GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

North Carolina, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

Authors
Maya Wedemeyer
David Knapp

Contributors
Maya Fransz-Myers
Jinkook Lee
Drystan Phillips
Kanghong Shao
Judith Solomon
Michael Upchurch

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

North Carolina, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in North Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In North Carolina, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, North Carolina's Medicaid LTC system has been subject to three major policy reforms: in 1995 it ended its 209(b) status and authorized Medicaid eligibility for aged, blind, and disabled Supplemental Security Income (SSI) recipients; in 1999 it added an eligibility track for aged and disabled individuals with incomes up to 100% of the federal poverty level; and in 2023 it implemented ACA Medicaid expansion to include coverage for adults ages 19-64 with incomes up to 138% of the FPL.

Key Dates

First law: 1965

Major changes since 1992: 1995, 1999, 2023

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1994

Overview

Long-term care (LTC) benefits in North Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in North Carolina is administered at the state level by the Department of Human Resources, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in North Carolina are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Alternatives Program for Disabled Adults—CAP/DA).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by CAP/DA are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for CAP/DA are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis unless the individual meets specific criteria for priority consideration.

Benefit programs vary in dependence requirements. Home Health and Personal Care Services require the individual to have a medical necessity for services, while Nursing Facility and CAP/DA beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

During this policy period, North Carolina implemented its Medicaid Estate Recovery program effective October 1, 1994. This allowed the state to seek recovery of payments from a deceased individual's estate for nursing facility services, home and community-based services, and related hospital prescription drug services.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

North Carolina Law for Medicaid

- North Carolina Administrative Code: Title 10A, Health and Human Services
- North Carolina General Statutes: Chapter 108A, Social Services
- North Carolina General Statutes: Chapter 108C, Medicaid Provider Requirements

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for North Carolina Medicaid spending on beneficiaries in fiscal year 1992 was 66.52%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (66.52% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for North Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in North Carolina.

Eligibility for Medicaid in North Carolina for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States

  During this policy period, North Carolina was one of a few states that used more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: During this policy period, monthly income may not exceed North Carolina's Medicaid Protected Income Level (PIL). In 1992, this was $242 for an individual and $317 for a couple. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community (NCDMA, 1992a).[1]
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community (NCDMA, 1992a).[2]
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[3]
  - Citizenship/immigration requirements: The applicant must be a U.S. Citizen or non-citizen who meets additional eligibility requirements.[4]
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income over a six-month period. The resulting amount must be spent on qualifying medical bills and services. PILs vary by family size. In 1992, the PIL was $242 for an individual and $317 for a couple (NCDMA, 1992a). This standard has remained the same since 1990. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[1]
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[2]
    - Asset transfer: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.

- Other requirements
  - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks
There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Community Alternatives Program for Disabled Adults (CAP/DA)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 18 with a physical disability and reside in one of the counties offering CAP/DA program services. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available. Program applicants are waitlisted on a first-come, first-serve basis.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Home and Community Care Block Grant (HCCBG): A program administered through the Division of Aging that provides non-Medicaid home and community-based services to older North Carolinians.[6]
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services
Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Personal Care Services
Personal care services (PCS) provide (NCDMA, 1992a; NCDMA, 1995b):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Beneficiaries are limited to 80 hours of PCS per month.

Nursing Facility Care
Nursing Facility Care does not provide home care.

CAP/DA
CAP/DA provides in-home aide services, which provide assistance with seven ADLs —bathing, dressing, eating, toileting, hygiene, mobility, and transfer —and with key IADLs that include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management (NCDMA, 1995a).

Semi-residential care

Home Health Services, Personal Care Services, Nursing Facility Care
These programs do not provide semi-residential care.

CAP/DA

CAP/DA provides Adult Day Health Care (ADHC) services. ADHC centers provide supervision, physical and speech therapies, social services, and sometimes meals to recipients in a group setting (NCDMA, 1995a; NCIM, 2003; NCDHHS, 2023c).

Residential care

Home Health Services, Personal Care Services, CAP/DA

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment (NCDMA, 1992a; NCDMA, 1995b; NCDMA, 1999c; NCDHHS, 2023e).

Other benefits

North Carolina Medicaid provides additional state plan benefits related to LTC (NCDMA, 1992; S.L. 1991-59):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CAP/DA

Information pending requested materials.[17]

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the North Carolina Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.75-80; NCDMA, 2000a; NCDHHS, 2023d).

Personal Care Services

Personal care services are provided by personal care service aides (PCS Aides) or in-home nurse aides, depending on the services required. Services are provided through state-certified in-home care agencies (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel as authorized by a physician (42 CFR 483.30-35; NCDMA, 2000b; NCDHHS, 2023e).

CAP/DA

CAP/DA in-home aide and personal assistance services are provided by certified nursing assistants and PCS Aides through state-certified in-home care agencies (NCDMA, 1999a; NCDHHS, 2023c).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (NCDMA, 1992a; NCDMA, 1995b).

Personal Care Services

The beneficiary must require assistance with activities of daily living (ADLs) due to a medical condition in order to function safely at home, and must have personal care services authorized by a physician as medically necessary (NCDMA, 1992a; NCDMA, 1995b).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must have their level of care needs and Medicaid eligibility approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDMA, 1992a; NCDMA, 1995b).

CAP/DA

The beneficiary must meet NFLOC, and be at risk of institutionalization if not for the provision of CAP/DA program services (NCDMA, 1992a; NCDMA, 1995a; NCDMA, 1995b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (NCDHHS, 2023d; NCDMA, 2000a; 42 CFR 484.55).

Personal Care Services

Personal care services must be reassessed and reauthorized at least annually, or more frequently if this is determined to be necessary based on the beneficiary's level of functional disability and prognosis for improvement or rehabilitation (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (NCDHHS, 2023e; 42 CFR 483.128). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (NCDHSR, 2023; 42 CFR 483.20).

CAP/DA

CAP/DA beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs (NCIM, 2003; NCDHHS 2023c).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Personal Care Services, Nursing Facility Care

There is no age requirement.

CAP/DA

The individual must be at least age 18 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (NCDMA, 1992a; NCDMA, 1995).

Personal Care Services

The beneficiary must require assistance with activities of daily living (ADLs) due to a medical condition in order to function safely at home, and must have personal care services authorized by a physician as medically necessary (NCDMA, 1992a; NCDMA, 1995).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must be approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDMA, 1992a; NCDMA, 1995).

CAP/DA

The beneficiary must meet NFLOC and be at risk of institutionalization if not for the provision of CAP/DA program services (NCDMA, 1992a; NCDMA, 1995).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary's physician must certify that the individual is homebound, and that home health services are medically necessary (NCDMA, 1992a; NCDMA, 1995b). Additional information about the evaluation process for home health services during this policy period is pending requested materials.[17]

Personal Care Services

The beneficiary's physician must certify that the personal care services authorized in their plan of care are medically necessary (NCDMA, 1992a; NCDMA, 1995b). Additional information about the evaluation process for personal care services during this policy period is pending requested materials.[17]

Nursing Facility Care

Level of care determinations for nursing facilities are prepared by the beneficiary's attending physician using the FL-2 form, which is used to certify that a beneficiary requires a skilled nursing facility level of care. While there are no objective thresholds or criteria set by the state to define skilled nursing facility level of care, patient information in a range of categories including functional limitations, personal care assistance, and ambulatory status is collected in Section 16 of the form to help the beneficiary's physician arrive at their determination (Van Houtven & Domino, 2005). See Box 1 for a full list of information collected in the FL-2 form to help physicians assess level of care for potential nursing facility residents.

Nursing facilities are also required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for more information on

the MDS.

CAP/DA

An individual applies for CAP/DA program services at their county's lead agency. The individual's care needs are assessed, and if deemed eligible, they are placed on a waitlist administered on a first-come first-serve basis. Once the beneficiary is admitted into the program, CAP/DA case managers authorize services and arrange for their provision. Case managers also conduct annual continued need reviews to reauthorize continued need for CAP/DA services (NCIM, 2003). Additional information about the evaluation process for the CAP/DA program during this policy period is pending requested materials.[17]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A physician must authorize the medical necessity of Home Health Services in the context of a plan of care (NCDMA, 1992a).

Personal Care Services

The beneficiary must have personal care services authorized by a physician as medically necessary (NCDMA, 1992a).

Nursing Facility Care

Nursing facilities conduct comprehensive assessments of each resident to determine and certify level of care and service needs. The Division of Medical Assistance oversees level of care determinations, and contracts with the Medical Review of North Carolina to monitor the accuracy and appropriateness of resident assessments (NCDMA, 1992a).

CAP/DA

Each county administers its CAP/DA program through a lead agency selected by county commissioners that can include the county Department of Social Services (DSS), a health department, an area agency for the aged, or a hospital located in that county. The individual's eligibility for program services is initially assessed by an assessment team comprising one social worker from the lead agency and one registered nurse. Once a CAP/DA slot becomes available, the beneficiary's county lead agency case manager conducts a comprehensive assessment to determine the services needed and that the beneficiary meets NFLOC. Reassessments conducted by the case manager occur annually or with a change in condition (NCDMA, 1995a; NCDMA, 2001; NCDHHS, 2013).

Benefit limitations

Can you mix LTC benefits?

All North Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

Starting in October 1994, North Carolina enforces Estate Recovery as required by federal law. The acceptance of Medicaid in North Carolina creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for LTC services after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt is not

enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, Personal Care Services, CAP/DA
There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care
Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. The PNA has been $30 per month since 1987.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1995-1998

Policy change in 1995
Effective January 1, 1995, North Carolina replaced its 209(b) eligibility track with the slightly less restrictive Supplemental Security Income (SSI) limits. Aged, blind, and disabled beneficiaries of SSI are now automatically eligible for Medicaid, and do not have to process a separate application or be held to the more restrictive 209(b) financial eligibility criteria (NCDMA, 1995b).

Other policy changes during this period:

- (1995) By the end of the calendar year, the CAP/DA program for home and community-based services was offered in each of North Carolina's 100 counties (NCIM, 2003).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the US after August 22, 1996 from receiving federally funded Medicaid (as well as other forms of public assistance) for at least five years after immigration.
- (1997) The Department of Human Resources, which was responsible for administering the state Medicaid program, was combined with the Departments of Public Welfare, Public Health, and Mental Health, and was renamed the Department of Health and Human Services.

