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Final Report of the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care

November 5, 2008

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Executive Summary

The 123rd Legislature established the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care through the passage of LD 2052 and enactment of Resolve 2007, Chapter 209. The Blue Ribbon Commission to Study the Future of Home-based and Community-based Care was formed to address the needs of Maine's increasingly elderly population.

Pursuant to the resolve, 11 members were appointed to the Commission by the Governor, President of the Senate and Speaker of the House of Representatives. On July 30, the Legislative Council approved a request by Representative Margaret Craven, the House Chair of the Commission, to authorize the Commission to increase the number of meetings from 4 meetings to 6 meetings. The Executive Director of the Legislative Council provided notice on September 10 that the Legislative Council had accepted a contribution of outside funding sufficient to fund the work of the Commission.

The resolve charged the Commission with the following duties:

- Examine and make recommendations on the development of choices to meet unmet needs and financing options to ensure access to and affordability of long-term home-based and community-based care;

- Create a coherent blueprint to ensure the sustainability of long-term home-based and community-based care options that provide choice and quality for the State's elderly and disabled citizens, many of whom are eligible for home-based and community-based care services and are not receiving them, forcing them into more costly institutional care; and

- Submit a report to the First Regular Session of the 124th Legislature no later than November 5, 2008 that includes the findings of the Commission and recommendations, including suggested legislation.

The Blue Ribbon Commission to Study the Future of Home-based and Community-based Care held 5 meetings on September 12 and 22 and October 9, 20 and 28. All meetings were open to the public and were broadcast by audio transmission over the Internet. Most of the meetings included opportunities for the public to address the Commission.

The Commission makes the following findings and recommendations, with one abstention:

Findings and Recommendations

- **Finding #1**: The Commission recommends that the State adopt a vision that Maine's system of long-term services and supports should optimize the physical health, mental health, functional well-being and independence of older adults and adults with physical disabilities through high quality services and supports that are provided in settings that reflect the needs and choices of the consumers and that are delivered in a manner that is flexible, innovative and cost-effective.

- **Recommendation #1**: The Commission recommends that the current statutory language in 22 MRSA § 7301, which summarizes the State's findings and policies for in-home and community support services for adults with long-term care needs, should be amended to include a new vision statement that highlights support for a system that optimizes the physical health, mental health, functional well-being and independence of older adults and adults with physical disabilities through high quality services and supports that are provided in settings that reflect the needs and choices of the consumers and that are delivered in a manner that is flexible, innovative and cost-effective.

- **Finding #2**: The Commission supports the development of a proposal for a unified budget for long-term care to facilitate coordinated planning and allow the transfer of funds among programs to ensure that programs are serving individuals in their preferred setting:
  - **Recommendation #2**:The Commission recommends directing the Commissioner of Health and Human Services, and Commissioner of Administrative and Financial Services and the Office of Fiscal and Program Review to prepare a revised chart of accounts that will concentrate all long-term care accounts for the elderly and adults with physical disabilities in the Office of Elder Services, including program and administrative costs even in the OES Central Office, into one set of accounts, excluding the Office of MaineCare services, mental health, mental retardation and developmental disabilities services, that will be complimentary to the State's vision for a consumer-centered approach. The Commissioner of DHHS and DAFS must provide a report and a proposal for a unified budget, that can be implemented by July 1, 2010, by January 1, 2010 to the joint standing committees having jurisdiction over health and human affairs and appropriations and financial affairs.

- **Finding #3:** The Commission supports funding home and community-based services that respect individual choice and flexibility within the long-term care system and that provide more individuals with the ability to receive services in settings of their own choice in a cost-effective and person-centered manner.
  - **Recommendation #3:** The Commission recommends that the Department of Health and Human Services make it a priority to reduce the waiting list for home and community-based care and homemaker services this year as part of the FY 09-10 budget, and to eliminate the waiting lists in their entirety no later than the end of the FY 2010-11 biennium.

- **Finding #4:** The Commission finds that the work of the volunteers for the Meals on Wheels and medical ride transportation programs is valuable in supporting the ability for many elderly to choose home and community-based services in Maine.
  - **Recommendation #4**: The Commission recommends an increase in funding for the Priority Social Services program (services including Meals on Wheels transportation and medical ride transportation) by $500,000/year to address the rising costs for these volunteers across the State. This recommendation is qualified by a statement from Commission members that they are committed to working towards finding funding sources for the recommendation.

- **Finding #5:** The Commission supports the work of the Aging and Disability Resource Centers (ADRC's) and recognizes that they have suffered a loss in federal funding that will critically impact their ability to continue providing valuable services.
    - **Recommendation #5:** The Commission recommends providing funding for the 3 Area Agencies on Aging that had federal funding for ADRC's and the 2 other Area Agencies on Aging that wish to operate ADRC's in the total amount of $300,000 per year. As a condition of the ADRC's obtaining this funding, the Commission would require the ADRC's to work with hospitals, nursing facilities and residential care facilities to improve the discharge planning process to explore home and community-based options to the fullest extent possible. This should include improving the provision of information to the consumer, improving consumer choice in the discharge process, increasing consumer counseling for those choosing self-directed care, and education on the availability of hospice services where they may be appropriate. The commission also encourages hospitals and DHHS, through Goold Health Systems medical eligibility assessment, to work together to improve the discharge process and counseling for home and community-based options in a manner similar to the ADRC's. The Commission recommends reports back from DHHS to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services 1 and 2 years from the appropriation of the new funding.

