APPENDIX A

Authorizing Resolve, Resolve 2007, Chapter 209

RESOLVE 2007, CHAPTER 209
H.P. 1436 - L.D. 2052

Resolve, To Create the Blue Ribbon Commission To Study the Future of Home-based and Community-based Care

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, work to study the unmet needs and financing options of long-term home-based and community-based care must begin before the end of the legislative session because the State has an increasingly elderly population and there is a shortage of long-term home-based and community-based care workers; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Blue Ribbon Commission established. Resolved: That the Blue Ribbon Commission To Study Long-term Home-based and Community-based Care, referred to in this resolve as "the commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of 11 members:

1. Five members appointed by the President of the Senate as follows:

A. Two members of the Senate, including one member of the party holding the highest number of seats and one member of the party holding the 2nd highest number of seats; and
B. Three members who are experts in the field of long-term home-based and community-based care financing and service; and

2. Five members appointed by the Speaker of the House as follows:

A. Four members of the House of Representatives, including 2 members of the party holding the highest number of seats and 2 members of the party holding the 2nd highest number of seats; and
B. One member who has been a consumer of long-term home-based and community-based care; and

3. One member of the Governor's office designated by the Governor at the Speaker's request; and be it further

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission; and be it further

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve.

The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the commission, which must be no later than 30 days following the appointment of all members; and be it further

Sec. 5. Duties. Resolved: That the commission shall 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. Given that the State has the oldest median age of any state in the nation, the commission shall 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 be it further

Sec. 6. Staff assistance. Resolved: That, notwithstanding Joint Rule 353, the Legislative Council shall provide necessary staffing services to the commission; and be it further

Sec. 7. Outside funding. Resolved: That the commission shall seek outside funding to fully fund all costs of the commission and in accordance with the policy of the Legislative Council with regard to outside funding. If sufficient outside funding has not been received by the commission by October 1, 2008 to fully fund all costs of the commission, no meetings are authorized and no expenses of any kind may be incurred or reimbursed; and be it further

Sec. 8. Report. Resolved: That, no later than November 5, 2008, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the First Regular Session of the 124th Legislature; and be it further

Sec. 9. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Study Commissions - Funding 0444

Initiative: Provides an allocation to the Legislature in fiscal year 2008-09 to fund per diem and other expenses of this study.

OTHER SPECIAL REVENUE FUNDS	2007-08	2008-09
Personal Services	$0	$1,320
All Other	$0	$2,750
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$4,070

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership list, Blue Ribbon Commission to Study the Future of Home-based and Community-based Care

Blue Ribbon Commission to Study Long-term Home-based and Community-based Care

Resolve 2007, Chapter 209

Total Members: 11 **Appt Deadline:** May 17, 2008

Governor

1 Governor's Office

Appointment	Pat Ende

President of the Senate

3 Experts in Long-term Home-based & Community-based Care Financing & Service

Appointment	Julie Fralich
Appointment	Linda Samia
Appointment	Diana Scully

2 Senators (One from each of the two major political parties)

Appointment	Kevin L. Raye
Appointment	Philip L. Bartlett

Speaker of the House

1 Consumer of Long-term Home-based & Community-based Care

Appointment	Susan Linet

4 House Members (2 from each of the two major political parties)

Appointment	H. Sawin Millett
Appointment	James J. Campbell
Appointment	Janet T. Mills
Appointment	Margaret M. Craven

**** Members Appointed = 11 Total Members = 11 ****

APPENDIX C

Agendas and meeting Notes, Meetings 1 through 5

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Agenda – Meeting #1
Friday, September 12, 2008
Room 211, Cross State Office Building, Augusta

Overview and Vision for Maine's Long-term Care System

9:00 – 9:30am	Welcome and Introductions	Senator Philip Bartlett and Representative Margaret Craven
9:30 – 11am	Maine's Long-term Care System	Diana Scully, DHHS Office of Elder Services, and Commission member
11:00 - 12noon	Long-term Care Needs Assessment and Projection model	Julie Fralich, Muskie School of Public Service, and Commission member
12:00 – 1:00pm	Lunch break	
1:00 – 2pm	Presentation on consumer-centered systems, long-term care public-private partnerships	Kevin Mahoney, Boston College
2:00 - 2:30pm	Public Comment	
2:30 - 3:00pm	Commission discussion, identification of issues for future meetings	Jane Orbeton, OPLA, staff

Note: Future meeting dates will be determined at this meeting. Commission members should bring their calendars.

Blue Ribbon Commission to Study the Future of
Long-term Home-based and Community-based Care
Meeting Notes, September 12, 2008

1. Present were Rep. Margaret Craven, Sen. Philip Bartlett, Rep. Sawin Millett, Rep. Janet Mills, Rep. James Campbell, Julie Fralich, Diana Scully, Patrick Ende, Dr. Susan Linet, and Linda Samia.

2. Diana Scully, Director of the Office of Elder Services, DHHS, Julie Fralich, Muskie School, and Kevin Mahoney, Boston College Graduate School of Social Work, presented information to the commission and engaged in discussion with the commission. During the public comment period the following persons spoke with the commission: Dennis Fitzgibbon, Alpha One, Pam Allen, Seniors Plus and Elder Independence of Maine, Brenda Gallant, Long-term Care Ombudsman Program, Vicki Purgavie, Home Care and Hospice Alliance of Maine, Rick Erb, Maine Health Care Association, Susan Giguere, Care and Comfort home care agency, and Nancy Kelleher, AARP.