Overview

Long-term care (LTC) benefits in North Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in North Carolina is administered at the state level by the Department of Human Resources, which was renamed the Department of Health and Human Services in 1997, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in North Carolina are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Alternatives Program for Disabled Adults—CAP/DA).

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Benefit programs vary in dependence requirements. Home Health and Personal Care Services require the individual to have a medical necessity for services, while Nursing Facility and CAP/DA beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

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North Carolina Law for Medicaid

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Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for North Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in North Carolina.

Eligibility for Medicaid in North Carolina for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[7] In 1995, the monthly federal benefit amount was $458 for an individual and $687 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple(NCDMA, 1995b).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]
  - Citizenship/immigration requirements: The applicant must be a U.S. Citizen or non-citizen who meets additional eligibility requirements.[4] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible.The spend down amount is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income over a six-month period. The resulting amount must be spent on qualifying medical bills and services. PILs vary by family size. In 1992, the PIL was $242 for an individual and $317 for a couple (NCDMA, 1995b). This standard has remained the same since 1990. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[8]
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Community Alternatives Program for Disabled Adults (CAP/DA)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 18 with a physical disability. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available. Program applicants are waitlisted on a first-come, first-serve basis.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Home and Community Care Block Grant (HCCBG): A program administered through the Division of Aging that provides non-Medicaid home and community-based services to older North Carolinians.[6]
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Personal Care Services

Personal care services (PCS) provide (NCDMA, 1992a; NCDMA, 1995b):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Beneficiaries are limited to 80 hours of PCS per month.

Nursing Facility Care
Nursing Facility Care does not provide home care.

CAP/DA
CAP/DA provides in-home aide services, which provide assistance with seven ADLs —bathing, dressing, eating, toileting, hygiene, mobility, and transfer —and with key IADLs that include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management (NCDMA, 1995a).

Semi-residential care

Home Health Services, Personal Care Services, Nursing Facility Care
These programs do not provide semi-residential care.

CAP/DA
CAP/DA provides Adult Day Health Care (ADHC) services. ADHC centers provide supervision, physical and speech therapies, social services, and sometimes meals to recipients in a group setting (NCDMA, 1995a; NCIM, 2003; NCDHHS, 2023c).

Residential care

Home Health Services, Personal Care Services, CAP/DA
These programs do not provide residential care during this policy period.

Nursing Facility Care
Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment (NCDMA, 1992a; NCDMA, 1995b; NCDMA, 1999c; NCDHHS, 2023e).

Other benefits

North Carolina Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CAP/DA
CAP/DA provides the following services in addition to those offered under the state plan, unless otherwise noted (NCDMA, 1995a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day, also referred to as "Meals on Wheels"
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: In-home and out-of-home services provided to program beneficiaries as short-term relief for the beneficiary's primary unpaid caregiver, which can be used in lieu of day, evening, or overnight care
- Specialized medical supplies: Supplies that are necessary to promote continued community integration and avoid institutionalization, such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes
- Home mobility aids: Physical adaptations, minor modifications, and the provision of equipment and monitoring systems that enhance the participant's mobility, safety, and independence in their home and community, which can include the installation of ramps and handrails; the widening of doorways; kitchen, bedroom, or bathroom modifications; or vehicle accessibility modifications (in later policy periods this benefit is referred to as "Home modifications")

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the North Carolina Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.75-80; NCDMA, 2000a; NCDHHS, 2023d).

Personal Care Services

Personal care services are provided by personal care service aides (PCS Aides) or in-home nurse aides, depending on the services required. Services are provided through state-certified in-home care agencies (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel as authorized by a physician (42 CFR 483.30-35; NCDMA, 2000b; NCDHHS, 2023e).

CAP/DA

CAP/DA in-home aide and personal assistance services are provided by certified nursing assistants and PCS Aides through state-certified in-home care agencies (NCDMA, 1999a; NCDHHS, 2023c).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (NCDMA, 1992a; NCDMA, 1995b).

Personal Care Services

The beneficiary must require assistance with activities of daily living (ADLs) due to a medical condition in order to function safely at home, and must have personal care services authorized by a physician as medically necessary (NCDMA, 1992a; NCDMA, 1995b).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must have their level of care needs and Medicaid eligibility approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDMA, 1992a; NCDMA, 1995b).

CAP/DA

The beneficiary must meet NFLOC, and be at risk of institutionalization if not for the provision of CAP/DA program services (NCDMA, 1992a; NCDMA, 1995a; NCDMA, 1995b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (NCDHHS, 2023d; NCDMA, 2000a; 42 CFR 484.55).

Personal Care Services

Personal care services must be reassessed and reauthorized at least annually, or more frequently if this is determined to be necessary based on the beneficiary's level of functional disability and prognosis for improvement or rehabilitation (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (NCDHHS, 2023e; 42 CFR 483.128). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (NCDHSR, 2023; 42 CFR 483.20).

CAP/DA

CAP/DA beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs (NCIM, 2003; NCDHHS 2023c).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Personal Care Services, Nursing Facility Care

There is no age requirement.

CAP/DA

The individual must be at least age 18 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (NCDMA, 1992a; NCDMA, 1995b).

Personal Care Services

The beneficiary must require assistance with activities of daily living (ADLs) due to a medical condition in order to function safely at home, and must have personal care services authorized by a physician as medically necessary (NCDMA, 1992a; NCDMA, 1995b).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must be approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDMA, 1992a; NCDMA, 1995b).

CAP/DA

The beneficiary must meet NFLOC and be at risk of institutionalization if not for the provision of CAP/DA program services (NCDMA, 1992a; NCDMA, 1995).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary's physician must certify that the individual is homebound, and that home health services are medically necessary (NCDMA, 1992a; NCDMA, 1995b). Additional information about the evaluation process for home health services during this policy period is pending requested materials.[17]

Personal Care Services

The beneficiary's physician must certify that the personal care services authorized in their plan of care are medically necessary (NCDMA, 1992a; NCDMA, 1995b). Additional information about the evaluation process for personal care services during this policy period is pending requested materials.[17]

Nursing Facility Care

Level of care determinations for nursing facilities are prepared by the beneficiary's attending physician using the FL-2 form, which is used to certify that a beneficiary requires a skilled nursing facility level of care. While there are no objective thresholds or criteria set by the state to define skilled nursing facility level of care, patient information in a range of categories including functional limitations, personal care assistance, and ambulatory status is collected in Section 16 of the form to help the beneficiary's physician arrive at their determination (Van Houtven & Domino, 2005). See Box 1 for a full list of information collected in the FL-2 form to help physicians assess level of care for potential nursing facility residents.

Nursing facilities are also required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for more information on the MDS.

CAP/DA

An individual applies for CAP/DA program services at their county's lead agency. The individual's care needs are assessed, and if deemed eligible, they are placed on a waitlist administered on a first-come first-serve basis. Once the beneficiary is admitted into the program, CAP/DA case managers authorize services and arrange for their provision. Case managers also conduct annual continued need reviews to reauthorize continued need for CAP/DA services (NCIM, 2003). Additional information about the evaluation process for the CAP/DA program during this policy period is pending requested materials.[17]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A physician must authorize the medical necessity of Home Health Services in the context of a plan of care (NCDMA, 1995b).

Personal Care Services

The beneficiary must have personal care services authorized by a physician as medically necessary (NCDMA, 1995b).

Nursing Facility Care

Nursing facilities are required to maintain utilization review committees (URC), comprising two physicians per review, to evaluate the skilled nursing level of care required by nursing facility residents. Their report and level of care certification is submitted to the Division of Medical Assistance, and the DMA contracts with the Medical Review of North Carolina (MRNC) to monitor URC level of care recommendations by reviewing a sample of FL-2 forms monthly and conducting occasional site reviews as needed (NCDMA, 2000b). The DMA contracts with a different organization, First Mental Health, Inc. (FMH), to conduct and process the pre-admission screening and annual review (PASARR) (NCDMA, 2000c).

CAP/DA

Each county administers its CAP/DA program through a lead agency selected by county commissioners that can include the county Department of Social Services (DSS), a health department, an area agency for the aged, or a hospital located in that county. The individual's eligibility for program services is initially assessed by an assessment team comprising one social worker from the lead agency and one registered nurse. Once a CAP/DA slot becomes available, the beneficiary's county lead agency case manager conducts a comprehensive assessment to determine the services needed and that the beneficiary meets NFLOC. Reassessments conducted by the case manager occur annually or with a change in condition (NCDMA, 1995a; NCDMA, 2001; NCDHHS, 2013).

Benefit limitations

Can you mix LTC benefits?

All North Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, North Carolina enforces Estate Recovery. The acceptance of Medicaid in North Carolina creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for LTC services after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt is not enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, Personal Care Services, CAP/DA

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. The PNA has been $30 per month since 1987.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 1999-2022

Policy change in 1999
Effective January 1, 1999, the North Carolina General Assembly authorized a new Medicaid financial eligibility track covering aged and disabled individuals with incomes up to 100% of the federal poverty limit (NCDMA, 1999).

During this policy period, a number of changes were made to state plan personal care services (PCS):

- (2002) In response to budgetary constraints and high demand for the service, PCS were subjected to a 3.5 hour daily limit and the total monthly service cap was reduced from 80 hours to 60 hours per month (NCDMA, 2002).
- (2003) In response to many PCS recipients requiring more than 60 monthly service hours to remain at home, a new enhanced Personal Care Services-Plus (PCS-Plus) benefit was introduced allowing beneficiaries to qualify for an additional 20 hours monthly of PCS, subject to additional functional need requirements (NCDMA, 2003).
- (2011) In-home care services for adults (IHCA) replaced PCS and PCS-Plus personal care service benefits, implementing new ADL-based eligibility criteria. Monthly service caps were set at 80 hours per month (CMS, 2011; NCGA, 2010).
- (2012) IHCA was renamed PCS and consolidated under a 1915(i) state plan amendment, keeping the eligibility criteria and service limitations set in 2011 (NCDMA, 2012a; NCDMA 2012c).
- (2013) The General Assembly amended the PCS benefit to allow for an additional 50 hours per month of PCS to be authorized, subject to additional eligibility criteria (CMS, 2014; NCGA, 2013).