- **Finding #6:** The Commission supports continuing the family caregiver project that was undertaken in 2007-2008 as a demonstration project by the Area Agencies on Aging.
    - **Recommendation #6:** The Commission recommends funding the family caregiver project for $200,000 per year. This recommendation is qualified by a statement from Commission members that they are committed to working towards finding funding sources for the recommendation.

- **Finding #7:** The Commission recognizes the value in assistive technology in supporting home and community-based long-term care.
    - **Recommendation #7**: The Commission recommends that the Department of Health and Human Services explore uses of and develop funding sources for assistive technology to help accomplish the State's vision.

- **Finding #8**: The Commission recommends that the Department of Health and Human Services continue to support the 7 tax credit assisted assisted-living projects that include assisted living service packages funded by MaineCare.
    - **Recommendation#8:** The Commission recommends directing the Department of Health and Human Services to explore alternative non-Medicaid sources of funding for the 7 tax credit-assisted assisted living programs, if it becomes necessary, to ensure that these programs survive.

- **Finding #9:** The Commission supports adequate training and fair compensation and benefits for direct care workers in home and community-based care through agencies and in self-directed care and in residential care facilities and nursing facilities.
    - **Recommendation #9:** The Commission recommends directing the Department of Health and Human Services to work with interested parties to develop a comprehensive and systematic approach to reimbursement, health benefits and training for direct care workers in home and community-based, residential facilities and nursing facilities and to report back to the joint standing committees having jurisdiction over health and human services and appropriations and financial affairs by December 1, 2009.

- **Finding #10:** The Commission supports reversing the spending trend in long-term care to increase the numbers of people served and dollars expended in home and community-based care as compared to residential facility and nursing facility care.
    - **Recommendation #10:** The Commission recommends directing the Department of health and Human Services to report annually on its progress in reversing the spending trend to the joint standing committees having jurisdiction over health and human services and appropriations and financial affairs beginning January 15, 2010.

I. INTRODUCTION

The Blue Ribbon Commission to Study the Future of Home-based and Community-based Care was established through the passage of LD 2052 and enacted as Resolve 2007, Chapter 209. Pursuant to the resolve, 11 members were appointed to the Commission by the Governor, President of the Senate and Speaker of the House of Representatives. On July 30, the Legislative Council approved a request by Representative Margaret Craven, the House Chair of the Commission, to authorize the commission to increase the number of meetings from 4 meetings to 6 meetings. The Executive Director of the Legislative Council provided notice on September 10 that the Legislative Council had accepted contribution of outside funding sufficient to fund the work of the Commission.

The duties of the commission are set forth in the resolve as follows:

- Examine and make recommendations on the development of choices to meet unmet needs and financing options to ensure access to and affordability of long-term home-based and community-based care;

- Create a coherent blueprint to ensure the sustainability of long-term home-based and community-based care options that provide choice and quality for the State's elderly and disabled citizens, many of whom are eligible for home-based and community-based care services and are not receiving them, forcing them into more costly institutional care; and

- Submit a report to the First Regular Session of the 124th Legislature no later than November 5, 2008 that includes the findings of the Commission and recommendations, including suggested legislation.

II. COMMISSION PROCESS

The Blue Ribbon Commission to Study the Future of Home-based and Community-based Care held meetings on September 12 and 22 and October 9, 20 and 28. All meetings were open to the public and were broadcast by audio transmission over the Internet. Most of the meetings included opportunities for the public to address the Commission.

At the first meeting of the Commission, on September 12th, Diana Scully, Director of the Office of Elder Services in the Department of Health and Human Services presented background information on Maine's long-term care system. Julie Fralich of the University of Southern Maine, Muskie School of Public Policy presented information on the long-term care needs assessment model and projection model. Dr. Kevin Mahoney of Boston College Graduate School of Social Work presented information on consumer-centered systems and long-term care public-private partnerships.

The second meeting of the Commission began with discussion of the duties of the Commission. Commission member Linda Samia of the University of Southern Maine, College of Nursing and Health Professions, presented information on evidence-based programs in long-term care,

specifically the Healthy Aging programs. Romaine Turyn of the Office of Elder Services in the Department of Health and Human Services provided information on the development and implementation of an evidence-based Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) program for caregivers of persons with dementia. Maureen Booth of the University of Southern Maine, Muskie School of Public Service, presented information on home and community-based Medicaid waivers, the Maine waiver programs and federal requirements to ensure the high quality of services provided under Medicaid waiver programs.

The third Commission meeting included a teleconference with John Wren and Gregory Case, United States Department of Health and Human Services, Administration on Aging, addressing federal issues in long-term care and options for the states. Valerie Sauda, Eastern Agency on Aging, spoke on Maine's experience with Aging and Disability Resource Centers. Pamela Allen from Elder Independence of Maine and Seniors Plus presented an overview of services provided by the Area Agencies on Aging.

During the fourth Commission meeting briefings were presented by Janice Daku on the Maine Keeping Seniors Home program and Dennis Fitzgibbons on Alpha One and its services, including advocacy, information and referral, skills training, peer support and administration of consumer-directed personal assistance services programs. Noelle Merrill, Eastern Agency on Aging, provided information on affordable assisted living, Diana Scully, the Department of Health and Human Services, Office of Elder Services, spoke to what Maine needs in long-term care and Brenda Gallant, Long-term Care Ombudsman, presented the consumers' perspectives. Lisa Alecxih, from the Lewin Group, provided information on home and community-based initiatives in other states and spoke of the challenges facing Maine. Paul Saucier, Muskie School of Public Service, University of Southern Maine, briefed the Commission on Medicaid managed care in other states, managed Medicare services and opportunities for Maine. At the end of the meeting Commission members discussed adopting a vision statement, statements of core principles and specific strategies to further the vision statement and core strategies.