3. The following information was requested for the commission:
   A. How many people are on waiting lists for homemaker and home-based care services, at what levels of care are those persons, and what are the reasons for the waiting lists? For each program for which lack of funding is the reason for the waiting list, what amounts of General Fund and federal funds would be required to fully fund the waiting list? Request made to Diana Scully, DHHS.
   B. When comparing the distribution of Medicaid expenditures for older adults and adults with disabilities among Maine, Oregon, Idaho, New York, Vermont, Massachusetts, New Hampshire and Rhode Island, what are the demographics of those same states? Request made to Diana Scully, DHHS.
   C. Please provide a list of activities of daily living (ADL's) and instrumental activities of daily living (IADL's). Request made to Diana Scully, DHHS.
   D. Please provide information on evidence-based services being provided in Maine. Request made to Diana Scully, DHHS.
   E. Please provide specific examples and explanations on DHHS requirements for home and hospice care that are unduly burdensome to providers of care and suggested by providers for repeal or alteration. Request made to Vicki Purgavie, Home Care and Hospice Alliance of Maine.
   F. Information was requested on for-profit and not-for-profit health care agencies in Maine. Request made to Diana Scully, DHHS and Vicki Purgavie, Home Care and Hospice Alliance of Maine.
   G. Information was requested on the use of respite care, both facility-based and home and community-based. Request made to Diana Scully, DHHS.
   H. Information was requested on expanding LIHEAP and energy conservation efforts in the community. Jane will discuss this request with Patrick Ende.
   I. Information was requested on telehealth in Maine. Request made to Diana Scully, DHHS.

4. The following persons requested time to address the commission: Dennis Fitzgibbon, Vicki Purgavie and Rick Erb.

5. Future meetings of the commission were set for Monday, September 22, Thursday, October 9, Monday, October 20 and Tuesday, October 28. Each day 9am to 3pm, in Room 211 Cross Building.

Blue Ribbon Commission to Study the Future of
Long-term Home-based and Community-based Care
Meeting Notes, September 12, 2008

1. Present were Rep. Margaret Craven, Sen. Philip Bartlett, Rep. Sawin Millett, Rep. Janet Mills, Rep. James Campbell, Julie Fralich, Diana Scully, Patrick Ende, Dr. Susan Linet, and Linda Samia.

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   F. Information was requested on for-profit and not-for-profit health care agencies in Maine. Request made to Diana Scully, DHHS and Vicki Purgavie, Home Care and Hospice Alliance of Maine.
   G. Information was requested on the use of respite care, both facility-based and home and community-based. Request made to Diana Scully, DHHS.
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Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Agenda – Meeting #2
Monday, September 22, 2008
Room 211, Cross State Office Building, Augusta

Meeting 2: Quality and Evidence-based programs

9:00 – 9:15	Welcome and review of prior meeting	Chairpersons Senator Bartlett and Representative Craven
9:15-9:45	Review of charge to the commission from PL 2007, chapter 209	Chairpersons Senator Bartlett and Representative Craven
9:45-10	Evidence-based Program for caregivers of persons with dementia	Romaine Turyn, DHHS
10-10:15	Break	
10:15 – 11:15	Evidence Based Programs – Healthy Aging	Linda Samia, USM School of Nursing
11:15 – 12:00	Overview of federal quality requirements	Maureen Booth, Muskie School, USM
12:00 – 1:00	Lunch break	
1:00 – 2:15	Presentation and discussion of information requested at Meeting #1	
2:15 – 2:30	Public Comment	
2:30 – 3:00	Commission discussion, identification of issues for future meetings	

Future meeting dates:
Thursday, October 9
Monday, October 20
Tuesday, October 28

Blue Ribbon Commission to Study the Future of
Long-term Home-based and Community-based Care
Meeting Notes, September 22, 2008

1. Present were Rep. Margaret Craven, Rep. Sawin Millett, Rep. Janet Mills, Rep. James Campbell, Sen. Kevin Raye, Julie Fralich, Diana Scully, Patrick Ende, Dr. Susan Linet, and Linda Samia.

2. Rep. Craven opened the meeting and led the commission in a discussion of the charge in Resolve 2007 Chapter 209, including whether the commission should be looking at long-term care for all populations or just for the elderly and physically disabled adults. Discussion proceeded about what "coherent blueprint" means, the development of a philosophy of long-term care based on the AARP rebalancing report on page ix of the report, and background information on the report. Commission members requested information on the State's profile tool grant.

3. In the morning commission member Linda Samia presented information on evidence-based programs initiated in Maine in the category of Evidence-based Healthy Aging. She was followed by Romaine Turyn, DHHS, who spoke on implementing a Healthy Ideas program for caregivers of persons with dementia. Maureen Booth, USM Muskie School, presented information on federal quality requirements for home- and community-based long-term care Medicaid waiver programs.

4. In the afternoon Peter Merrill, MaineHousing, presented information on the LIHEAP program and weatherization and central heating programs. Molly Baldwin, Home Care for Maine, presented information on the burden of certain state and federal regulatory requirements and fielded questions on reimbursement rates to agencies and pay scales for home care workers. Diana Scully, DHHS, presented information requested at the first meeting of the commission and distributed handouts on those issues and on the declaration of Falls Prevention Week.

5 **A decision was made to move the starting time of the commission meetings to 9:30am** to better accommodate persons traveling from a distance on the morning of the meetings.

Please note: Future meetings of the commission are set for Thursday, October 9, Monday, October 20 and Tuesday, October 28. Each day 9:30am to 3pm, in Room 211 Cross Building.

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Agenda – Meeting #3
Monday, October 9, 2008
Room 211, Cross State Office Building, Augusta

Meeting 3: The federal perspective on long-term care and Maine's experience with Aging and Disability Resource Centers

9:30	Welcome	Chairpersons Senator Bartlett and Representative Craven
9:30-10:15	Issues in long-term care: the federal perspective	John Wren and Gregory Case, US DHHS, Administration on Aging
10:15-10:30	Break	
10:30 – 11:15	Maine's experience with Aging and Disability Resource Centers	Valerie Sauda, Eastern Maine Area Agency on Aging
11:15 – 12:00	The consumer perspective on long-term care	Brenda Gallant, Long-term Care Ombudsman
12:00 – 1:00	Lunch break	
1:00 – 2:15	Overview of services provided by area agencies on aging	Pam Allen, Elder Independence of Maine and Seniors Plus
2:15 – 2:30	Public Comment	
2:30 – 3:00	Information requested at meeting #2, Commission discussion, identification of issues for future meetings	

Future meeting dates:
Monday, October 20
Tuesday, October 28

Blue Ribbon Commission to Study the Future of
Long-term Home-based and Community-based Care
Meeting Notes, October 9, 2008

1. Present were Rep. Margaret Craven, Senator Bartlett, Rep. Sawin Millett, Rep. Janet Mills, Sen. Kevin Raye, Julie Fralich, Diana Scully, Patrick Ende, and Linda Samia.