Other policy changes during this period:

- (2007) Estate recovery rules were amended to apply to nursing facility services and HCBS program services, but not to state plan personal care services or home health services (NCGA, 2007).
- (2007) The Deficit Reduction Act of 2005 mandated two changes to Medicaid financial eligibility standards applicable to nursing facility residents and CAP/DA program beneficiaries, implemented in North Carolina effective November 1, 2007 (NCDHHS, 2007):
  - The lookback period for all transfers of assets was lengthened from 36 to 60 months.
  - While the value of an individual's home was previously excluded, a home equity limit of $500,000 was imposed, making beneficiaries with home equity in excess of this amount ineligible for institutional or CAP/DA program services. This figure increases annually with inflation.
- (2012) Community transition services, home modification, training, and assistive technology were added as benefits to the Community Alternatives Program for Disabled Adults (CAP/DA) (NCDMA, 2012b).
- (2013) The Service request form replaced the FL-2 form for CAP/DA program level of care determinations.
- (2019) Coordinated caregiving was added as service benefit to the CAP/DA program.
- (2019) In 2015, the North Carolina General Assembly enacted S.L. 2015-245, directing Medicaid to transition from predominantly fee-for-service to a managed care delivery system, which was phased in by region beginning in November 2019. This applies only to Medicaid beneficiaries receiving state plan home health and personal care services, and individuals requiring nursing facility stays of up to 90 days. CAP/DA program beneficiaries and nursing facility residents of over 90 days are excluded, and remain covered through the fee-for-service delivery system (NCDMA, 2019b).

Overview

Long-term care (LTC) benefits in North Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in North Carolina is administered at the state level by the Department of Health and Human Services, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in North Carolina are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Alternatives Program for Disabled Adults—CAP/DA).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by CAP/DA are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those

applying for CAP/DA are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis unless the individual meets specific criteria for priority consideration.

Benefit programs vary in dependence requirements. Home Health and Personal Care Services require the individual to have a medical necessity for services, while Nursing Facility and CAP/DA beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

North Carolina Law for Medicaid

- North Carolina Administrative Code: Title 10A, Health and Human Services
- North Carolina General Statutes: Chapter 108A, Social Services
- North Carolina General Statutes: Chapter 108C, Medicaid Provider Requirements

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for North Carolina Medicaid spending on beneficiaries in fiscal year 1999 was 63.07%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (63.07% in 1999), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for North Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in North Carolina.

Eligibility for Medicaid in North Carolina for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[7] In 1999, the monthly federal benefit amount was $500 for an individual and $751 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple(NCDMA, 1999).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]
    - Home equity limit: Starting in 2007, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. This figure increases annually with inflation.[11]
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal poverty limit (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1999, this was $687 for an individual and $922 for a couple. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[12]
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple(NCDMA, 1999). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
    - Asset transfer: same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income over a six-month period. The resulting amount must be spent on qualifying medical bills and services. PILs vary by family size. In 1992, the PIL was $242 for an individual and $317 for a couple (NCDMA, 1999). This standard has remained the same since 1990. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[12]
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Medicaid (BCCM): Starting in 2000, women under age 65 with incomes at or below 250% of the FPL who are diagnosed with and in need of treatment for breast or cervical cancer, or precancerous conditions of the breast or cervix, are provided full Medicaid coverage.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Community Alternatives Program for Disabled Adults (CAP/DA)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 18 with a physical disability. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available. Program applicants are waitlisted on a first-come, first-serve basis unless they meet specific criteria that allow them to be prioritized such as if the beneficiary is transitioning from a nursing facility, is an existing CAP/DA beneficiary moving from a different county, has an active AIDS diagnosis, or is diagnosed with Alzheimer's disease or related disorder. See Box 4 for the full list of CAP/DA criteria for priority consideration.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- CAP/Choice: Between 2004 and 2011, North Carolina implemented a demonstration program called CAP/Choice to provide home and community-based services through participant direction. In 2011 the services were folded into the CAP/DA program.
- Healthy Opportunities Pilot: Starting in 2022, this program began offering food, transportation, and housing services to eligible beneficiaries receiving home health or personal care services through NC Medicaid Managed Care in three pilot regions of the state.
- Money Follows the Person (MFP): Beginning in 2009, this program assists people living in nursing facilities in moving back into their own communities to receive long-term care through home and community-based services.
- Program of All-Inclusive Care for the Elderly (PACE): Beginning in 2004, North Carolina offers the PACE program providing comprehensive medical and social services to some older adults still living in the community.
- Home and Community Care Block Grant (HCCBG): A program administered through the Division of Aging that provides non-Medicaid home and community-based services to older North Carolinians.[6]
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Starting in 2013, home health services are capped at 75 skilled nursing visits and 100 home health aide visits per year (NCDMA, 2013).

Personal Care Services

Personal care services (PCS) provide hands-on assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the beneficiary's home or living environment. Throughout this policy period, and in response to a rapid rise in demand for services, North Carolina's state plan PCS underwent several reforms (DMA, 2003b):

- In January 2002 PCS were capped at 3.5 hours per day, and in December of the same year PCS were further limited from 80 to 60 service hours per month (NCDMA, 2002).
- In November 2003 Personal Care Services-Plus (PCS-Plus) was implemented as an added benefit, allowing beneficiaries to access an additional 20 PCS hours per month with no daily limitations. In order to qualify, beneficiaries must meet additional and more stringent functional impairment criteria activities of daily living (ADLs) (NCDMA, 2003).
- In January 2011, both PCS and PCS-Plus were replaced by in-home care for adults (IHCA), a consolidated PCS benefit capped at 80 hours per month (CMS, 2011; S.L. 2010-31).
- In 2013, IHCA was renamed PCS with an additional 50 service hours per month available for authorization subject to additional eligibility criteria (S.L. 2013-306).

Nursing Facility Care
Nursing Facility Care does not provide home care during.

CAP/DA
CAP/DA provides in-home aide services, which provides assistance with ADLs such as eating, bathing, dressing, and grooming, as well as with IADLs such as light housekeeping, laundry, meal preparation, and simple household repairs or yard maintenance (NCDMA, 1999).

Semi-residential care

Home Health Services, Personal Care Services, Nursing Facility Care
These programs do not provide semi-residential care.

CAP/DA
CAP/DA provides Adult Day Health Care (ADHC) services. ADHC centers provide supervision, physical and speech therapies, social services, and sometimes meals to recipients in a group setting (NCDMA, 1995a; NCIM, 2003; NCDHHS, 2023c).

Residential care

Home Health Services, Personal Care Services, CAP/DA
These programs do not provide residential care during this policy period.

Nursing Facility Care
Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment (NCDMA, 1992a; NCDMA, 1995b; NCDMA, 1999c; NCDHHS, 2023e).

Other benefits

North Carolina Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CAP/DA
CAP/DA provides the following services in addition to those offered under the state plan, unless otherwise noted (DMA, 1999a, NCDMA, 2012b):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day, also referred to as "Meals on Wheels"
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Non-emergency medical transportation: Additional coverage of non-medical transportation to community services and activities
- Respite: In-home and out-of-home services provided to program beneficiaries as short-term relief for the beneficiary's primary unpaid caregiver, which can be used in lieu of day, evening, or overnight care
- Specialized medical supplies: Supplies that are necessary to promote continued community integration and avoid institutionalization, such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes
- Home modification: Physical adaptations, minor modifications, and the provision of equipment and monitoring systems that enhance the participant's mobility, safety, and independence in their home and community, which can include the installation of ramps and handrails; the widening of doorways; kitchen, bedroom, or bathroom modifications; or vehicle accessibility modifications
- Training: Instruction provided to a program participant or the participant's unpaid primary caregiver to teach skills that enhance the ability of the program participant to independently care for themselves, and that build caregiving competencies of the primary unpaid caregiver

- Community transition services: Reimbursement for one-time expenses such as moving expenses, essential furnishings, and set-up fees or deposits that help the individual make the transition from institutional care to a home environment
- Assistive technology: Adaptive equipment that improves functional capabilities, such as home automation, computer accessibility software and hardware, telecare devices
- Coordinated caregiving: Supportive services aimed at improving skills related to living in the community, including social skill development, linkages to local resources, and assistance with ADLs or IADLs, intended to promote the program participant's independence

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the North Carolina Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.75-80; NCDMA, 2000a; NCDHHS, 2023d).

Personal Care Services

Personal care services are provided by personal care service aides (PCS Aides) or in-home nurse aides, depending on the services required. Services are provided through state-certified in-home care agencies (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel as authorized by a physician (42 CFR 483.30-35; NCDMA, 2000b; NCDHHS, 2023e).

CAP/DA

CAP/DA in-home aide and personal assistance services are provided by certified nursing assistants and PCS Aides through state-certified in-home care agencies (NCDMA, 1999a; NCDHHS, 2023c).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (NCDMA, 1999c). To satisfy the homebound requirement, the beneficiary's medical record must certify the home as the most appropriate setting for the services ordered due to the fact that travel to an out-patient setting would create medical hardship or interfere with the effectiveness of the service (NCDMA, 2000a). From 2005, the homebound requirement was eliminated. However, the home must be certified as the most appropriate setting for services by satisfying one or more of the following (NCDMA, 2005b):

- The beneficiary would require ambulance transportation.
- The beneficiary requries assistance in leaving the home, such as with opening doors and other routine activities.
- The beneficiary is wheelchair bound with a medical condition that precludes leaving the home on a regular basis.
- The beneficiary is medically fragile or unstable.
- Leaving the home would interfere with the effectiveness of the services.

Personal Care Services

The beneficiary must require assistance with activities of daily living (ADLs) due to a medical condition in order to function safely at home, and must have personal care services (PCS) authorized by a physician as medically necessary (NCDMA, 1999c). Between 2003 and 2011 with the implementation of the new PCS-Plus benefit, to qualify for PCS an individual must have unmet needs in

at least two out of nine qualifying ADLs and to qualify for PCS-Plus they must require extensive assistance in at least three ADLs. Starting in 2011 when the PCS and PCS-Plus programs were recombined into one in-home care benefit program the beneficiary must require hands-on assistance in either two or three ADLs depending on the level of assistance needed (NCGA, 2010). The beneficiary cannot have a family member or informal caregiver able and willing to provide the authorized services during the times in which they are provided (NCDMA, 2007).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must have their level of care needs and Medicaid eligibility approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDMA, 1999c).