The fifth and final meeting of the Commission was devoted largely to discussion among Commission members. Diana Scully presented information from the Office of Elder Services, Department of Health and Human Services, including the information and referral process that starts with the Area Agencies on Aging and Aging and Disability Resources Centers and the medical eligibility assessment performed under DHHS contract by Goold Health Systems. She also presented a chart showing MaineCare funded long-term care services and state only General Fund funded long-term care services. Commission members discussed the failure of the State to live up to the policy statement in Title 22 Maine Revised Statutes section 7301 and discussed updating the statute to incorporate the vision of the commission for the home and community-based long-term care system. Commission members discussed proposals for recommendations and adopted recommendations set forth in section IV of this report. Finally the commission opened the meeting for presentations by members of the public. Testimony was presented and questions were answered by Nancy Kelleher, AARP, Joyce Gagnon and Roy Gedat, Maine PASA, Noelle Merrill, EAA, Rick Erb, Maine Health Care Association and Vicki Purgavie, Home Care and Hospice Alliance of Maine.

III. HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES

A. OVERVIEW

Maine's population of elderly persons and adults with disabilities have a strong preference for living in their communities and for maintaining their independence and their good health. They need access to health care, they are concerned about healthy and affordable food, fuel costs and transportation. They are concerned about the wages that their caregivers are paid and the need for increased hours of home care staff and home health services.[1] These consumers of long-term care are among the millions nationwide who receive assistance from the formal, paid long-term care system and from the informal, unpaid system. Although nationally three quarters of the persons who are elderly and adults with disabilities receive assistance only from the informal, unpaid help of family and unpaid caregivers,[2] and in Maine 136,569 families provided care for family members and friends,[3] this report will focus on the formal, paid portion of long-term care, specifically the portion for which reimbursement is paid through the Medicaid program.

Long-term care for elders and adults with disabilities includes residential, hospital and institutional services, daily living services, clinical care and treatment, financial and material supports, and coordination services.[4] Together this broad array of care and services provides the supportive system for elders and adults with disabilities so that they may live safely and affordably in a setting appropriate to their needs and of their own choice, maintaining family and community connections and the friendships that they have built over the years.

- Within the category of hospital and institutional services are nursing facilities, general and psychiatric hospital services, and residential care services.

- Within the category of residential services are residential options, including assisted living, congregate housing, adult family care homes, and supportive housing services, ranging from daily living services to clinical services.

- Within the category of daily living services are home and community-based services including: personal assistance, adult day health, homemaker, handyman/chore services, respite, transportation and environmental modifications.

- Within the category of clinical care and treatment are nursing services, physical, occupational and speech therapies, rehabilitation services, mental health treatment, hospice services and medication management.

- Within the category of financial and material services are nutrition services, food programs, rental assistance, and income support services.

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[1] "Survey of Maine People Receiving Home-Based Services," presented by Brenda Gallant, Long-term Care Ombudsman, October 20, 2008.
[2] "A Balancing Act: State Long-Term Care Reform," AARP Public Policy Institute, July 2008, page 1.
[3] "The Consumer Perspective," presented by Brenda Gallant, Long-term Care Ombudsman, October 20, 2008.
[4] Categories of Long Term Care and Support Services and Range of Potential Needs of Elders and Adults with Disabilities, Muskie School of Public Service, September 10, 2008.

- Within the category of coordination of services are adult protective services, care coordination and home care coordination services.

The broad array of residential care and services, supports and programs for elders and adults with disabilities has grown over the past 20 years to include more home and community-based services and more involvement in the decisions and management of care by consumers and their families. Policy and funding decisions have re-focused nursing facility care to serve consumers who are the most medically needy, frail and disabled as a result of Alzheimer's and other dementias. Hand-in-hand with this re-focusing, home and community-based services and supports and residential services have been encouraged and funded.

State budget pressures and the loss of some sources of federal funding recently have increased the pressure on agencies to tightly manage programs and services. Some programs have decreased the number of hours of service per month that a consumer qualifies for under the program. Consumer programs that identify and combat depression and other mental illness have begun. Participation has grown in programs to educate and involve consumers in wellness, prevention, healthy lifestyles and strategies for healthy aging. Efforts to safeguard the high quality of long-term services and supports continue and will include a focus on evidence-based services.

The State's plan for services for the elderly and persons with disabilities is set forth clearly in the State Plan on Aging for October 1, 2008 to September 30, 2012, which was submitted in 2008 in compliance with the requirements of the federal Older Americans Act. The State Plan sets forth four goals of the Maine Department of Health and Human Services, Office of Elder Services, as follows:[5]

> Goal 1 – Empower older people and their families to make informed decisions about, and be able to easily access, existing health and long-term care options.
>
> Goal 2 – Enable older adults to remain safely in their own homes, ensuring a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
>
> Goal 3 – Empower older people to stay active, healthy and connected to their communities through employment, civic engagement, and evidence-based diseased and disability prevention programs.
>
> Goal 4 – Protect the rights of older adults, and enhance the response to elder abuse.