2. Senator Bartlett opened the meeting and provided a brief overview of the agenda for the day.

3. John Wren and Gregory Case, US DHHS, Administration on Aging, spoke on state options for long-term care and on the importance of developing a comprehensive vision and strategies to attain measurable goals. He suggested getting away from a program focus and instead focusing on populations. He suggested looking at Medicaid as only one part of a long-term care system that is largely informal, community-based and family focused. He advocates developing strategies to expand the formal delivery of home and community-based services to support the family-based system of care, funding them from savings from the nursing facility side. He suggested that long-term care is a private-public partnership with the family at the center and formal supports and services available to supplement the family and for persons who do not have family supports and services available to them. John Wren spoke favorably of:

Aging and disability resource centers (ADRC's)
"Own Your Own Future" initiatives to encourage individual responsibility
Building prevention into the long-term care agenda
Moving toward flexible service packages
Project 2020 efforts on nursing facility diversion at the hospital discharge level

4. Valerie Sauda, Eastern Area Agency on Aging, presented information on the ADRC in Bangor, their focus on education and information services, their use of technology for management purposes and to learn of available services, their need for stable funding to replace the ADRC grant and their use of telemedicine services. She suggested an electronic Medicaid application and safety net services for persons on waiting lists.

5. Pamela Allen presented information on the work of the Area Agencies on Aging and Elder Independence of Maine's home care coordination work for DHHS. *She will try to get information on waiting lists and the numbers of providers over a few years to look for correlations.* She stated that declining numbers of providers may not cause loss of services as much as it may deprive consumers of choice of providers, a required element in Medicaid home care. A question was raised about possible savings in administrative costs.

6. In the public comment period Joyce Segee of Saco River Health Services spoke of the problems of the direct care workforce caused by low pay levels and restrictions on reimbursement for travel time and expenses. Molly Baldwin, Home Care for Maine, spoke of home care services provided under different DHHS programs, their reimbursement rates, and their supervision and training requirements. Kathy Pears, Alzheimer's Association, provided information on home care for persons with Alzheimer's disease and dementia. *Vicki Purgavie, Home Care and Hospice Alliance of Maine, provided information on the annual gross revenues of home care and hospice agencies. She said that she is still working on information on undue administrative burdens.* Kim Robertson, of Aroostook County, spoke of providing home care services in northern Maine. She endorsed telehealth, discussed

the difficulty of retaining direct care workers while not paying for travel time or expenses, and discussed the problems of service delivery as needed by the consumer and as ordered by Elder Independence of Maine after the medical eligibility assessment by Goold Health. *Information was requested on medical eligibility assessment and the contract with Goold Health.*

7. *Rep. Craven asked Diana Scully for information on levels of reimbursement for care management in home care. Rep. Craven also asked about* "Own Your Own Future" *initiatives to encourage individual responsibility for long-term care.*

8. Time was not available for the Commission to begin brainstorming ideas for desired outcomes of the Commission's work. Senator Bartlett and Rep. Craven asked that Commission members be invited to send initial brainstorming submissions to Jane Orbeton at jane.orbeton@legislature.maine.gov. Submissions are due by 9am on Monday, October 20.

9. Members of the Commission and Brenda Gallant, Long-term Care Ombudsman and Graham Newson, Association of Area Agencies on Aging, proceeded to the Inn at City Hall for a tour of the assisted living residence. Kathy Jorgensen, Administrator of the residence, provided information, a tour and an opportunity to meet a number of residents. The Commission thanks Kathy and the residents for an informative and impressive tour.

Please note: The meetings of the commission on Monday, October 20 and Tuesday, October 28 are scheduled for 9:30am to 3pm, in Room 211 Cross Building.

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Agenda – Meeting #4
Monday, October 20, 2008
Room 211, Cross State Office Building, Augusta

Meeting 4: Home- and community-based long-term care options in Maine and other states

9:30 -9:35	Welcome	Chairpersons Senator Bartlett and Representative Craven
9:35-9:45	Keeping Seniors Home	Janice Daku, Western Maine Community Action Agency
9:45 -11:00	Home- and community-based long-term care options – Initiatives in other states and new ideas	Lisa Alecxih, Lewin Group
11:00 -12:00	Managed long-term care as a re-balancing strategy	Paul Saucier, Director, Institute for Public Sector Innovation, Muskie School of Public Policy
12:00 – 1:00	Lunch break	
1:00-1:30	Presentation on Home Care Coordination	Dennis Fitzgibbons, Executive Director, Alpha One
1:30-2:00	Home- and community-based long-term care options – Two perspectives on what Maine has and what Maine needs	Diana Scully, DHHS Noelle Merrill, EAAA
2:00-2:20	The consumer perspective on long-term care	Brenda Gallant, Long-Term Care Ombudsman
2:20-3:15	Brainstorming ideas for committee recommendations and identification of information needed for meeting #5	
3:15-3:30	Public comment period	

Future meeting date:
Tuesday, October 28

Blue Ribbon Commission to Study the Future of
Long-term Home-based and Community-based Care
Meeting Notes, October 20, 2008

1. Present were Rep. Margaret Craven, Senator Bartlett, Rep. Sawin Millett, Julie Fralich, Diana Scully, Rep. James Campbell, and Dr. Susan Linet.

2. Representative Craven opened the meeting and provided a brief overview of the agenda for the day.

3. Janice Daku, from Western Maine Community Action, program manager for Keeping Seniors Home, briefed the commission on their work with low income and very low income seniors. She provided examples of persons who were helped with getting a ramp built, repairing or replacing an uninhabitable home, lowering kitchen counters, installing grab bars and weatherization projects. Janice provided copies of the Fallon survey of housing situations and adjustments of older persons that Keeping Seniors Home uses in their work around the State.