CAP/DA

The beneficiary must meet NFLOC, be at risk of nursing facility placement, and have a physician certify that their needs can safely be met in a home-based environment through CAP/DA services (NCIM, 2003). In 2015, CAP/DA eligibility guidelines were revised slightly to require the beneficiary to be at risk of institutionalization within 30 days, and after 2017, the beneficiary must require assistance with a minimum of two out of seven qualifying activities of daily living (ADLs) —bathing, dressing, eating, mobility, personal hygiene, toileting, and transferring —and must require at least one CAP/DA program service, in addition to case management, in order to function in the community (NCDMA, 2015, NCDMA, 2017a). The beneficiary must also have an absence of a family member, caregiver, landlord, or community resource able and willing to meet their medical, psycho-social, and functional needs (NCDMA, 2017b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (NCDHHS, 2023d; NCDMA, 2000a; 42 CFR 484.55).

Personal Care Services

Personal care services must be reassessed and reauthorized at least annually, or more frequently if this is determined to be necessary based on the beneficiary's level of functional disability and prognosis for improvement or rehabilitation (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (NCDHHS, 2023e; 42 CFR 483.128). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (NCDHSR, 2023; 42 CFR 483.20).

CAP/DA

CAP/DA beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs (NCIM, 2003; NCDHHS 2023c).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Personal Care Services, Nursing Facility Care

There is no age requirement.

CAP/DA

The individual must be at least age 18 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, and the beneficiary's home must be the most appropriate setting for the services ordered in their plan of care. This means the beneficiary's medical record must certify a medical reason that services should be provided in the patient's home instead of a physician's office, clinic, or outpatient setting. Between 1999-2007, the following guidelines satisfy this requirement:

- Due to the beneficiary's illness, injury, or disability, going to an out-patient setting for the needed service would create medical hardship for the patient. This can include an individual who requires ambulance transportation, has shortness of breath that significantly hinders travel, or for whom leaving the home is likely to cause an exacerbation of their condition.
- The beneficiary is so frail or unstable that their physician certifies leaving the home is undesirable or detrimental. This can include an individual with shortness of breath that significantly hinders travel, with a medical condition requiring protection from exposure to infections, or who has other medical conditions likely to be exacerbated by leaving the home.
- Leaving the home would interfere with the effectiveness of the service. This can include an individual who requires assistive devices at home, who would need to travel for over an hour to seek services, or who needs them repeated at frequencies that would be difficult to accommodate in a clinic or physician's office (e.g., daily IV infusions or insulin injections).

After 2008, the guidelines were revised slightly as follows:

- The beneficiary requires assistance in leaving the home, such as with opening doors and other routine activities.
- The beneficiary is non-ambulatory or wheelchair bound with a medical condition that precludes leaving home on a regular basis.
- The beneficiary would require ambulance transportation.
- The beneficiary is medically frail or unstable, which can include an individual with shortness of breath that significantly hinders travel, with a medical condition requiring protection from exposure to infections, or who has other medical conditions likely to be exacerbated by leaving the home.
- Leaving the home would interfere with the effectiveness of the service. This can include an individual who would need to travel for over an hour to seek services, or who needs them repeated at frequencies that would be difficult to accommodate in a clinic or physician's office (e.g., daily IV infusions or insulin injections).

Personal Care Services

The beneficiary must have a medical condition that requires the direct and ongoing care of the physician prescribing the services, must be medically stable, and must require help with personal care tasks due to their medical condition. Personal care services (PCS) must be in complement to, and not a replacement for, existing family and community supports (NCDMA, 1999a).

Starting in 2003 with the implementation of PCS-Plus, to qualify for PCS a beneficiary must have an unmet need in being unable to independently perform at least two out of nine qualifying activities of daily living (ADLs): bed mobility, transfer, ambulation, eating, toilet use, bathing, dressing, personal hygiene, and self-monitoring of medications. To qualify for PCS-Plus, the beneficiary must qualify for PCS and also meet one of the following three criteria (NCDMA, 2007):

- Require extensive assistance with four or more ADLs
- Require extensive assistance with three or more ADLs and need an in-home aide to perform at least one task
- Require extensive assistance with three or more ADLs and have a medical or cognitive impairment that requires extended time to perform needed personal care services

In 2011, the PCS and PCS-Plus two-tiered benefit was replaced with one new service called in-home care for adults (IHCA), where beneficiaries are required to satisfy one of the following three criteria (NCGA, 2010):

- Three of the five qualifying ADLs with limited hands-on assistance
- Two ADLs, one of which requires extensive assistance
- Two ADLs, one of which requires assistance at the full dependence level

The five qualifying ADLs are: eating, dressing, bathing, toileting, and mobility.

IHCA was renamed PCS in 2013, but the dependence criteria remain the same. Starting in 2013, up to 50 additional hours of PCS can be authorized if the beneficiary meets the following additional eligibility criteria (NCGA, 2013):

- Requires an increased level of supervision
- Requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills
- Regardless of setting, the beneficiary requries a physical environment that includes modifications and safety emasures to safeguard the beneficiary becasue of their gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills
- The beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggerssive behavior, and an increased incidence of falls such as requiring an enhanced level of supervision, requiring environmental modifications and enhanced safety measures, or exhibiting a history of safety concerns related to inappropriate wandering or increased incidence of falls.

Nursing Facility Care

The beneficiary must require a Nursing Facility Level of Care (NFLOC). While North Carolina does not have a list of specific criteria to be met to satisfy NFLOC, the following qualifying conditions are listed as examples of factors that frequently indicate the need for a skilled nursing level of care through 2005 (NCDMA, 2000c):

- 24-hour provision of direct services that a physician certifies as requiring a registered nurse
- 24-hour observation and assessment of resident needs
- Intensive rehabilitative services ordered by a physician at least 5 times per week
- Administration and/or control of medication as required
- Any of the following procedures needed: colostomy, ileostomy, gastrostomy, oxygen therapy, tracheostomy, sterile dressings, or ulcer care

Starting in 2005 the following qualifying conditions are listed for consideration amid a comprehensive evaluation of the resident's medical and psychosocial needs. See Box 5 for a full list of qualifying conditions and considerations that may be used to justify NFLOC (NCDMA, 2005a).

- Need for services that require a registered nurse for a minimum of 8 hours daily
- Need for 24-hour observation and needs assessment by a registered nurse
- Need for administration and control of medications that by law are the exclusive responsibility of licensed nurses
- Need for restorative measures to restore function or prevent a progression in disability
- Special therapeutic diets
- Nasogastric and gastronomy tubes, or respiratory therapy, requiring continued monitoring and administration
- Wounds and care of decubitus ulcers or open areas
- Cognitive disabilities impacting the beneficiary's ability to perform ADLs independently

CAP/DA

CAP/DA beneficiaries are evaluated for admission into the program based on four key factors: the need for CAP/DA services, whether the beneficiary requires a nursing facility level of care, the resources available to meet the person's home care needs, and whether the care needed can safely be provided within the monthly program cost limit (NCDMA, 1999a, NCDMA, 2008). The individual must be at risk of institutionalization within 30 days, and require the level of long-term services and supports typically provided in a nursing facility (NCDHHS, 2012). While North Carolina does not have a list of specific criteria to be met to satisfy the need for skilled nursing level of care, see Box 6 for a list of needs that can either individually or in combination be considered to justify the level of care required for CAP/DA program eligibility.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary's physician identifies the need for home health services and provides signed, written orders that detail the medically necessary services in a plan of care. The plan of care is authorized using form HCFA-485, known later as form CMS-485, which is submitted to a state-certified home health agency for delivery and supervision of the care needed (NCDMA, 2000a). Starting on August 1, 2011, a physician, a nurse practitioner, or a physician's assistant is required to have a face-to-face meeting with the beneficiary to certify their need for and the appropriateness of home health services (DMA, 2011).

Personal Care Services

A beneficiary is referred to a personal care services (PCS) agency or in-home care agency by their physician. The agency dispatches a registered nurse to assess the beneficiary's medical condition as well as the condition of their home environment to authorize services and build a plan of care. This information is submitted in a DMA-3000 form also known as a PCS Physician Authorization for Certification and Treatment (PACT) Form, or an agency assessment instrument that contains the same information, back to the beneficiary's physician for final review and authorization (NCDMA, 2007; NCDMA, 1999b). By 2013, a state-contracted independent assessment entity (IAE) was appointed to resolve conflicts of interest arising from service providers conducting the PCS assessments, and by 2017 a new form called the DMA-3051, also known as the PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need form was implemented to standardize PCS assessments statewide (NCDHHS, 2017).

Nursing Facility Care

A utilization review committee (URC) reviews each new Medicaid recipient's level of care at the first scheduled committee meeting after admission, at 30, 60, and 90 days after admission, and every 90 days after that. Level of care reviews are prepared using the FL-2 form, and are submitted to the Division of Medical Assistance for monitoring and periodic review (NCDMA, 2000b). After 2005 URCs are no longer required at nursing facilities, and level of care as well as treatment plans are approved by the beneficiary's attending physician (NCDMA, 2005a).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for more information on the MDS.

CAP/DA

An individual applies for CAP/DA program services at their county's lead agency. The individual's eligibility for waiver services is initially assessed and annually redetermined by an assessment team comprising one social worker from the lead agency and one registered nurse. Comprehensive assessments are completed using the FL-2 form, which was replaced by a Service Request Form (SRF) in 2013 (NCDHHS, 2013). The forms are used to determine services needed and that the beneficiary meets NFLOC. Once deemed eligible, beneficiaries are placed on a waitlist administered on a first-come first-serve basis, unless they meet specific criteria that allow them to be prioritized such as if the beneficiary is transitioning from a nursing facility, is an existing CAP/DA beneficiary moving from a different county, has an active AIDS diagnosis, or is diagnosed with Alzheimer's disease or related disorder. See Box 4 for the full list of CAP/DA criteria for priority consideration. Once the beneficiary is accepted into the program, the FL-2 or SRF is sent to a case management entity (CME) where case managers arrange for the necessary services (NCDMA, 1999a).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A physician must certify that the beneficiary requires medically necessary home health services and part of a written plan of care that is reviewed every 60 days. Assessments are conducted by registered nurses, who also develop the plan of care needed by the beneficiary. While services must be certified by a physician as medically necessary, after 2010 authorized nurse practitioners or physician assistants can conduct assessments and authorize forms on the physician's behalf (NCGS 90-18.3; NCDMA, 2000a; NCDMA, 2010).

Personal Care Services

A beneficiary is initally referred to receive personal care services (PCS) by their primary care or attending physician, who must also authorize that personal care services are medically necessary. Once the referral is made, a state-certified personal care services provider dispatches a registered nurse to conduct the initial assessment as well as annual reassessments of eligibility for state plan personal care services, which must be signed by the attending physician for authorized services to begin (NCDMA, 1999b). Starting in 2010, an independent assessment entity designated by the Division of Medical Assistance (DMA) is responsible for conducting the assessments that authorize services to begin (NCDMA, 2010b).

