DISABILITY RIGHTS
NORTH CAROLINA

Champions for Equality and Justice

North Carolina General Assembly Legislative Updates

Senate Bill 744

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Overview

- Medicaid Reform
- Changes to State/County Special Assistance
- Public Guardianship
- Personal Care Services

MEDICAID REFORM

Medicaid Reform Generally

- The House and Senate were unable to agree on a plan, although changes to the state's Medicaid Program are inevitable
- Both plans place a large emphasis on budget predictability moving forward—each plan differs on how to achieve this
- The previously proposed November Special Session will not happen

Senate Plan

- This plan would result in greater change to who is managing our state's Medicaid funds than the House plan.

Key Distinctions:

- Provider-led and commercial managed care organizations would compete for enrollees (privatization)
- Full-capitation by 2018
- Divides the state into regions where more than one Medicaid program could be offered
- Integration of physical and behavioral health by 2016
- Removes oversight of Medicaid Program from within DHHS to a separate agency
  - Replaces Division of Medical Assistant with the Department of Medical Benefits run by a seven-member board of directors

House Plan

- This plan for reform has been favored and supported by Governor McCory and DHHS

Key Distinctions:

- Adds public, provider-led, Accountable Care Organizations to manage physical health services
  - Allows for the preservation of the current LME/MCO structure
  - ACOs would be responsible for working with the MCOs with a consumer that needed services on both the physical and behavioral sides with oversight from DHHS
- Full capitation by 2020
- Keeps oversight of Medicaid Program inside of DHHS
- Integrating of physical and behavioral health would be studied

Medicaid Appeals

SECTION 12H.27.(a)-(c)

- Amends appeals related to non-LME/MCO decisions
- Shifts the burden of proof to the recipient in all appeals
- Clarifies that in all appeals where a recipient accepts an offer to mediate and then does not attend the mediation without good cause recipient shall have their appeal dismissed.
- Shifts the burden of proof in provider appeals to the provider.

STATE/COUNTY SPECIAL ASSISTANCE PROGRAM

SECTIONS 12D.1.(a)-(h), 12H.38.(a)-(d)

Current Standard to Receive SA

- Over 65 years old

OR

- Between the ages of 18 to 65 and is permanently or totally disabled or is legally blind

AND

- Had insufficient income or resources to provide a reasonable subsistence compatible with decency and health.

Income-Related Changes to SA

Prior Standard:

- Insufficient income or resources to provide a reasonable subsistence

Legislative Change:

- Reduces SA eligibility to those individuals whose income is, at or below, 100% of the Federal Poverty Level (FPL)

- Based on the 2014 FPL Guidelines released by the U.S. Dept. of Health and Human Services, for a household of one to qualify for SA, his/her income would have to be equal to or less than:
  - $11,670 per year
  - $972.50 per month

Residency-Related Changes to SA

Prior Standard:

- An individual could use a relative's address to establish residency in NC and could immediately start receiving SA upon their arrival in the state

Legislative Change:

- An individual must be a resident of NC for at least 90 days immediately prior to receiving SA

SA and Medicaid Eligibility

Prior Standard:

- SA eligibility and Medicaid eligibility were coupled together
- Recipients of SA are automatically deemed eligible for Medicaid without regard for the presence of a qualifying disability or income level

Legislative Change:

- If DHHS wants access to funds within the Medicaid Contingency Reserve, for budget overruns, they will be required to submit a state plan amendment to CMS to decouple Medicaid eligibility from SA eligibility
- SA recipients will no longer be able to automatically qualify for Medicaid just because they are receiving SA

"Grandfather" Clauses for SA Eligibility

- Any individual who is receiving or becomes eligible to receive benefits under the SA program, prior to November 1, 2014, will not be affected by any of the new eligibility provisions and will be able to continue receiving SA—even if they do not meet the new eligibility criteria

- Allows Medicaid recipients who are approved to receive SA benefits, up until 30 days after CMS approval of the state plan amendment (effective date of income-related changes), to retain their eligibility for Medicaid after the changes go into effect

- These changes must be approved by the Centers for Medicare and Medicaid Services (CMS)

Effective Date of Changes to SA

- Some of the changes to SA may never happen
  - The income-related changes as well as the "grandfather" clauses are contingent on CMS approval of the Medicaid State Plan Amendment
  - The state plan amendment, requesting approval of these changes, will be submitted to CMS by October 31, 2014
  - If approved by CMS, changes would go in effect within 30 days
- The residency-related changes do not require CMS approval, and will take effect on November 1, 2014

PUBLIC GUARDIANSHIP

SECTIONS 12D.3.(a)-(d), 12D.4.(a)-(b)

Public Guardian Complaints

- Directs DHHS and the Administrative Office of the Courts to develop a plan regarding the Department's evaluation of complaints pertaining to wards under the care of publicly funded guardians in order to ensure that, in addition to current requirements, the complaint process should incorporate a face-to-face observation of the ward, an interview with the ward, or both.

- Requires that an individual with experience in understanding the unique needs and abilities of the ward be assigned to conduct the observation or interview

- A report of the findings and recommendations are due by October 1, 2014

Alternatives to Public Guardianship

Directs DHHS continue using existing protections concerning guardians as paid service providers, but to also consult with Clerks of Court, MCOs, Elder Law Associations, State Bar Association to study and develop:

- Model plans for transitioning a ward to an alternative guardianship arrangement when an individual guardian of the person becomes unable or unwilling to serve
- The intent of the study is to focus on ways to prevent and reduce the reliance on the appointment of public guardians
- A report of the findings and recommendations are due by October 1, 2014

Conflicts of Interest

- Directs DHHS to continue to study whether it is reasonable to allow guardians to also be a paid direct-care provider, as long as there is a utilization of care coordination services to provide oversight

- A report of the findings and recommendations are due by October 1, 2014

Status Report Changes

- Applies only to corporate and public guardians

Requirements of the status report:

- Information regarding residence, education, employment, and rehabilitation/habilitation
- Efforts by guardian to restore competency, seek limited or alternative guardianship
- Recommendations for implementing a more limited guardianship, preserving for the ward the opportunity to exercise rights that are within the ward's comprehension and judgment.

PERSONAL CARE SERVICES

SECTION 12H.10.(a)–(c)

Personal Care Services (PCS)

PCS Management:

- Directs DMA to propose a financial plan by March 1, 2015, to contain the budget growth of PCS and to keep the total PCS budget at the same level as the fiscal year 2014-2015 certified budget for PCS.
- Authorizes the HHS Oversight Committee to engage an outside contractor to study issues related to reforming and redesigning PCS while meeting the State's obligations under the ADA and *Olmstead*.

PCS Study Optional Program:

- Allocates $300,000 to contract for a study to define a new limited PCS optional service program
- DHHS will also study and report on Adult Care Home inspections, procedures and processes
- Findings from the study are due December 1, 2015.

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