4. Lisa Alecxih, from the Lewin Group, provided information on home and community-based initiatives in other states and new ideas for consideration. Lisa spoke of the benefits of looking at the budget of long-term care services as a single combined fund of money, mentioning Vermont's experience with establishing a goal of 50% of persons with long-term care needs being served on the nursing facility side and 50% on the home and community-based services side. She suggested setting a goal and adopting a number of strategies to achieve the goal. She listed Maine's challenges and what will be needed to overcome the challenges as follows:

Challenges:

- Growing demand and changing expectations
- Insufficient numbers of workers and high turnover rates
- Constraints on reimbursement
- Financing silos and institutional bias of Medicaid
- Lack of insurance to spread risk

Overcoming those challenges will require:

- Wise public policy decisions
- Smart business choices by providers
- Greater personal responsibility

5. Paul Saucier, Muskie School of Public Policy, Institute of Public Sector Innovation, provided information to the commission on managed Medicaid long-term care in other states, managed Medicare services and opportunities for Maine. He spoke of using managed Medicaid long-term care to seek greater value, through initiatives that address issues of quality and cost. Paul spoke of federal changes that will bring Special Needs Plans in Medicare into agreements with state Medicaid programs by 2010. He provided information on the 4 companies offering Medicare managed care plans in Maine: Martin's Point (Generations), United (Evercare), Aetna and Arcadia (Northeast Community Plan) and the shift this will bring to state agencies as they shift

from utilization review and service-by-service rules to defining and monitoring system outcome and contracting administration and specifications. He also mentioned the potential of benefit to the state through budget control and benefit to consumers through potential value-added services. Paul spoke of the early development of Medicaid managed care through the PACE program. He provided information on Massachusetts, New Mexico, Texas and Wisconsin and noted the different populations and services covered by their managed long-term care programs, statewide coverage, integration with Medicare and enrollments.

6. Dennis Fitzgibbons, Alpha One, briefed the commission on the mission and responsibilities of Alpha One, its 30-year history, primary program and advocacy roles, its position as a national leader in designing and implementing consumer-directed programs and its serving as a model for John Wren's work in cash and counseling program design. Dennis spoke of the need for systemic change to enable consumer to obtain the services they need in the manner they choose, with workers who are paid sufficiently. He mentioned the legislative direction of Resolve 2005, chapter 199 and asked that DHHS maintain consumer choice but simplify access and program operations, consolidate responsibilities and the provider network. Dennis provided information on the 3 consumer-directed personal assistance services programs – Section 12 consumer-directed attendant services (349 participants), Section 22 home and community benefits for the physically disabled (155 participants) and Chapter 11 consumer-directed personal assistance services (109 participants) (HBC). All participants are assessed by and referred by Goold Health Systems. Alpha One provides skills instruction, case management and administrative functions and is paid $125 per month per participant. *Information was requested on Resolve 2005, chapter 199. Jane will coordinate preparation of this information.*

7. Diana Scully, DHHS, provided information on what Maine has and what Maine needs. She mentioned the increase from 2000 to 2006 in residential care that offset a decrease in the number of nursing facility beds and that the percentage of the long-term care budget dedicated to home and community based services has decreased. Diana mentioned the some of the mechanics of long-term care: eligibility, care management and flexibility. She stated that Maine needs to increase the respect accorded to its elders, to listen to their needs and to provide sufficient wages for long-term care workers to ensure that the workers are available as needed. Diana spoke of the need to expand family care homes, affordable assisted living, support for persons with disabilities and elders in their own homes, encouraging more volunteers, providing incentives to facilities to retool and to serve persons with specialized needs, adopting unified budgets, and expanding the use of new technologies.

8. Noelle Merrill, Eastern Area Agency on Aging, spoke of the history of the affordable assisted living model, which provides a tenant a rental apartment at $75 per day (from a landlord) and a package of supportive services including assistance with medication at $56 per day (from an assisted living services provider). She spoke of the success of the model and of her hopes for more affordable assisted living sites.

9. Brenda Gallant, Long-Term Care Ombudsman, briefed the commission on the results of an August 2008 survey of 1300 long-term care consumers who received care in their homes and

their caregivers. She mentioned their top 3 concerns: maintaining good health, aging in place and maintaining independence; and their top 3 wishes: more hours of home health service, food and medication discounts and services to keep people in their homes. Brenda spoke of the lack of funding for home and community-based services forcing people who would be appropriately served in the community to move to institutions in order to get the services they need. Brenda praised the family caregiver support provided with the $200,000 that was available last year. The funding was divided among the 5 AAA's, allowing expenditure of up to $1000 per consumer to enable the consumer to be cared for at home.

10. Commission members began a brainstorming process, regarding the recommendations of the commission.

Vision

Members mentioned (but saved for later the details on) having a vision for a comprehensive long-term care system, perhaps building on the presentation of John Wren, the CMS vision of long-term care and Maine's statutory basis for home and community-based services in Title 22, section 7301, and the AARP rebalancing report, page 12. A vision that places the individual with their needs and choices at the center, surrounded by their family and community supports, with public services providing an extra layer of support (not at the center).

Core principles

Members discussed making statements of core principles in 4 areas: access to services, choice and independence, financing and sustainability and infrastructure.

Members mentioned the following:

- Having a good visual overview of the long-term care system in Maine, providing information on the settings, services, consumers.
- Combining funding in a unified budget in order to bring planning and spending together.
- Spending sufficient GF funds to maximize the Medicaid HCBS waiver.
- The threshold for nursing facility care and its connection to the waiver.
- Rebalancing the home and community-based system and the nursing and residential care systems, within available resources, directing more resources to the home and community-based side. Management of the numbers of institutional beds.
- Expansion of self-directed care.
- Use of evidence-based services.
- Sustainability within the whole long-term care system.
- Project 2020 principles of access, evidence-based services and diversion from facility-based care.
- Establishing benchmarks (using Lisa Alecxih's model) to establish a starting point and progress over time.
- Using the waiting list as a benchmark.
- Encouraging services with low cost and high benefit (supporting the family caregiver, encouraging home sharing, encouraging volunteerism).