Nursing Facility Care

Until 2005, Nursing facilities were required to maintain utilization review committees (URC), comprising two physicians per review, to evaluate the skilled nursing level of care required by nursing facility residents using the FL-2 form. Their report and level of care certification was submitted to the DMA, which contracted with the Medical Review of North Carolina (MRNC) to monitor URC level of care recommendations by reviewing a sample of FL-2 forms monthly and conducting occasional site reviews as needed (NCDMA, 2000b). A state-approved third-party vendor conducts the pre-admission screening and resident review (PASRR) (NCDMA, 2000c).

Starting in 2005, the beneficiary's attending physician at the nursing facility determines that the individual requires a nursing facility level of care (NFLOC), and submits the FL-2 form to the Department of Social Services (DSS) for confirmation (NCDMA, 2005a).

CAP/DA

Each county administers its CAP/DA program through a lead agency selected by county commissioners that can include the county Department of Social Services (DSS), a health department, an area agency for the aged, or a hospital located in that county. The individual's eligibility for program services is initially assessed by an assessment team comprising one social worker from the lead agency and one registered nurse. Once a CAP/DA slot becomes available, the beneficiary's county lead agency case manager conducts a comprehensive assessment to determine the services needed and that the beneficiary meets NFLOC. Reassessments conducted by the case manager occur annually or with a change in condition (NCDMA, 1995a; NCDMA, 2001; NCDHHS, 2013).

Benefit limitations

Can you mix LTC benefits?

All North Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, North Carolina enforces Estate Recovery. The acceptance of Medicaid in North Carolina creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for LTC services after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt is not enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, Personal Care Services, CAP/DA

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. The PNA has been $30 per month since 1987.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 4: Policy enacted 2023-2024

Policy change in 2023
Effective December 1, 2023, North Carolina implemented eligibility track 2c, Medicaid expansion under the Affordable Care Act. The expansion extends Medicaid coverage to a new population of adults who were previously ineligible for Medicaid. This new population may receive long-term care (LTC), including nursing facility care and home and community-based services (HCBS). Medicaid expansion covers adults between the ages of 19 and 64 with incomes up to 138% of the Federal Poverty Level. States that have adopted the expansion receive an enhanced federal matching rate (FMAP) for the newly covered population.

Overview

Long-term care (LTC) benefits in North Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in North Carolina is administered at the state level by the Department of Health and Human Services, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in North Carolina are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Alternatives Program for Disabled Adults—CAP/DA).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by CAP/DA are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for CAP/DA are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis unless the individual meets specific criteria for priority consideration.

Benefit programs vary in dependence requirements. Home Health and Personal Care Services require the individual to have a medical necessity for services, while Nursing Facility and CAP/DA beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

North Carolina Law for Medicaid

- North Carolina Administrative Code: Title 10A, Health and Human Services
- North Carolina General Statutes: Chapter 108A, Social Services
- North Carolina General Statutes: Chapter 108C, Medicaid Provider Requirements

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for North Carolina Medicaid spending on beneficiaries in fiscal year 2023 was 72.69%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (72.69% in 2023), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for North Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in North Carolina.

Eligibility for Medicaid in North Carolina for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2023, the monthly federal benefit amount was $914 for an individual and $1,371 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (NCDHHS, 2023a).
    - Asset transfer: The applicant, their spouse, or their legal representative may not dispose of resources or income for less than fair market value on or after the look-back date or else they will be subject to a period of ineligibility for services.[14]
    - Home equity limit: The equity interest in the individual's home may not exceed $688,000, or else they will be ineligible for LTC services. This figure increases annually with inflation.[11]
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2023 this was $1,215 for an individual and $1,644 for a household of two (NCDHHS, 2023b). See Table 2 for historical FPLs. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[15]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[16]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65 or disabled, and enrolled in Medicare.[5]

- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2023 this was $1,677 for an individual and $2,268 for a household of two. See Table 2 for historical FPLs.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income over a six-month period. The resulting amount must be spent on qualifying medical bills and services. PILs vary by family size. In 2023, the PIL was $242 for an individual and $317 for a couple or household of two. This standard has remained the same since 1992 (NCDHHS, 2023g). Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[15]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[16]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[6]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Medicaid (BCCM): Women under age 65 with incomes at or below 250% of the FPL who are diagnosed with and in need of treatment for breast or cervical cancer, or precancerous conditions of the breast or cervix, are provided full Medicaid coverage.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community Alternatives Program for Disabled Adults (CAP/DA)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 18 with a physical disability. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available. Program applicants are waitlisted on a first-come, first-serve basis unless they meet specific criteria that allow them to be prioritized such as if the beneficiary is transitioning from a nursing facility, is an existing CAP/DA beneficiary moving from a different county, has an active AIDS diagnosis, or is diagnosed with Alzheimer's disease or related disorder. See Box 4 for the full list of CAP/DA criteria for priority consideration.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Healthy Opportunities Pilot: This program offers food, transportation, and housing services to eligible beneficiaries receiving home health or personal care services through NC Medicaid Managed Care in three pilot regions of the state.
- Money Follows the Person (MFP):This program assists people living in nursing facilities in moving back into their own communities to receive long-term care through home and community-based services.
- Program of All-Inclusive Care for the Elderly (PACE): North Carolina offers the PACE program providing comprehensive medical and social services to some older adults still living in the community.
- Home and Community Care Block Grant (HCCBG): A program administered through the Division of Aging that provides non-Medicaid home and community-based services to older North Carolinians.[6]
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services

Home Health provides (NCDHHS, 2023d):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home Health provides up to 75 skilled nursing visits and 100 home health aide visits per year.

Personal Care Services

Personal care services (PCS) provide hands-on assistance with qualifying activities of daily living (ADLs) at least once per week in the beneficiary's home or living environment (NCDHHS, 2023f). See Box 7 for a full list of tasks and services that can be provided by Medicaid PCS. Qualifying ADLs are bathing, dressing, mobility, toileting, and eating, and beneficiaries are limited to 80 hours per month and 3.5 hours per day of services. An additional 50 hours of PCS per month can be authorized if the beneficiary meets additional eligibility requirements (NCGA, 2013).

Nursing Facility Care

Nursing Facility Care does not provide home care.

CAP/DA

CAP/DA provides in-home aide services, which provide assistance with seven ADLs —bathing, dressing, eating, toileting, hygiene, mobility, and transfer —and with key IADLs that include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management (NCDHHS, 2023c).

Semi-residential care

Home Health Services, Personal Care Services, Nursing Facility Care

These programs do not provide semi-residential care.

CAP/DA

CAP/DA provides Adult Day Health Care (ADHC) services. ADHC centers provide supervision, physical and speech therapies, social services, and sometimes meals to recipients in a group setting (NCDMA, 1995a; NCIM, 2003; NCDHHS, 2023c).

Residential care

Home Health Services, Personal Care Services, CAP/DA

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment (NCDMA, 1992a; NCDMA, 1995b; NCDMA, 1999c; NCDHHS, 2023e).

Other benefits

North Carolina Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CAP/DA

CAP/DA provides the following services in addition to those offered under the state plan, unless otherwise noted (NCDHHS, 2022):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: meal preparation and delivery to the beneficiary of one nutritional meal per day, also referred to as "Meals on Wheels"

- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Non-emergency medical transportation: Additional coverage of non-medical transportation to community services and activities
- Respite: In-home and out-of-home services provided to program beneficiaries as short-term relief for the beneficiary's primary unpaid caregiver, which can be used in lieu of day, evening, or overnight care
- Specialized medical supplies: supplies that are necessary to promote continued community integration and avoid institutionalization, such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes
- Home Modification: physical adaptations, minor modifications, and the provision of equipment and monitoring systems that enhance the participant's mobility, safety, and independence in their home and community. This can include the installation of ramps and handrails; the widening of doorways; kitchen, bedroom, or bathroom modifications; or vehicle accessibility modifications
- Training: Instruction provided to a program participant or the participant's unpaid primary caregiver to teach skills that enhance the ability of the program participant to independently care for themselves, and that build caregiving competencies of the primary unpaid caregiver
- Community transition services: Reimbursement for one-time expenses such as moving expenses, essential furnishings, and set-up fees or deposits that help the individual make the transition from institutional care to a home environment
- Assistive technology: Assistive technology: Adaptive equipment that improves functional capabilities, such as home automation, computer accessibility software and hardware, telecare devices
- Coordinated caregiving: supportive services aimed at improving skills related to living in the community, including social skill development, linkages to local resources, and assistance with ADLs or IADLs, intended to promote the program participant's independence

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the North Carolina Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.75-80; NCDMA, 2000a; NCDHHS, 2023d).

Personal Care Services

Personal care services are provided by personal care service aides (PCS Aides) or in-home nurse aides, depending on the services required. Services are provided through state-certified in-home care agencies (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel as authorized by a physician (42 CFR 483.30-35; NCDMA, 2000b; NCDHHS, 2023e).

CAP/DA

CAP/DA in-home aide and personal assistance services are provided by certified nursing assistants and PCS Aides through state-certified in-home care agencies (NCDMA, 1999a; NCDHHS, 2023c).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must have their need for skilled nursing or home health aide services certified as medically necessary by a physician. Their need for services provided in the home must be documented in their medical record as necessary due to one or more of the following reasons (NCDMA, 2011):

- The beneficiary would require ambulance transportation.
- The beneficiary requries assistance in leaving the home, such as with opening doors and other routine activities.
- The beneficiary is wheelchair bound with a medical condition that precludes leaving the home on a regular basis.
- The beneficiary is medically fragile or unstable.
- Leaving the home would interfere with the effectiveness of the services.

Personal Care Services

The beneficiary must have a medical condition, cognitive impairment, or disability that supports the need for hands-on assistance in either two or three ADLs depending on the level of assistance needed. A physician must authorize that personal care services are medically necessary at least once per week, and that they can be safely provided in a home-based environment. The beneficiary also cannot have a family member or informal caregiver able and willing to provide the authorized services during the times in which they are provided (NCDHHS, 2023f).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC), must have their level of care needs and Medicaid eligibility approved prior to admission to a nursing facility, and must have a physician certify continuous need for nursing facility care (NCDHHS, 2023e).