Maine law, in Title 22, Chapter 1621, section 7301, articulates the state's policy for in-home and community support services for adults with long-term care needs. In this law the state recognizes the importance of increasing the availability of in-home and community-based long-term care

[5] State Plan on Aging, Maine Department of Health and Human Services, Office of Elder Services, October 1, 2008 to September 30, 2012, page 5.

and establishes a policy that encourages the use of in-home and community-based services wherever appropriate. The law reads as follows:

*1. **Findings.** The Legislature finds that:*

A. In-home and community support services have not been sufficiently available to many adults with long-term care needs;

B. Many adults with long-term care needs are at risk of being or already have been placed in institutional settings, because in-home and community support services or funds to pay for these services have not been available to them;

C. In some instances placement of adults with long-term care needs in institutional settings can result in emotional and social problems for these adults and their families; and

D. For many adults with long-term care needs, it is less costly for the State to provide in-home and community support services than it is to provide care in institutional settings.

*2. **Policy.** The Legislature declares that it is the policy of this State:*

A. To increase the availability of in-home and community support services for adults with long-term care needs;

B. That the priority recipients of in-home and community support services, pursuant to this subtitle, shall be the elderly and disabled adults who are at the greatest risk of being, or who already have been, placed inappropriately in an institutional setting; and

C. That a variety of agencies, facilities and individuals shall be encouraged to provide in-home and community support services.

In addition, Title 22, Chapter 1621 requires the Department of Health and Human Services to establish and administer programs of in-home and community support services for adults with long-term care needs. The chapter specifically mentions respite care for persons with Alzheimer's disease, payment to qualified relatives and demonstration projects. The chapter declares that an eligible adult is entitled to services if sufficient funds are available and directs the Department of Health and Human Services to adopt rules to administer home and community-based support programs after consultation with consumers, representatives of consumers or providers of services.[6]

B. POPULATION

Maine's population is old, earning itself the distinction of second oldest in the country when measured by median age and 7th oldest when measured by percent of the population 65 years of age and older.[7] Persons from 65 to 74 years of age will increase by 46% from 2006 to 2015, while persons from 75 to 84 years of age increase only 3% and persons 85 years of age and older increase 29%.[8] As the years pass the percentage of older adults is increasing and the percentage of younger persons is decreasing.

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[6] Title 22, Maine Revised Statutes, Chapter 1621.

[7] State Plan on Aging, Maine Department of Health and Human Services, Office of Elder Services, October 1, 2008 to September 30, 2012, page 7.

[8] Historical and Projected Use of Long Term Care Services in Maine, Julie Fralich, Muskie School of Public Service, University of Southern Maine, page 5.

The Commission received the services of Julie Fralich, of the Muskie School of Public Service, University of Southern Maine, in projecting service needs from current services data and population growth estimates.[9] These projections follow the growth patterns indicated by the aging of Maine's population.

- The projected changes from 2006 to 2015 in the average monthly consumers using nursing facility care are a decrease of 10% in MaineCare nursing facility care and a decrease of 14% in nursing facility care reimbursed through all payors.
- In residential care the projections show an increase for MaineCare residential care of 28% and an increase of 25% for residential care reimbursed through all payors.
- For home care reimbursed through the MaineCare program, projections show an increase in all types of care: 12% in the elderly and adult waiver, 21% in private duty nursing, 30% in personal care services, 2% in home health and 10% in consumer-directed personal attendant services.
- The State-only funded programs of home care project increases across all programs: 21% in homemaker services, 27% in Levels I, II and III of home-based care and 37% in Level IV of home-based care.

The Commission heard presentations on the effect of demographics. The pressures on family caregivers will increase. Healthy aging, wellness and chronic disease care programs will increase in importance in order to slow the rate of growth of persons requiring long-term care.[10] Home and community-based services and supports for the elderly and adults with disabilities will be challenged to meet the demands for services from persons needing care who wish to continue to reside in their homes and to find qualified workers, who currently provide services under 5 different MaineCare programs.[11] It will become increasingly difficult to find paid caregivers. Nursing facilities and residential care private nonmedical institutions (PNMI's) will continue their service to persons requiring institutional level care, the State's most medically needy and frail. They too will be challenged to find qualified staff to provide the hands on care delivered by their facilities.

C. SERVICES DATA

Maine's formal, paid long-term care system includes nursing facility services, residential care facility services provided in private non-medical institutions (PNMI's), home health services, private duty nursing services, personal care services, home-based care services for the elderly and disabled, home-based care for the physically disabled, day health, consumer-directed personal assistance services, day health services and hospice services. Of these services the highest costs and largest number of consumers are in nursing facility and residential care PNMI services. The

[9] Historical and Projected Use of Long Term Care Services in Maine, Julie Fralich, Muskie School of Public Service, University of Southern Maine, pages 15 and 16.

[10] Evidence-based Healthy Aging Programs, Presentation by Linda Samia, University of Southern Maine, College of Nursing and Health Professions, September 22, 2008.

[11] Chart of direct-care worker MaineCare policy section, hourly rate, supervision and training, presented by Mollie Baldwin, Home Care for Maine, September 22, 2008.

other services and supports, being home and community-based, cost less per year and per consumer than facility-based services.

