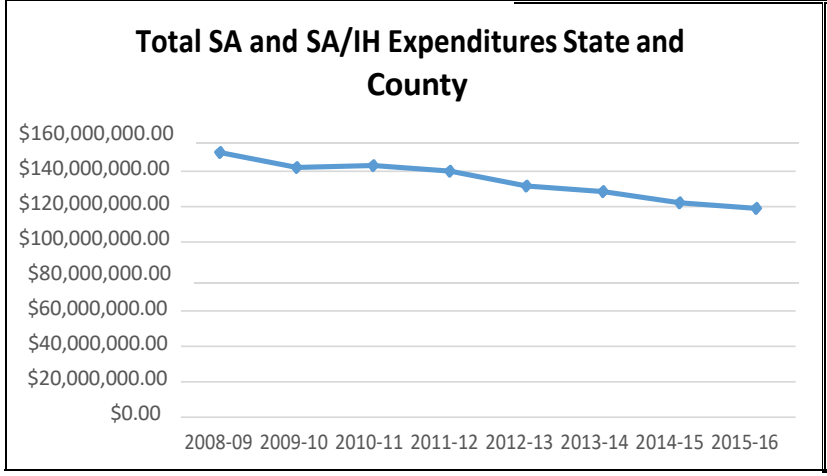
Appendix 7 (continued)							
SCU	0.0%	2.6%	3.4%	3.8%	7.9%		13.2%
Part 6: Estimate total enrollment							
	BASE	$30	$50	$75	$100	$213	$190
ACH	20,229	20,545	21,283	21,493	21,704	24,233	
SCU	3,345	3,433	3,459	3,471	3,610		3787
Part 7: Estimated Enrollment increase (from base scenario)							
	BASE	**$30**	**$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	

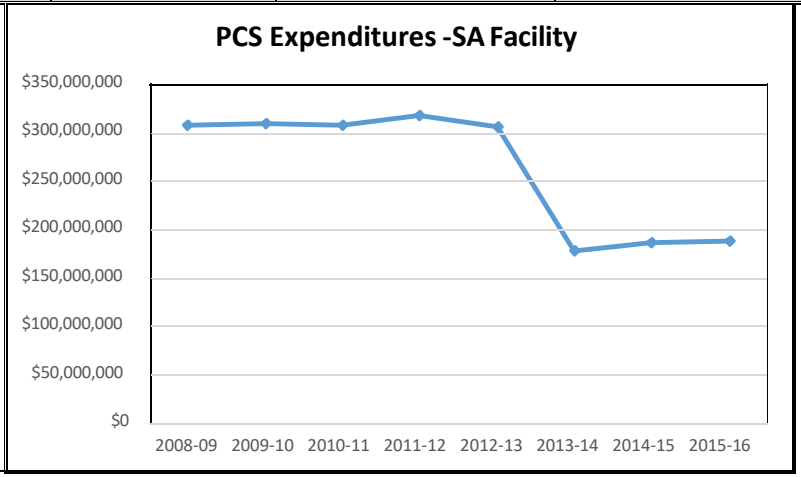
Division of Medicaid Assistance, February, 2017

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;