CAP/DA

The beneficiary must meet NFLOC, be at risk of nursing facility placement, and have a physician certify that their needs can safely be met in a home-based environment through CAP/DA services. They must require assistance with a minimum of two out of seven qualifying activities of daily living (ADLs) —bathing, dressing, eating, mobility, personal hygiene, toileting, and transferring —and they must require at least one CAP/DA program service, in addition to case management, in order to function in the community (NCDHHS, 2023c). The beneficiary must also have an absence of a family member, caregiver, landlord, or community resource able and willing to meet their medical, psycho-social, and functional needs (NCDHHS, 2022b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (NCDHHS, 2023d; NCDMA, 2000a; 42 CFR 484.55).

Personal Care Services

Personal care services must be reassessed and reauthorized at least annually, or more frequently if this is determined to be necessary based on the beneficiary's level of functional disability and prognosis for improvement or rehabilitation (NCDMA, 1999b; NCDHHS, 2023f).

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (NCDHHS, 2023e; 42 CFR 483.128). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (NCDHSR, 2023; 42 CFR 483.20).

CAP/DA

CAP/DA beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs (NCIM, 2003; NCDHHS 2023c).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Personal Care Services, Nursing Facility Care

There is no age requirement.

CAP/DA

The individual must be at least age 18 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary's medical record must support one or more of a list of reasons why the service must be provided through home health rather than in a physician's office, clinic, or other in-patient setting (NCDHHS, 2023d):

- The beneficiary requires assistance, such as with opening doors and other routine activities, due to a physical impairment or a medical condition, making it difficult getting to and from the physician's office, clinic, or other outpatient setting.
- The beneficiary is non-ambulatory or wheelchair bound.
- The beneficiary would require ambulance transportation.
- The beneficiary is medically fragile or unstable: travel would be detrimental to or exacerbate their health, the beneficiary is experiencing severe pain, the beneficiary should not be exposed to infection due to their medical condition, and beneficiaries recovering fro major surgeries.
- Leaving the home would interfere with the effectiveness of services: travel to outpatient services would require more than 1 hour of driving time, services are needed at frequencies that would be difficult to accomodate in a physician's office, clinic, or outpatient setting.
- The beneficiary requires training for assistive technology and home modifications.

Additionally, for skilled nursing services the beneficiary must require medically necessary skilled nursing care that can only be directly provided and monitored by a registered nurse. For home health aide services, the beneficiary must require help with personal care or with ADLs as specified in their plan of care, and services must be provided under the supervision of of a registered nurse (NCDHHS, 2023d).

Personal Care Services

In order to qualify for personal care services (PCS), the beneficiary must have a medical condition, disability, or cognitive impairment that results in unmet needs in:

- Three of the five qualifying ADLs with limited hands-on assistance;
- Two ADLs, one of which requires extensive assistance; or
- Two ADLs, one of which requires assistance at the full dependence level.

The beneficiary must also reside in a home-based private living arrangement, or in a licensed adult care or group home. The five qualifying ADLs are: bathing, dressing, mobility, toileting, and eating. See Box 8 for how a beneficiary's performance in each ADL is assessed on a five point scale ranging from totally independent to totally dependent (NCDHHS, 2023f). Up to 50 additional hours of PCS can be authorized if the beneficiary meets additional eligibility criteria, such as requiring an enhanced level of supervision, requiring environmental modifications and enhanced safety measures, or exhibiting a history of safety concerns related to inappropriate wandering or increased incidence of falls (S.L. 2013-306).

Nursing Facility Care

The beneficiary must require a Nursing Facility Level of Care (NFLOC). While North Carolina does not have a list of specific criteria to be met to satisfy NFLOC, the following qualifying conditions are listed for consideration amid a comprehensive evaluation of the resident's medical and psychosocial needs. See Box 5 for a full list of qualifying conditions and considerations that may justify NFLOC (NCDHHS, 2023e).

- Need for services that require a registered nurse for a minimum of 8 hours daily

- Need for 24-hour observation and needs assessment by a registered nurse
- Need for administration and control of medications that by law are the exclusive responsibility of licensed nurses
- Need for restorative measures to restore function or prevent a progression in disability
- Special therapeutic diets
- Nasogastric and gastronomy tubes, or respiratory therapy, requiring continued monitoring and administration
- Wounds and care of decubitus ulcers or open areas
- Cognitive disabilities impacting the beneficiary's ability to perform ADLs independently

CAP/DA

In order to qualify for the NFLOC required for entry into the CAP/DA program for home and community-based services, the beneficiary must satisfy one of 12 qualifying conditions from a list that is similar to the conditions to be considered for NFLOC in a nursing facility. See Box 9 for a full list of qualifying conditions, only one of which must be satisfied to meet the qualifying NFLOC for functional eligibility for CAP/DA program services.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary's physician, physician's assistant, or a nurse practitioner must have a face-to-face meeting to assess the beneficiary's need for home health services. Written orders that detail the medical necessity of services prescribed in a plan of care must be authorized by a physician, or by a registered nurse or physician's assistant on their behalf. The plan of care is authorized using form CMS-485, which is submitted to a state-certified home health agency for delivery and supervision of the care needed. See CMS (2023a) for a copy of the CMS-485 form. Verbal authorization provided by the physician to a home health agency can initiate care, provided that written orders are supplied within 60 calendar days. The plan of care must be recertified every 60 days to ensure services continue to be medically necessary (NCDHHS, 2023d).

Personal Care Services

A physician must first make referral for personal care services (PCS) using the DMA-3051 form also known as the PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need form, which is sent to a state-contracted independent assessment entity (IAE) and must certify:

- That the physician authorizes the IAE to perform a personal care services assessment
- The medical diagnosis and supporting information that results in unmet need for PCS assistance
- A signed and dated PCS referral request that attests to the medical necessity of the service

The IAE then conducts the initial assessment as well as annual reassessments, which can occur more frequently as needed given the beneficiary's level of functional disability and prognosis for recovery. These assessments occur in the beneficiary's home environment, and based on the outcome the number of hours and services awarded to the beneficiary are forwarded to a PCS provider who accepts the beneficiary and completes a service plan before PCS provision can begin (NCDHHS, 2023f).

Nursing Facility Care

Level of care determinations for nursing facilities are prepared by the beneficiary's attending physician using the FL-2 form, which is used to certify that a beneficiary requires a skilled nursing level of care. Once certified by a physician or an approved registered nurse, the form is submitted to a state-certified Utilization Review Contractor (URC) for final approval (NCDHHS, 2023e).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for more information on the MDS.

CAP/DA

An individual applies for CAP/DA program services at their county's lead agency. The individual's eligibility for waiver services is initially assessed and annually redetermined by an assessment team comprising one social worker from the lead agency and one registered nurse. The assessments are completed using the Service Request Form (SRF), which is a comprehensive assessment used to determine services needed and that the beneficiary meets NFLOC. Once deemed eligible, beneficiaries are placed on a waitlist administered on a first-come first-serve basis, unless they meet specific criteria that allow them to be prioritized such as if the beneficiary is transitioning from a nursing facility, is an existing CAP/DA beneficiary moving from a different county, has an active AIDS diagnosis, or is diagnosed with Alzheimer's disease or related disorder. See Table 3 for the full list of CAP/DA criteria for priority consideration. Once the beneficiary is accepted into the program, the SRF is sent to a case management entity (CME) where case managers arrange for the necessary services (NCDHHS, 2023c).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A physician must certify that the beneficiary requires medically necessary home health services and part of a written plan of care that is reviewed every 60 days. Assessments are conducted by registered nurses, who also develop the plan of care needed by the beneficiary. While services must be certified by a physician as medically necessary, authorized nurse practitioners or physician assistants can conduct assessments and authorize forms on the physician's behalf (NCGS 90-18.3; NCDHHS, 2023d).

Personal Care Services

A beneficiary is initally referred to receive personal care services (PCS) by their primary care or attending physician, who must also authorize that personal care services are medically necessary. Once the referral is made, an independent assessment entity conducts the initial assessment as well as annual reassessments of eligibility for state plan personal care services (NCDHHS, 2023f).

Nursing Facility Care

The beneficiary's attending physician at the nursing facility determines that the individual requires a nursing facility level of care (NFLOC) using the FL-2 form. This form is submitted to the Department of Social Services (DSS) via online portal, and the DSS confirms the beneficiary's functional as well as financial eligibility for state plan nursing facility care. A state-approved third-party vendor conducts the pre-admission screening and resident review (PASRR), which is submitted separately online but indicated on the FL-2 form using an identification code. NCDHHS, 2023e.

CAP/DA

Each county administers its CAP/DA program through a lead agency selected by county commissioners that can include the county Department of Social Services (DSS), a health department or agency for the aged, or a hospital located in that county. The individual's eligibility for waiver services is initially assessed by an assessment team comprising one social worker from the lead agency and one registered nurse. Once a CAP/DA slot becomes available, a state-appointed case management entity (CME) schedules an in-person visit to complete a comprehensive assessment using the Service Request Form (SRF) to determine the services needed and that the beneficiary meets NFLOC. Reassessments conducted by the CME occur annually or with a change in condition (NCDHHS, 2023c).

Benefit limitations

Can you mix LTC benefits?