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Agenda – Meeting #5
Tuesday, October 28, 2008
Room 211, Cross State Office Building, Augusta

9:30am	Welcome
9:35am	Review of information requested at Meeting #4
9:45am	Commission discussion of duties *1. 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* *2. Create a coherent blueprint to ensure the sustainability of long-term home-based and community-based care options that provide choice and quality*
12noon	Lunch break
1pm	Public comment period *New information* *Ideas for the Commission vision or mission statement* *Ideas for statements of core principles or strategies* *Other*
1:15pm	Continued Commission discussions Commission decisions on its report and recommendations to the 124th Legislature
3pm	Discussion of procedure for finalizing the report of the Commission
3:30pm	Adjournment

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care
Meeting Notes, October 28, 2008

1. Present were Rep. Margaret Craven, Senator Bartlett, Rep. Sawin Millett, Senator Kevin Raye, Julie Fralich, Diana Scully, Linda Samia, Patrick Ende, Rep. James Campbell, and Dr. Susan Linet.

2. Senator Bartlett opened the meeting and provided a brief overview of the agenda for the day.

3. Diana Scully presented information from the Office of Elder Services, Department of Health and Human Services, presented information on 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. This chart shows the program, describes the services, qualifications and co-payment requirements. In addition it shows the numbers of consumers served per month in 2006, the cost per consumer and the total annual cost of the program.

4. Senator Bartlett and Representative Craven assisted commission members in a discussion of the existing home and community-based care statute in Title 22, section 7301. The commission discussed the failure of the State to live up to the policy statement in section 7301 and discussed updating the statute to incorporate the vision of the commission for the home and community-based long-term care system. The commission directed staff to proceed with drafting a vision statement for the commission report and an update to section 7301, incorporating items from Julie Fralich's draft and the AARP report.

5. Senator Bartlett and Representative Craven assisted commission members in a discussion of findings and recommendations. The report will also contain a statement that members of the Commission, with one abstention, 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 (transportation for Meals on Wheels and medical ride transportation) and recommendation #6 on funding for the family caregivers program. On all findings and recommendations one commission member abstained and all others voted for the 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 highlight the new vision statement that highlights 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.

- **Finding #2**: The Commission supports the development of a proposal for a unified budget to facilitate coordinated planning and allow the transfer of funds among programs to facilitate serving individuals in their preferred setting:
  - **Recommendation #2**: Resolve, directing the Commissioner of DHHS, the Commissioner of DAFS and the Office of Fiscal and Program Review to prepare a revised chart of accounts that will concentrate all long-term care service 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, MH and MR/DD 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 committee having jurisdiction over health and human affairs and having jurisdiction over 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 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 State 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 (Meals on Wheels transportation and medical ride transportation) by $500,000/year to address the rising costs for these volunteers across the State.

- **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 supports providing funding for the 3 Area Agencies on Aging that had federal funding for ADRC's and the 2 Area Agencies on Aging that wish to operate ADRC's in the amount of $300,000/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, which 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 AFA and HHS Committees 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 asd a demonstration project by the Area Agencies on Aging.
  - **Recommendation #6:** The commission supports funding the family caregiver project for $200,000/year.

- **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 DHHS explore uses of and develop funding sources for assistive technology to help accomplish the State's vision.

- **Finding #8**: The Commission recommends that DHHS continue to support the 7 tax credit assisted assisted-living projects that include assisted living service packages funded by MaineCare.
  - **Recommendation#8:** The Commission supports the 7 tax credit assisted assisted-living projects funded by MaineCare and directs DHHS to explore alternative non-Medicaid sources of funding, 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 workers.
  - **Recommendation #9:** Resolve, directing the DHHS 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 with 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 also supports a resolve directing the DHHS to report annually on its progress in reversing the spending trend to the joint standing committees with jurisdiction over health and human services and appropriations and financial affairs beginning January 15, 2010.

6. 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, EAAA, Rick Erb, Maine Health Care Association and Vicki Purgavie, Home Care and Hospice Alliance of Maine.

7. The commission concluded its work at the meeting and reviewed the process for absentee voting and review of the draft report. The chairs will make final decisions on any questions of substance forwarded by commission members in the review of the draft report. Twenty-four hours is reserved for absentee voting by Representative Mills and Senator Bartlett. A draft report will be sent to commission members by the end of the day on Friday, with a publication due date of November 5.

APPENDIX D

Some Information About Maine's Long-term Care System
Presentation by Diana Scully, Department of Health and Human Services, Office of Elder Services, September 12 and October 28, 2008

Some Information about Maine's Long Term Care System

Prepared for the

Blue Ribbon Commission to Study the Future of Long Term Home-Based and Community-Base Care

by the

Office of Elder Services

Maine Department of Health and Human Services

September 12, 2008

Maine's Long Term Care System

Outline for Presentation by Diana Scully
September 12, 2008

1. Ways to understand long term care (LTC)

- ⇒ Definition and vision *see handout*
- ⇒ People who receive services and supports
- ⇒ Caregivers—paid and family
- ⇒ Range of potential needs *see handout*
- ⇒ Domains of LTC *see handout*
- ⇒ Programs and services *more below*
- ⇒ Funding *more below*
- ⇒ Terms and acronyms *see handout*

2. Home- and community-based services in Maine over the past 28 years *see handout*

3. Array of LTC services today

- ⇒ Facility-based services
- ⇒ Home and community-based services
- ⇒ Consumer-directed services
- ⇒ LD 519 Demonstration
- ⇒ Evidence-based healthy aging services *see handout*
- ⇒ Persons served and costs *see handout*
- ⇒ Balance across the major LTC components *see handout*
- ⇒ How Maine compares to other states *see handout*

4. Drivers of use of LTC services

- ⇒ Aging of the population
- ⇒ Income
- ⇒ Increase in people with needs
- ⇒ Declines in disability rates
- ⇒ People living healthier lives
- ⇒ Consumer demands for choice
- ⇒ Availability of formal and informal caregivers

5. What's happening nationally?

- ⇒ Centers for Medicare and Medicaid Services (CMS)
- ⇒ Administration on Aging (AoA)
- ⇒ Project 2020—Aging Network *see handout*