Overview of Maine-Care Funded Home and Community-Based Services FY 2006

Program	Services	How to Qualify	Co-Pay	# Consumers Served per Month	Cost per Consumer per Month	Total Annual Cost
MaineCare Home Health	Nursing, Therapy, Social Work	Financially eligible; meet medical requirements; doctor's order	$5 month	741	$484	$4,302,349
MaineCare Private Duty Nursing/ Personal Care Services *	Nursing, Homemaking, Personal Care, Family Provider Option	Financially eligible; meet medical requirements	$5 month	743 PDN 1,384 PCS	$494 PDN $649 PCS	$4,407,872 PDN $10,774,142 PCS
MaineCare Adult Day Health	Exercise, Health Monitoring, Socialization, Nursing	Financially eligible; meet medical requirements	$5 month	56	$613	$412,668
MaineCare: Consumer-Directed Attendant Services	Personal Care Services, Skills Training	Financially eligible; need help with daily activities; able to direct own care	$5 month	303	$813	$2,951,040
MaineCare Home Care Waiver: Consumer-Directed *	Skills training, Personal Care Emergency Response Care Coordination	Financially eligible; age 18+; must be nursing home medically eligible; able to direct own care	$5/month	200	$2,497	$5,993,118
MaineCare Home and Community Benefits: Elderly and Adults with Disabilities *	Personal Care, Homemaking, Nursing, Therapy, Care Coordination, Family Provider Option	Financially eligible; 18-59, 60-64 if disabled, 65+ must be medically eligible for nursing home	Based on income	716	$1,686	$14,483,982

Overview of Maine's State-Funded Home and Community-Based Services FY 2006

PROGRAM	SERVICES	HOW TO QUALIFY	CO-PAY	# Consumers Served per Year	Cost per Consumer per Year	Total Annual Cost
Home Based Care: Consumer-Directed *	Personal Assistance Services, Skills Training	Age 18-59 years old; need help with daily activities; able to direct own care	4% of monthly income; 3% of assets over $30,000	*will get data from OACPDS*	*will get data from OACPDS*	*will get data from OACPDS*
Home Based Care: Elders and Other Adults *	Personal Care, Homemaking, Nursing, Therapy, Care Coordination, Family Provider Option	Age 18+; need help with daily activities	4% monthly income; 3% of assets over $15,000	2,005	$3,458	$6,932,627
Homemaker *	Homemaking, chores, grocery shopping, laundry, transportation, some personal care, Family Provider Option	Age 18+; need help with daily activities; financially eligible	20% of cost of services	1,636	$1,254	$2,051,555
Alzheimer's Respite	In-home respite, institutional respite, adult day care	Diagnosis of dementia; caregiver needs respite; financially eligible	20% of cost of services	603	$783	$472,046
Adult Day Services **	Socialization, exercise	Need help with daily activities; financially eligible	20% of cost of services	71	$4,108	$291,674

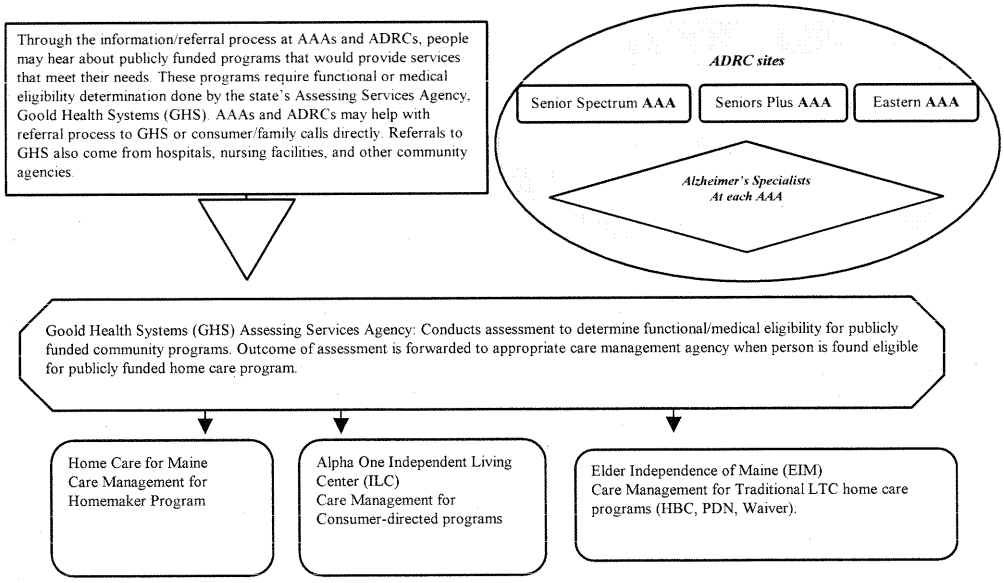
*Includes consumer-directed services.
** Numbers for Adult Day Services are for FY 2007.

Prepared by Office of Elder Services, DHHS

October 28, 2008

Information and referral services are available through a number of sources for consumers and their families regarding long-term services and supports in home and community-based settings and in residential care PNMI facilities and nursing facilities. The Area Agencies on Aging (Aroostook Agency on Aging, Eastern Agency on Aging, Spectrum Generations, SeniorsPlus and Southern Maine Agency on Aging) have long been an accessible and reliable source of information for the public. The agencies have Alzheimer's specialists, operate a variety of programs needed by the populations in their regions, recruit the assistance of many volunteers and enjoy broad and strong supports from community groups, businesses and the general public. Eastern Agency on Aging, Spectrum Generations and SeniorsPlus have been very successfully operating Aging and Disability Resource Centers (ADRC's), with funding from the federal Administration on Aging, however they have not been granted continuing funding. Through these centers, which include the participation of many community groups and volunteers, information and referrals are provided about community resources and programs across the full range of services and supports and facilities, both with and without publicly funded assistance.