All North Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, North Carolina enforces Estate Recovery. The acceptance of Medicaid in North Carolina creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for LTC services after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt is not enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, Personal Care Services, CAP/DA

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. The PNA has been $30 per month since 1987.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: North Carolina Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	66.52%
1993	65.92
1994	65.14
1995	64.71
1996	64.59
1997	63.89
1998	63.09
1999	63.07
2000	62.49
2001	62.47
2002	61.46
2003	64.04
2004	65.06
2005	63.63
2006	63.49
2007	64.52
2008	64.05
2009	74.03
2010	74.98
2011	70.64
2012	65.28
2013	65.51
2014	65.78
2015	65.88
2016	66.24
2017	66.88
2018	67.61
2019	67.16
2020	71.68
2021	73.60
2022	73.85
2023[1]	72.69
2024	66.29

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Box 1: North Carolina Medicaid Program Long Term Care Services FL-2 Form (1992-2024)

The North Carolina Medicaid Long Term Care Services (FL-2) Form gathers the following patient information in Section 16 of the form to help physicians to determine whether the beneficiary requires a skilled nursing facility level of care:

- Disoriented: Constantly, or Intermittently
- Ambulatory status: Ambulatory, Semi-ambulatory, or Non-ambulatory
- Bladder: Continent, Incontinent, Indwelling catheter, or External catheter
- Bowel: Continent, Incontinent, or Colostomy
- Inappropriate behavior: Wanderer, Verbally abusive, Injurious to self, Injurious to others, Injurious to property, or Other
- Functional limitations: Sight, Hearing, Speech, or Contractures
- Communication of needs: Verbally, Non-verbally, or Does not communicate
- Respiration: Normal, Tracheostomy, or Other
- Personal care assistance: Bathing, Feeding, Dressing, or Total care
- Activities/Social: Passive, Active, Group participation, Re-socialization, or Family supportive
- Skin: Normal, Other, Decubiti (describe), and/or Dressings
- Nutrition status: Diet, Supplemental, Spoon, Parenteral, Nasogastric, Gastrostomy, Intake and output, Force fluids, Weight, and Height
- Physician visits: 30 days, 60 days, or Over 180 days
- Neurological: Convulsions/seizures, Grand mal, Petit mal, and Frequency

Source: NCDMA, 1992b

Box 2: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to rpevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2023b)

Table 2: Historical North Carolina Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422	$633				
1993	434	652				
1994	446	669				
1995	458	687				
1996	470	705				
1997	484	726				
1998	494	741				
1999	500	751	$687	$922		
2000	513	769	696	938		
2001	531	796	716	968		
2002	545	817	739	995		
2003	552	829	749	1,010		
2004	564	846	776	1,041		
2005	579	869	798	1,070		
2006	603	904	817	1,100		
2007	623	934	851	1,141		
2008	637	956	867	1,167		
2009	674	1,011	903	1,215		
2010	674	1,011	903	1,215		
2011	674	1,011	908	1,226		
2012	698	1,048	931	1,261		
2013	710	1,066	958	1,293		
2014	721	1,082	973	1,311		
2015	733	1,100	981	1,328		
2016	733	1,100	990	1,335		
2017	735	1,103	1,005	1,354		
2018	750	1,125	1,012	1,372		
2019	771	1,157	1,041	1,410		
2020	783	1,175	1,064	1,437		
2021	794	1,191	1,074	1,452		
2022	841	1,261	1,133	1,526		
2023	914	1,371	1,215	1,644	$1,677	$2,268
2024	943	1,415	1,255	1,703	1,732	2,351

Source: SSA (2024)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2023, corresponding to the implementation of the new eligibility track under the Affordable Care Act.

Box 4: CAP/DA Priority Categories (2013-2024)

CAP/DA program applicants are generally admitted into the program or placed on a waitlist on a first-come first-serve basis. However, individuals who want to be deinstitutionalized and those in need of immediate protection from abuse, neglect, or exploitation are placed in a priority category and are expedited for immediate consideration of program participation. If there is a waitlsit in their county of residence, the following individuals are prioritized to the top of the waitlist:

- Age 18-21 transitioning from the children's CAP program (CAP/C)
- Individuals with an active AIDS diagnosis with a T-Count of 200
- Eligible approved CAP/DA program beneficiaries who are transferring to another county
- Previously approved CAP/DA program beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement
- Individuals transitioning from a nursing facility through the Money Follows the Person program
- Individuals transitioning from a nursing facility using the Community Transition program service
- Individuals identified as at risk by their local Department of Social Services who have an order of protection by Adult Protective Service for abuse, neglect, or exploitation
- An individual who is terminally ill and enrolled in the Hospice program
- Individuals with Alzheimer's Disease or related disorders

Source: NCDHHS (2013), NCDHHS (2022)

Box 5: Qualifying Conditions for Nursing Facility NFLOC (2005-2023)

The following are listed for consideration in assessing NFLOC for nursing facility care in North Carolina, and are not intended to be the only determinants of a beneficiary's need for nursing facility care. Professional judgement and a thorough evaluation of the beneficiary's medical condition and psychosocial needs are also necessary.
Qualifying conditions to be considered when assessing a beneficiary for NFLOC include the following:

- Need for services that, by physician judgement, require a registered nurse for a minimum of 8 hours daily.
- Need for 24-hour observation and assessment of resident needs by a registered or licensed practical nurse.
- Need for administration and control of medications that, according to state law, are the exclusive responsibility of licensed nurses, requiring daily observation for effectiveness and side effects.
- Need for restorative nursing measures to maintain or restore maximum function or to prevent the progression of disability, which can include: encouraging residents to achieve independence in ADLs, or training in ambulation and gait.
- Special therapeutic diets that require supervision and monitoring by a registered dietician.
- Nasogastric and gastronomy tubes requiring monitoring and observation.
- Respiratory therapy such as oxygen as a temporary, intermittent, or continuous therapy as a component of a stable treatment plan
- Wounds and care of decubitus ulcers or open areas.
- Dialysis as part of a maintenance treatment plan.
- Rehabilitative services by a licensed therapist as part of a maintenance treatment plan.
- Diabetes, when daily observation of dietary intake and medication administration is required for proper control.
- Cognitive disabilities impacting the ability of a resident to independently perform ADLs, resulting in the need for hands-on assistance.

Conditions when in combination may justify NFLOC include the following:

- Need for teaching and counseling: related to a disease process, disability, diet, or medication.
- Adaptive programs: training a resident to reach their maximum potential (e.g. bowel and bladder training or restorative feeding).
- Ancillary therapies: supervision of resident performence of procedures taught by physical, occupational, or speech therapists.
- Injections: requiring administration and professional judgement by a licensed nurse.
- Treatments: temporary cast, braces, splint, hot or cold applications, or other interventions requiring nursing care and direction.
- Psychosocial considerations: including age, length of stay, location and condition of spouse, proximity of social support, effect of transfer on resident, or acute psychological symptoms.

Source: NCDMA (2005), NCDHHS (2023e)

Box 6: Qualifying Conditions for CAP/DA Skilled Nursing Level of Care (2012-2016)

Requirements for Skilled Nursing Level of Care for CAP/DA program entry can include the need for any of the following:

- Performance of direct services that require supervision of a registered or licensed practical nurse.
- Observation and assessment of recipient needs by a registered nurse or licensed practical nurse: The licensed nursing services should be intensive and directed to an acute episode or a change in the treatment plan that would require such concentrated monitoring.
- A stabilization period if the recipient's medical condition declines.
- Teaching, as part of an active treatment requiring a licensed nurse.
- Treatment due to unplanned weight loss. The weight loss must be significant clinically and in relation to the recipient's total body mass.
- Intensive rehabilitative services ordered by a physician and provided at least 5 times per week, not to exceed 6 weeks, by a licensed physical, occupational, or speech therapist.
- Administration and/or control of medication as required by state law to be the exclusive responsibility of licensed nurses.
- Nasogastric/gastrostomy feedings requiring supervision and observation by licensed nurses.
- Respiratory therapy including monitoring needs or careful regulation of flow rate of oxygen, or nasopharyngeal/tracheal suctioning.
- Isolation, when medically necessary as a limited measure because of contagious or infectious disease.
- Wound care of open areas which are infected, extensive, or chronic, or decubitus ulcer.
- Treatment due to uncontrolled diabetes, requiring daily administration of insulin and monitoring of blood glucose levels, or involving frequent hypoglycemic episodes requiring IV or oral intervention.

The following factors, while alone may not justify a skilled level of care, can in combination justify the level of care requried for program entry. The determination requries careful judgment on the part of the authorizing physician:

- Frequent laboratory procedures when intimately related to medication administration, e.g. monitoring anticoagulants, arterial blood gas analysis, or PRN blood sugars.
- Injections or medications requiring frequent/routine administration by a licensed nurse.
- Treatments or prcedures requiring observation, evaluation, and assistance by skilled personnel for proper use or the recipient's safety, e.g. oxygen, hot packs, hot soaks, catheterizations, etc.
- Mental and behavioral problems requiring treatment or observation by skilled professional personnel to the extent deemed appropriate for a nursing facility.
- Dialysis, either as hemodialysis or peritoneal dialysis as part of a maintenance or treatment plan, or as new dialysis during a stabilization period not to exceed four weeks.

Source: NCDHHS (2012)

Box 7: State Plan Personal Care Services (2021-2024)

Medicaid covers any of the following personal care services at least once per week, providing assistance with one of five qualifying activities of daily living (ADLs) —bathing, dressing, mobility, toileting, and eating:

- Hands-on assistance to address unmet needs with qualifying ADLs
- Set-up, supervision, cueing, prompting, and guiding, when provided as part of the hands-on assistance with qualifying ADLs
- Assistance with home management Instrumentals of Daily Living (IADLs) that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's care at home
- Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment
- Assistance with adaptive or assistive devices when directly linked to the qualifying ADLs
- Assistance with the use of durable medical equipment when directly linked to the qualifying ADLs
- Assistance with special assistance (assistance with ADLs that requires a nurse aide) and delegated medical monitoring tasks

Source: NCDHHS (2023e)

Box 8: ADL Performance Impairment Criteria for Personal Care Services (2013-2024)

The five qualifying ADLs are: bathing, dressing, mobility, toileting, and eating.

The beneficiary's dependence in each ADL is assessed based on their ability to perform the task as follows:

- 0. Totally independent: The beneficiary is able to self-perform 100 percent of the activity, with or without aids or assistive devices, and without moitoring or assistance setting up supplies and environment.
- 1. Needs verbal cueing or monitoring only: The 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: The 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: The beneficiary is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity.
- 4. Full Dependence: The beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity

Source: NCDHHS (2023)

Box 9: Qualifying Conditions for CAP/DA NFLOC (2017-2024)

One of the following twelve criteria must be met for a beneficiary to be eligible for CAP/DA program services. For item number twelve, either two or more conditions from Category I or one or more conditions from both Category I and II must be satisfied to establish CAP/DA NFLOC:

- Need for services that, by physician judgement, require the supervision of a registered or licensed professional nurse.
- Nursing services that must be intensive and directed to an acute episode or a change in the treatment plan that requires concentrated monitoring.
- Restorative nursing measures used to maintain or restore maximum function or to prevent advancement of progressive disability. These can include: a coordinated plan that assists the beneficiary in achieving independence in activities of daily living, use of preventive measures or devices to prevent or delay the development of contractures, ambulation and gait training, or assistance with transferring so the beneficiary would not necessarily require skilled nursing care.
- Dialysis as part of a maintenance treatment plan.
- Treatment for a specialized therapeutic and physician-prescribed diet.
- Administration or control of medication as required by state law to be the exclusive responsibility of a licensed nurse.
- Nasogastric or gastrostomy feedings requiring supervision and observation by a registered or licensed professional nurse.
- Respiratory therapy, including use of oxygen as a temporary, intermittent, or continuous therapy as part of a stable treatment plan.
- Isolation when medically necessary due to a contagious or infectious disease.
- Wound care of decubitus ulcers or open areas.
- Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan
- Either two or more conditions in Category I or one condition from both Category I and II as follows:
  - Category I (Either two or more, or at least one in combination with one from Category II):
    - Ancillary therapies: supervision of a beneficiary's performance in procedures taught by a physical, occupational, or speech therapist.
    - Chronic recurrent medical problems that require daily observation by licensed personnel for prevention and treatment.
    - Blindness
    - Injections requiring administration or professional judgement by a registered or licensed professional nurse.
    - Diabetes, with daily observation of dietary intake or medication administration required for proper physiological control.
    - Treatments, including temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.
    - Frequent falls due to physical disability or medical diagnosis.
    - Behavioral problems or symptoms due to cognitive impairment and depressive disorders such as wandering, verbal disruptiveness or aggression, physical aggression, or inappropriate behavior.
  - Category II (One or more conditions from both Category I and II):
    - Need for teaching and counseling related to a disease process, disability, diet, or medication.
    - Adaptive programs: re-training the beneficiary to reach their maximum potential; documentation must report the purpose of training and document progress.
    - Psychosocial determinants of health such as: acute psychological symptoms, age, length of stay, location and condition of spouse or primary caregiver, proximity and availability of social support, and effect of transfer on the individual.