6. Future of LTC services in Maine

- ⇒ Excerpts from Maine State Health Plan *see handout*
- ⇒ Maine has been a leader in rebalancing
- ⇒ Change in demographics will have big impact
- ⇒ Now is time to re-examine where we are and where we are going
- ⇒ LTC needs assessment
  - o Why we decided to do this
  - o Conducted by Muskie School and Lewin Group
  - o Baseline report – what has been happening
  - o LTC projection model – what is likely to happen based on assumptions fed into model
  - o Provides objective information to include in the mix of considerations about LTC

Home- and Community-Based Services in Maine Over the Past 28 Years

Early 1980s

- Governor's Task Force on Long Term Care
- "Stark financial situation…"
- Home-Based Care Act passed
- Supported by state leaders and advocates for elders and persons with disabilities
- New law was VERY FLEXIBLE; intended to fill gaps left by categorical programs

Early 1990s

- State budget crisis…
- Nursing home costs rising rapidly; represented 85% of LTC spending
- Little residential and home care capacity
- Consumers wanted alternatives to institutional care
- Policy goals:
  - Reduce reliance on institutional care
  - Increase support for home and community-based services
  - Better allocate resources
  - Improve quality of LTC services and assessment process
  - Increase access to LTC services and understanding of options
- Reforms:
  - Raised medical eligibility threshold for admission to nursing homes
  - Increased use of Medicare to pay for skilled nursing home care
  - Re-allocated some projected savings to home care and residential alternatives

Mid-1990s

- Maine set more stringent nursing home admission standards
- Legislature enacted universal pre-admission screening for anyone considering nursing home placement
- Invested in home care, residential alternatives and Alzheimer's respite services
- Revised nursing home medical eligibility criteria to qualify more persons with dementia
- Added Consumer-Directed Personal Care Services under Medicaid
- Consolidated care management statewide
- Home Based Care appropriation = $4.8 million (FY 1996)

Late 1990s

- For 1st time, more people received care at home than in nursing facilities
- More home-care consumers strained providers and care management agencies
- Launched automated system to determine medical eligibility and inform consumers about LTC options
- Community residential options continued to expand
- Home Based Care appropriation = $13.9 million (FY 1999)

Early 2000s

- Waiting lists for home care services had negative effect on choice and options
- Consumers and families frustrated with slow development of residential and assisted living options
- Attempted to base eligibility, spending, regulatory requirements and reimbursement on consumers' acuity
- Established levels of care based on acuity and reimbursement
- Modified rules to maximize Medicaid
- Transferred consumers from state-funded Home-Based Care program to Medicaid
- Added respite care as covered service to all home care programs
- Adopted curriculum for all personal care providers
- Explored registry for unlicensed assistive personnel
- Home-Based Care appropriation = $18.4 million—its highest point ever (FY 2001)

Mid-2000s

- Another state budget crisis…
- Reduced home care hours, costs allowed per level of care, and rates for providers
- Increased cost-sharing and decreased asset limits for home care consumers
- Initiated case mix reimbursement for Adult Family Care Homes and Assisted Living
- Enacted non-lapsing state funds
- Home care numbers down, nursing home numbers down, residential care numbers up
- Home-Based Care appropriation = $13.4 million (FY 2003); $9.7 (FY 2005)

2007 – 2008

- Another state budget crisis…
- Waiting lists begin end of summer of 2007 and continue to grow
- Some curtailed funding restored
- Home-Based Care appropriation = $10.7 million (FY 2008)

MAINE'S LONG-TERM SUPPORT SERVICES
PROGRAM DEFINITIONS AND POLICY REFERENCES

- **Each program has functional and financial eligibility criteria defined in policy.**
- **State funded programs are offered to people who are NOT eligible for a comparable MaineCare program.**

MAINECARE FUNDED LONG-TERM SUPPORT SERVICES: The following definitions are taken from the corresponding policies in the MaineCare Benefits Manual (MBM) that govern these categories of service. These are MaineCare-funded services.

- **Consumer-Directed Attendant Services (Section 12 of the MBM)**- Consumer Directed Attendant Services, also known as personal care attendant (PCA) services, or attendant services, enable eligible members with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer Directed Attendant Services include assistance with activities of daily living, instrumental activities of daily living, and health maintenance activities. The eligible member hires his/her own attendant, trains the attendant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services of the attendant.
- **Day Health Services (Section 26)** - health services that are needed to insure the optimal functioning of the member that are provided through a day health service. Day health services may include monitoring of health care, supervision, assistance with activities of daily living, nursing, rehabilitation, health promotion activities, exercise groups, counseling.
- **Elder & Adult Waiver (Section 19)** – Home and Community Benefits for the Elderly and Adults with Disabilities are in-home care and other services designed as a package to assist eligible members to remain in their homes, or other residential community settings, and thereby avoid or delay institutional nursing facility care. Home care services including nursing, personal care, therapies, adult day, respite for adults age 18-60 with disabilities and elders age 64+ with income < 300% federal poverty level (FPL) who are nursing facility level of care. Includes Family Provider Service Option – a consumer-directed model of service delivery.
- **Home Health Services (Section 40)** – Home health services are those skilled nursing and home health aide services, physical and occupational therapy services, speech-language pathology services, medical social services, and the provision of certain medical supplies, needed on a "part-time" or "intermittent" basis. Services are delivered by a Medicare certified home health agency to a member in his or her home or in other particular settings with limitations as described in Section 40.06.
- **Hospice (Section 43)** – Hospice services are a range of interdisciplinary services provided twenty four (24) hours a day, seven days a week to a person who is terminally ill and to that person's family. These services are to be delivered in the least restrictive setting possible by volunteers and professionals who are trained to help the member with physical, social, psychological, spiritual and emotional needs related to the terminal illness with the least amount of technology possible. Services are focused on pain relief and symptom management and are not curative in nature.
- **Nursing Facility Services (Section 67)** – Nursing facility services means services that are primarily professional nursing care or rehabilitative services for injured, disabled, or sick persons, needed on a daily basis and as a practical matter can only be provided in a nursing facility; ordered by and provided under the direction of a physician; and less intensive than hospital inpatient services.