Information and Referral for Long-term Care Services in Maine
Prepared by DHHS office of Elder Services, October 2008



In addition to the information and referral services provided at the Area Agencies on Aging, all persons applying for services under MaineCare, the Maine program of assistance under the federal Medicaid program, must be screened for financial eligibility by the Department of Health and Human Services, Office of Integrated Access and Support, and for medical eligibility by the agency under contract with the Department of Health and Human Services, Goold Health Systems. The medical eligibility assessment includes a review by the assessing nurse of services and supports appropriate for the applicant, including facility-based services and publicly funded home and community-based services and supports.

Maine has been a leader in downsizing the number of its nursing facility beds, having decreased the number of beds from 52 beds per 1000 persons of population in 2001 to 39 beds per 1000

persons of population in 2006. The Office of Elder Services points out in its Maine State Plan on Aging that during that time period, measuring by percentages of all persons receiving long-term care funded through the MaineCare program, persons receiving nursing facility care decreased from 42% to 38%, persons receiving home care decreased from 40% to 35% and persons receiving care in residential care facilities increased from 18% to 27%.[12]

D. WAITING LISTS

Waiting lists are a recognized tool for identifying unmet needs in the social services system. The waiting list for home and community-based services has grown in recent years and remains high. The waiting list includes many persons eligible for facility-based care. It includes persons who are not receiving any services yet and persons receiving services who need additional services or additional hours of services. In September 2008, 685 persons were waiting for home and community-based services and 627 for homemaker services[13]. Brenda Gallant, Maine's Long-Term Care Ombudsman, told the Commission that providing services to persons on the waiting lists is an improvement that must be made to Maine's home and community-based care system. Ms. Gallant noted that serving persons on the home and community-based care waiting list serves the consumer where he or she wants to be served. And, since it costs far less than facility-based care for which many persons on the waiting lists are eligible, serving persons on the home and community-based care waiting list is a cost-effective method of meeting the needs of the elderly and persons with disabilities.[14]

E. FUNDING

Funding is provided for a broad range of long-term care services through appropriations of State General Fund funding for state-only funding programs and purposes, appropriations of State General Fund funding as the seed for the MaineCare program to match federal funding in the Medicaid program, allocations of Other Special Revenue funds and allocations of federal funding for Medicaid services. In addition funding is provided for nutrition, evidence-based healthy aging and family caregiver programs and Alzheimer's specialists through grant funds from the Administration on Aging.

State budget appropriations of General Fund funding and allocations of other funding are made in biennial budgets and supplemental budgets that include 8 separate accounts as follows:

- General Fund, Office of Elder Services, Central Office
- General Fund, Long-term Care Services
- General Fund, Independent housing with services
- General Fund, Residential care for the elderly and persons with disabilities
- General Fund, State seed for MaineCare nursing facility care
- General Fund, State seed for MaineCare residential care facilities
- Other Special Revenue, residential care facilities
- Other Special Revenue, nursing facilities

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[12] State Plan on Aging, Maine Department of Health and Human Services, Office of Elder Services, October 1, 2008 to September 30, 2012, page 11.

[13] Home Based Care Wait List Statistics, presented by Diana Scully, DHHS, Office of Elder Services, September 17, 2008.

[14] Testimony before the Commission by Brenda Gallant, Long-Term Care Ombudsman, October 20, 2008.

Maine's Long-term Supports and Services for Adults		
MaineCare Programs: (requires MaineCare financial eligibility determined by OIAS)	**State Funded Programs:** (Asset Limits Apply)	**ADMN on Aging (AoA) Funded:**
MaineCare Home Health	OES Adult Day Services	Nutrition programs
Private Duty Nursing/Personal Care Services	OES Homemaker	Evidence-based Healthy Aging
Elderly and Adults w/ Disabilities Home & Community Benefits (HCB Waivers)	Home Based Care for Elders and Adults	Family Caregiver Program
Consumer-Directed HCB (Waiver)	Consumer-Directed Home Based Care	Alzheimer's Specialist Grant
Consumer-Directed Personal Attendant Services	Alzheimer's Respite Care	
MaineCare Adult Day Health	Independent Housing with Services	
Adult Family Care Homes		
Residential Care/Assisted Housing		
Nursing Facility		

•Goold assessors determine medical eligibility for over 14 different MaineCare and state funded in-home programs and nursing facility care.
•Elder Independence of Maine (EIM) coordinates and monitors state funded Home Based Care, MaineCare Home & Community Benefits for elderly and adults, and MaineCare Private Duty Nursing for adults
•Alpha One coordinates and monitors Physically Disabled Home & Community Benefits, Consumer directed PCA, and Consumer directed Home Based Care
•Home Care for Maine coordinates and monitors OES Homemaker program

Prepared by OES
Nov 2008

Federal financial participation in the Medicaid program provides states with federal dollars to match state general fund expenditures. The federal match rate is calculated based on each state's financial position relative to the other states. Running lately around 63%, the federal match rate enables Maine to provide services under the MaineCare program by spending around 37 cents for each dollar of service cost, matching that funding with 63 cents of federal funding. The federal fiscal year runs from October 1 to September 30th, resulting in a federal Medicaid match rate for State fiscal years from July 1 to June 30th that is a blended rate from 2 federal fiscal years. The blended rate for State fiscal year 2008 is 63.3% or .633 cents per dollar. The blended rate for State fiscal year 2009 is 64.14% or .6414 cents per dollar.

The Commission heard testimony about the use by some states of unified or global budgeting as a tool for achieving budget predictability. A unified budget was also spoken of as a means of integrating all long-term care programs and services in a unified planning process, coordinating funding sources, allowing a single management agency to set priorities among long-term care programs and to make adjustments as needed during the course of a budget year.