Source: NCDHHS (2023c)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Alternate Living Services (ALS): ALS homes provide 24-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home. Residents are responsible for covering room and board.

Area Agency for the Aged (AAA): Area Agencies for the Aged (AAAs) comprise a nationwide network of nonprofit organizations that serve older adults aged 60+ in each agency's locality. AAAs are state-based agencies that typically serve a geographic area of several neighboring counties. They receive federal funding authorized under the Older Americans Act to provide assistance and access to resources with a focus on the most vulnerable, with most agencies supplementing this funding with additional state or local funds.

CAP/DA Lead Agency: CAP/DA lead agencies are selected by each County Board of Commissioners to administer the CAP/DA program in each of North Carolina's 100 counties. CAP/DA lead agencies can be the county's Department of Social Services, a health department, an agency for the aged, or a hospital located in that county. The lead agency is typically responsible for eligibility assessments and case management, with lead agency registered nurses and social workers serving as case managers. In some cases the lead agency contracts with a separate organization to conduct program administration and oversight (called "contractual lead agencies").

Community Alternatives Program for Disabled Adults (CAP/DA): The Community Alternatives Program for Disabled Adults (CAP/DA)

is North Carolina's 1915(c) waiver program providing home and community-based services to older adults, as well as to younger adults with physical disabilities.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized.

County Departments of Social Services (DSS): County Departments of Social Services (DSS) administer a range of programs that provide financial assistance and social services to individuals and families. In some counties, the DSS administers the CAP/DA program providing home and community-based services to older adults.

Department of Human Resources: The Department of Human Resources, created in 1971, was responsible for administering North Carolina's Medicaid program until it was renamed the Department of Health and Human Services in 1997.

Department of Health and Human Services: The Department of Health and Human Services has administered North Carolina's Medicaid program since 1997, when it was created by combining a number of state departments including the Department of Human Resources, the Department of Public Welfare, the Department of Public Health, and the Department of Mental Health.

Division of Medical Assistance (DMA): The DMA was created within the Department of Human Resources (DHR) in 1978 to administer North Carolina's Medicaid program. It was moved under the Department of Health and Human Services (DHHS) in 1997 when the DMA was reorganized and combined with a number of other departments to become the DHHS.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries group. Instead, 209(b) states impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Family Caregiver Support Program: Services available to caregivers include trainings and education services as well as reimbursable services such as respite care, home modifications, and durable goods and medical supplies.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP for medical assistance is computed from a formula that

takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Home and Community Care Block Grant (HCCBG): Effective July 1, 1992, the North Carolina General Assembly established a Home and Community Care Block Grant for Older Adults to streamline and enhance the provision and coordination of in-home and community-based services for older adults. Older Americans Act block grants fund approximately 45 percent of the HCCBG through Area Agencies on Aging, which administer county programs on aging through grant agreements with Boards of County Commissioners and community service providers. Services provided through this program vary by county, and can include home delivered meals, adult day health care, congregate nutrition, home health services, housing and home improvement, senior companion services, health screenings, institutional respite, care management, and transportation services.

Homebound: An individual is considered homebound if they have a condition due to illness or injury that makes leaving the home medically inadvisable.

In-Home Care for Adults (IHCA): Between 2011-2012, the personal care services benefit for individuals age 21 or older was renamed In-Home Care for Adults (IHCA), with new eligibility standards and service restrictions. After 2012 IHCA was once again renamed personal care services, keeping the same eligibility standards and service limitations while being reorganized under 1915(i) state plan amendment authority.

Intermediate/Heavy care facility: A facility licensed to provide intermediate care on a 24-hour basis to individuals who do not require the degree of care and treatment provided in a skilled nursing facility, but who because of a mental or physical disability require nursing and related health and medical services in the context of a planned program of health care and management.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Level of Care Assessment (LOCA): An assessment instrument used until 2014 to determine if an applicant for Aging Waiver services was nursing facility clinically eligible (NFCE).

Level of Care Determination (LCD): An assessment instrument used between 2014-2018 to determine if an applicant for Aging Waiver home and community-based services was nursing facility clinically eligible (NFCE).

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration

of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Medicare: Federal health insurance program for people ages 65 and over, as well as certain people under 65 with a long-term disability, that helps pay for medical care services regardless of income, medical history, or health status. Medicare covers skilled nursing facility stays and some home health visits, but benefits are subject to a deductible and do not cover extended home health visits required for long-term care needs.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes. In 2018, an assessment instrument adapted from the MDS-home care (MDS-HC) was implemented for the Community HealthChoices program. The MDS-HC is a globally standardized assessment system for home care that is compatible with national MDS standards for nursing facilities, allowing for a more integrated assessment system across long-term care programs.

Money Follows the Person (MFP): A federal Medicaid program designed to move elderly nursing homes residents out of nursing homes and back into their own homes or the community.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility. Between 2011-2012, this benefit was temporarily renamed and referred to as In-Home Care for Adults (IHCA).

Personal Care Services-Plus (PCS-Plus): PCS-Plus is an enhancement to the PCS benefit implemented between 2003-2010 for beneficiaries with personal care needs that exceed the 60 hour monthly service limit for PCS. If beneficiaries meet the more stringent eligibility criteria, they are able to access an additional 20 service hours of PCS per month.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by

institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-Inclusive Care for the Elderly: A federally authorized program that provides comprehensive medical and social services to elderly individuals requiring a nursing facility level of care. PACE programs are typically provided under Medicare, however states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. Enrollment in PACE programs is typically capped at a relatively low number of participants.

Protected Income Level (PIL): The income limit Medically Needy applicants must spend down to meet. Federal rules require PILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level in effect as of July 16, 1996.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Section 1115 Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Section 1915(b) Waiver: Section 1915(b) of the Social Security Act gives the Secretary of HHS the authority to approve programs that allow states to modify their Medicaid delivery systems, enrolling beneficiaries in managed care plans that may utilize a central enrollment broker and that may limit the provider network. Savings from these programs can be used to provide additional non-Medicaid services to beneficiaries. 1915(b) waivers can be combined with 1915(c) waivers to provide home- and community-based services.

Section 1915(c) Waiver: Section 1915(c) of the Social Security Act gives the Secretary of HHS the authority to approve programs allowing states to offer home- and community-based services to Medicaid beneficiaries who need long-term care and who would otherwise be institutionalized. The program waives Medicaid comparability requirements, meaning that states can tailor the services to specific groups of enrollees and their needs.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Disability Insurance (SSDI) : Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In North Carolina, the community spouse is allowed to keep half of the couple's combined income, capped between the federally determined maximum and minimum Monthly Maintenance Needs Allowance (MMNA), which was $985-$1,718 in 1992 (NCDMA, 1992a).

2. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $13,740-$68,700 in 1992 (NCDMA, 1992a). In North Carolina, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

3. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, insome circumstances, to their sibling or adult child (KFF, 1999).

4. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).

5. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023c) for more information on these requirements.

6. Most states receive federal funding authorized by the Older Americans Act for local elderly assistance programs, but these are typically much smaller in funding and scope than Medicaid LTC benefits so they are not outlined in detail in these policy documents. They may be developed further in future research.

7. In North Carolina, the State Supplementary Payment (SSP) for Supplemental Security Income (SSI) recipients is a state supplement intended to augment SSI and help pay for room and board for aged, blind, and disabled residents of adult care homes. North Carolina's SSP is referred to as State/County Special Assistance (SA), and is funded by 50% county dollars and 50% state dollars. See 10A NCAC 71P.0804 for more.

8. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In North Carolina, the community spouse is allowed to keep half of the couple's combined income, capped between the federally determined maximum and minimum Monthly Maintenance Needs Allowance (MMNA), which was $1,254-$1,871 in 1995 (NCDMA, 1995).

9. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $14,964-$72,820 in 1995 (NCDMA, 1995). In North Carolina, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

10. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999). In 2006, the Deficit Reduction Act extended the look back period to 60 months for all assets.

11. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In North Carolina, the community spouse is allowed to keep half of the couple's combined income, capped between the federally determined maximum and minimum Monthly Maintenance Needs Allowance (MMNA), which was $1,382-$2,049 in 1999 (NCDMA, 1999).
13. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $16,392-$81,960 in 1999 (NCDMA, 1999). In North Carolina, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.
14. The look back period is 60 months prior to the date of application for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child.
15. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In North Carolina, the community spouse is allowed to keep half of the couple's combined income, capped between the federally determined maximum and minimum Monthly Maintenance Needs Allowance (MMNA), which was $1,382-$2,049 in 2023.
16. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $16,392-$81,960 in 2023. In North Carolina, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.
17. Our team has submitted a Freedom of Information Act (FOIA) request to the North Carolina Department of Health and Human Services Office of Communications. The requested documents will provide information on the CAP/DA program for the 1992 and 1995 chapters, as well as additional eligibility information for state plan and CAP/DA services in multiple chapters. Until then, these sections have missing information.

Version information

Current Version: 1.0 (March 2024)

Version History

- 1.0 (March 2024): First version.