- **Personal Care Services (Sections 6, 96)** –are those Activities of Daily living (ADL) and Instrumental Activities of Daily Living (IADL) services provided to a member by a home health aide, certified nursing assistant or a personal care assistant (also known as a personal support specialist), as appropriate, while completing tasks in accordance with an authorized plan of care.
- **Physically Disabled Waiver (Section 22)** – Personal attendant services for physically disabled adults age 18+ who are nursing facility level of care, have income < 300% federal poverty level (FPL) and self-direct their personal attendant services. The eligible member hires his/her own attendant, trains the attendant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services of the attendant.
- **Private Duty Nursing Services (PDN) (Section 96)** - are those services that are provided by a registered nurse and/or a licensed practical nurse, in accordance with the Board of Nursing Regulations, under the direction of the member's physician, to a member in his or her place of residence or outside the member's residence, when required life activities take the member outside his or her residence (school, preschool, daycare, medical appointments, etc.). Includes Family Provider Service Option – a consumer-directed model of service delivery.
- **Private Non-Medical Inst. (PNMI) (Section 97)** – Private Non-Medical Institution, also referred to as Residential Care, is an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, and treatment services to four or more residents in single or multiple facilities or scattered site facilities. Private non-medical institutions (PNMI) include residential care facilities that are case mix reimbursed and serve primarily older adults as well as other PNMIs that serve people with mental illness or people with substance abuse problems, and children.

STATE FUNDED LONG-TERM SUPPORT SERVICES: The following definitions are taken from the corresponding policies in the Office of Elder Services Policy Manual (OESPM) and the Office of Cognitive and Physical Disability Services Rules that govern these categories of service. These are state-funded services.

- **In-Home and Community Support Services for Elderly and Other Adults (Home Based Care) (Section 63 of the OESPM)**- In-Home and Community Support Services for Elderly and Other Adults, hereinafter referred to as Home Based Care (HBC), is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. Provision of these services is based on the availability of funds. State funds furnished through 22 MRSA §§7301-7306 and §§7321-7323 may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State HBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of care. Includes Family Provider Service Option – a consumer-directed model of service delivery.
- **Consumer-Directed Personal Assistance Services (Section 14-197, Chapter 11 of OACPDS rules)** A program, hereinafter referred to as **Consumer-Directed Home Based Care (CDHBC),** is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. State funds furnished through 34-B M.R.S.A. §5438 may not be used to supplant the resources available from

families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State CDHBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of service.

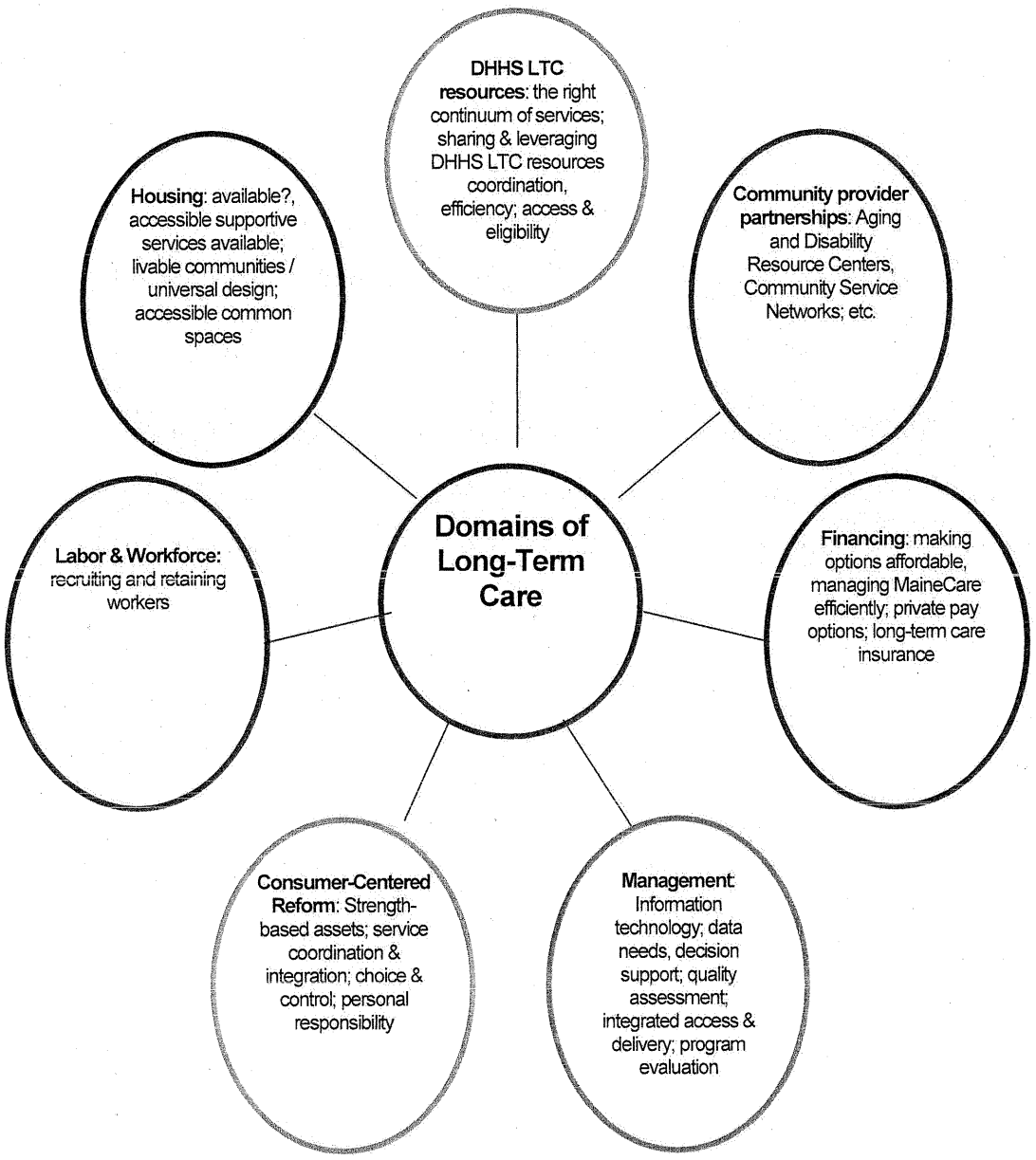
- **Adult Day Services (Section 61 of the OESPM)** - Adult Day Services are services provided by an appropriately licensed adult day program that receives funding assistance from the Office of Elder Services for consumers who require assistance in paying for this service. Services include assistance with activities of daily living while attending the day services program, provision of snacks and a meal while in attendance at adult day service program, provision of activities, socialization and stimulation, and transportation services necessary to perform activities and socialization services described in a recipients' plan of care, such as transport to medical appointments.
- **Office of Elder Services Homemaker Program (Section 69 of the OESPM)** – The OES Homemaker program is a state funded program to assist individuals with household or personal care activities that improve or maintain adequate well-being. Homemaker services may be provided for reasons of illness, disability, absence of a caregiver, or to prevent adult abuse or neglect. State homemaker funds shall be used to purchase only the covered services that will foster restoration of independence, consistent with the consumer's circumstances and the Authorized Plan of Care. Major service components include homemaker services, chore services, home maintenance services, incidental assistance with personal hygiene and dressing and household management services. Includes consumer-directed option.
- **Independent Housing with Services Programs (Section 62 of the OESPM)** receive Office of Elder Services funds to subsidize the cost of services at certain sites in compliance with 22 M.R.S.A. Chapter 1664. Independent Housing with Services means residential housing that consists of private dwelling units with an individual bathroom and an individual food preparation area, in addition to central dining facilities. An assisted housing supportive services program serves occupants as described in 22 M.R.S.A. § 7852 (3) through a comprehensive program of supportive services, serving three or more consumers at a site, including meals, housekeeping and chore assistance, service coordination/care management, personal care services, emergency response and other services that are delivered on the site of an Independent Housing and Services Program.
- **Respite Care for People with Alzheimer's Disease or Related Disorders (Section 68)** Services provided to individuals on a short-term basis, because of the absence of, or need for relief of, the caregiver. This service may be provided in the home, in a licensed Adult Day program, or in an institutional setting. An institution is an assisted living facility licensed according to 22 M.R.S.A. Section 7901-A-7902; a nursing facility, or unit, licensed according to 22 M.R.S.A. Section 1811-1824; an acute care or rehabilitation facility, licensed according to 22 M.R.S.A. Section 1811-1824; or a facility for the treatment or management of persons who have mental retardation or mental illness.