F. INITIATIVES IN OTHER STATES

A number of states have undertaken initiatives to rebalance within their Medicaid programs the proportion of long-term care being provided in home and community-based settings as compared to services being provided in facility-based settings. States have considered the numbers of persons receiving care in different settings, the amount and proportions of spending in different settings and the extent of waiting lists for different services. The have sometimes drafted statements of principle or philosophy. They have invested time and energy in developing a

comprehensive array of services so that persons needing assistance have choices that meet their needs and in streamlining and improving their Medicaid eligibility procedures and integrating long-term care and health care. Some states have unified state agency responsibility for programs, coordinated funding sources and adopted unified or global budgets.[15] They have increased consumer-driven self-directed care options, including "cash and counseling options" that allow personal choice and individualized budgeting, and incorporated consumer-defined measures of success in their quality improvement plans. They have amended their Medicaid financial eligibility requirements to encourage persons to purchase long-term care insurance to pay for long-term care services for specified time periods, with later qualification for Medicaid and an accompanying protection of personal resources.[16] They have provided incentives for facilities to reduce their numbers of long-term care beds and have transitioned some facility residents to more appropriate home and community-based services.[17]

Within their Medicaid programs a number of states have undertaken managed care for the elderly and persons with disabilities that is specifically designed to increase reliance on home and consumer-based services. These Medicaid managed care programs reflect the states in which they have been implemented: some are voluntary and some mandatory, some cover all services and some have exceptions for prescription drugs, primary and acute care, and behavioral health. Some programs are integrated with Medicare and some are not. Some apply across the full state and some apply only in specific cities, counties or regions. Some are fully capitated and some provide stop loss protection for the managed care contractor and value-added services for consumers. But all Medicaid managed care programs reflect efforts by the states to seek greater quality, measured in terms of access, coordination of services, attention to evidence based practices and pay based on performance measures. And all reflect efforts by the states to obtain greater budget predictability, flexibility and incentives with regard to some services and alignment of incentives for the consumer, the state and the managed care contractor that comport with a goal of increasing reliance on home and community-based care.[18]

IV. FINDINGS AND RECOMMENDATIONS

The Commission gave serious consideration to the current state law governing in-home and community support services for adults with long-term care needs as stated in Title 22 Maine Revised Statutes section 7301. Commission members found that this law, enacted by Public Law 1985, Chapter 511, sets forth clearly in its findings that in-home and community support services have not been sufficiently available and, as a result, adults with long-term care needs who could be served at home are at risk of moving to a facility. The law expresses the concern that, in some instances, an inappropriate placement can result in emotional and social problems and that

[15] Home and Community-Based Services, Initiatives in Other States and New Ideas, Presentation by Lisa Alecxih, the Lewin Group, October 20, 2008, page 6.
[16] Blue Ribbon Commission to Study the Future of Home-based and Community-based Care: Cash and Counseling, Kevin Mahoney. PhD, September 12, 2008.
[17] "A Balancing Act: State Long-Term Care Reform," AARP Public Policy Institute, July 2008, pages 12-15.
[18] National Developments in Medicaid Managed Long-Term Care, Paul Saucier, Muskie School of Public Services, University of Southern Maine, October 20, 2008.

providing in-home and community support services could be less costly to the State than providing facility-based services.
Commission members further noted that Title 22 Maine Revised Statutes section 7301 sets forth clearly that it is the policy of the State to increase the availability of in-home and community support services, that the elderly and adults with disabilities who are at risk of inappropriate placement in a facility or who have been placed inappropriately are priority recipients of in-home and community support services and that a variety of agencies, facilities and individuals shall be encouraged to provide in-home and community support services.

The Commission members reached a strong agreement, with one abstention, that the State has failed to achieve the policy goals articulated in the law and that the State should recommit itself to fulfilling the mission of providing meaningful choice for those elderly who would benefit from the availability of in-home and community support services. The Commission received advice from Lisa Alecxih, of the Lewin Group, that articulating a state vision of long-term care is a critical factor in success for the State in establishing a balance among the various services in long-term care.[19] The Commission agreed to formalize that commitment by amending section 7301 to add a vision statement indicating support for a system of long-term services and supports that optimizes the physical health, mental health, functional well-being and independence of older adults and adults with physical disabilities through high quality services and supports that are provided in settings that reflect the needs and choices of the consumers and that are delivered in a manner that is flexible, innovative and cost-effective.

In addition to the findings and recommendations, Commission members agreed, with one abstention, that the report also contain a statement that members of the Commission are committed to working towards finding funding sources for the 2 recommendations that identify funding for expansionary programs: recommendation #4 on funding for the Priority Social Services program (services including transportation for Meals on Wheels and medical ride transportation) and recommendation #6 on funding for the family caregivers program. Therefore it is noted that, with one abstention, the recommendations #4 and #6 are qualified by a commitment to work towards finding funding sources for the expenses in those recommendations. It is also noted that the Commission is authorized to report its recommendations, including suggested legislation, but pursuant to Joint Rule 353, section 8 is not authorized to submit legislation from the Commission.

[19] Home and Community-Based Services, Initiatives in Other States and New Ideas, Presentation by Lisa Alecxih, the Lewin Group, October 20, 2008, page 21.

Findings and Recommendations

- **Finding #1**: The Commission recommends that the State adopt a vision that Maine's system of long-term services and supports should optimize the physical health, mental health, functional well-being and independence of older adults and adults with physical disabilities through high quality services and supports that are provided in settings that reflect the needs and choices of the consumers and that are delivered in a manner that is flexible, innovative and cost-effective.
    - **Recommendation #1**: The current statutory language in 22 MRSA § 7301, which summarizes the State's findings and policies for in-home and community support services for adults with long-term care needs, should be amended to include a new vision statement that highlights support for a system that optimizes the physical health, mental health, functional well-being and independence of older adults and adults with physical disabilities through high quality services and supports that are provided in settings that reflect the needs and choices of the consumers and that are delivered in a manner that is flexible, innovative and cost-effective.

- **Finding #2**: The Commission supports the development of a proposal for a unified budget for long-term care to facilitate coordinated planning and allow the transfer of funds among programs to ensure that programs are serving individuals in their preferred setting:
    - **Recommendation #2**:The Commission recommends directing the Commissioner of Health and Human Services, and Commissioner of Administrative and Financial Services and the Office of Fiscal and Program Review to prepare a revised chart of accounts that will concentrate all long-term care accounts for the elderly and adults with physical disabilities in the Office of Elder Services, including program and administrative costs even in the OES Central Office, into one set of accounts, excluding the Office of MaineCare services, mental health, mental retardation and developmental disabilities services, that will be complimentary to the State's vision for a consumer-centered approach. The Commissioner of DHHS and DAFS must provide a report and a proposal for a unified budget, that can be implemented by July 1, 2010, by January 1, 2010 to the joint standing committees having jurisdiction over health and human affairs and appropriations and financial affairs.

- **Finding #3:** The Commission supports funding home and community-based services that respect individual choice and flexibility within the long-term care system and that provide more individuals with the ability to receive services in settings of their own choice in a cost-effective and person-centered manner.
    - **Recommendation #3:** The Commission recommends that the Department of Health and Human Services make it a priority to reduce the waiting list for home and community-based care and homemaker services this year as part of the FY 09-10 budget, and to eliminate the waiting lists in their entirety no later than the end of the FY 2010-11 biennium.

- **Finding #4:** The Commission finds that the work of the volunteers for the Meals on Wheels and medical ride transportation programs is valuable in supporting the ability for many elderly to choose home and community-based services in Maine.
  - **Recommendation #4**: The Commission supports an increase in funding for the Priority Social Services program (services including Meals on Wheels transportation and medical ride transportation) by $500,000/year to address the rising costs for these volunteers across the State. This recommendation is qualified by a statement from Commission members that they are committed to working towards finding funding sources for the recommendation.

- **Finding #5:** The Commission supports the work of the Aging and Disability Resource Centers (ADRC's) and recognizes that they have suffered a loss in federal funding that will critically impact their ability to continue providing valuable services.
  - **Recommendation #5:** The Commission recommends providing funding for the 3 Area Agencies on Aging that had federal funding for ADRC's and the 2 other Area Agencies on Aging that wish to operate ADRC's in the total amount of $300,000 per year. As a condition of the ADRC's obtaining this funding, the Commission would require the ADRC's to work with hospitals, nursing facilities and residential care facilities to improve the discharge planning process to explore home and community-based options to the fullest extent possible. This should include improving the provision of information to the consumer, improving consumer choice in the discharge process, increasing consumer counseling for those choosing self-directed care, and education on the availability of hospice services where they may be appropriate. The commission also encourages hospitals and DHHS, through Goold Health Systems medical eligibility assessment, to work together to improve the discharge process and counseling for home and community-based options in a manner similar to the ADRC's. The Commission recommends reports back from DHHS to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services 1 and 2 years from the appropriation of the new funding.

- **Finding #6:** The Commission supports continuing the family caregiver project that was undertaken in 2007-2008 as a demonstration project by the Area Agencies on Aging.
  - **Recommendation #6:** The Commission supports funding the family caregiver project for $200,000 per year. This recommendation is qualified by a statement from Commission members that they are committed to working towards finding funding sources for the recommendation.

- **Finding #7:** The Commission recognizes the value in assistive technology in supporting home and community-based long-term care.
  - **Recommendation #7**: The Commission recommends that the Department of Health and Human Services explore uses of and develop funding sources for assistive technology to help accomplish the State's vision.

- **Finding #8**: The Commission recommends that the Department of Health and Human Services continue to support the 7 tax credit assisted assisted-living projects that include assisted living service packages funded by MaineCare.
    - **Recommendation#8:** The Commission recommends directing the Department of Health and Human Services to explore alternative non-Medicaid sources of funding for the 7 tax credit-assisted assisted living programs, if it becomes necessary, to ensure that these programs survive.

- **Finding #9:** The Commission supports adequate training and fair compensation and benefits for direct care workers in home and community-based care through agencies and in self-directed care and in residential care facilities and nursing facilities.
    - **Recommendation #9:** The Commission recommends directing the Department of Health and Human Services to work with interested parties to develop a comprehensive and systematic approach to reimbursement, health benefits and training for direct care workers in home and community-based, residential facilities and nursing facilities and to report back to the joint standing committees having jurisdiction over health and human services and appropriations and financial affairs by December 1, 2009.

- **Finding #10:** The Commission supports reversing the spending trend in long-term care to increase the numbers of people served and dollars expended in home and community-based care as compared to residential facility and nursing facility care.
    - **Recommendation #10:** The Commission recommends directing the Department of health and Human Services to report annually on its progress in reversing the spending trend to the joint standing committees having jurisdiction over health and human services and appropriations and financial affairs beginning January 15, 2010.