MAINE LONG-TERM SUPPORT SERVICES ACRONYM LIST

Acronym/Abbreviation	Definition
AD	Alzheimer's Disease
ADC	Adult Day Care
ADHCB	Home and Community Benefits for Adults with Disabilities
ADL	Activity of Daily Living
ADW	Adults with Disabilities Waiver
AFCH	Adult Family Care Home
AHU	Administrative Hearings Unit
ALF	Assisted Living Facility
AO	Alpha One
APRC	Awaiting Placement for Residential Care
ASA	Assessing Services Agency
CDPAS	Consumer Directed Personal Attendant Services
CPS	Cognitive Performance Score
DHHS	Department of Health & Human Services
DME	Durable medical equipment
DX	Diagnosis
EC	Extraordinary Circumstances
EHCB	Home and Community Benefits for Elderly (EW)
EIM	Elder Independence of Maine
ERS	Emergency Response System
EW	Elderly Waiver
FPSO	Family Provider Service Option
GHS	Goold Health Systems
HBC	Home Based Care
HCB	Home and Community Benefits for Elderly/Adults with Disabilities
HCBS	Home and Community Based Services
HCCA	Home Care Coordinating Agency
HH	Home Health
HHA	Home Health Aide or Home Health Agency
IADL	Instrumental Activities of Daily Living
ILA	Independent Living Assessment
LOC	level of care
LTC	long term care
MBM	MaineCare Benefits Manual

Acronym/Abbreviation	Definition
MCD	Medicaid (now MaineCare)
MCR	Medicare
MDT	Multi Disciplinary Team
MED	Medical Eligibility Determination
MH	Mental Health
MHH	MaineCare Home Health
MNCR	MaineCare
MOW	Meals on Wheels
MR	Mental retardation
NF	Nursing Facility
OACPDS	Office of Cognitive and Physical Disability Services
OES	Office of Elder Services
OIAS	Office of Integrated Access & Support
OMS	Office of MaineCare Services
OOS	out of state
PA	Personal attendant or physician assistant
PCA	Personal Care Attendant/Assistant
PDN	Private Duty Nursing/Personal Care Services
PNMI	Private Non-Medical Institution
POC	Plan of Care
PSS	Personal Support Specialist
RCF	Residential Care Facility
ROI	Release of Information
SNF	Skilled Nursing Facility
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
TPL	Third Party Liability
UR	Utilization Review

"Domains" of Long-Term Care



Based on 1996 Long-Term Care Reform Plan of the Centers for Medicare and Medicaid Services (CMS) [1]

Definition of Long-term Care

- Care that is needed by individuals with long-term disabilities
- Individuals with frailty and/or dementia associated with aging
- Individuals with advanced chronic conditions; and
- Other individuals at or near the end-of-life.

Vision for Long-Term Care in the 21st Century

1. *Choice and independence*
    - Beneficiaries will have greater flexibility to choose from a broad spectrum of long-term care services, including home and community-based and facility-based services
    - "Money will follow the person" to the most appropriate and preferred setting rather than the person following the money to less appropriate and often more costly services.
    - Beneficiaries will also have access to affordable and accessible housing
    - All of these changes will enable services to be tailored to each individual's unique needs and preferences
2. *Adequate workforce*
    - The labor supply will satisfy the demand for services and that workers will have the proper training to be able to provide high quality care.
    - Compensation and working conditions will enable the system to both attract and retain paid/professional caregivers with appropriate skills.
    - Family caregivers, which are a critical component of the labor force for long-term care services, will have the training and supports they need to be able to provide high quality care to their family members.
3. *Access; information*
    - Beneficiaries will have access to the information they need to be able to make informed choices and plan for their future care needs.
    - Cost and quality information will enable beneficiaries to compare specific services across different providers,
    - Comprehensive "single entry points" will help beneficiaries to navigate the health care system.

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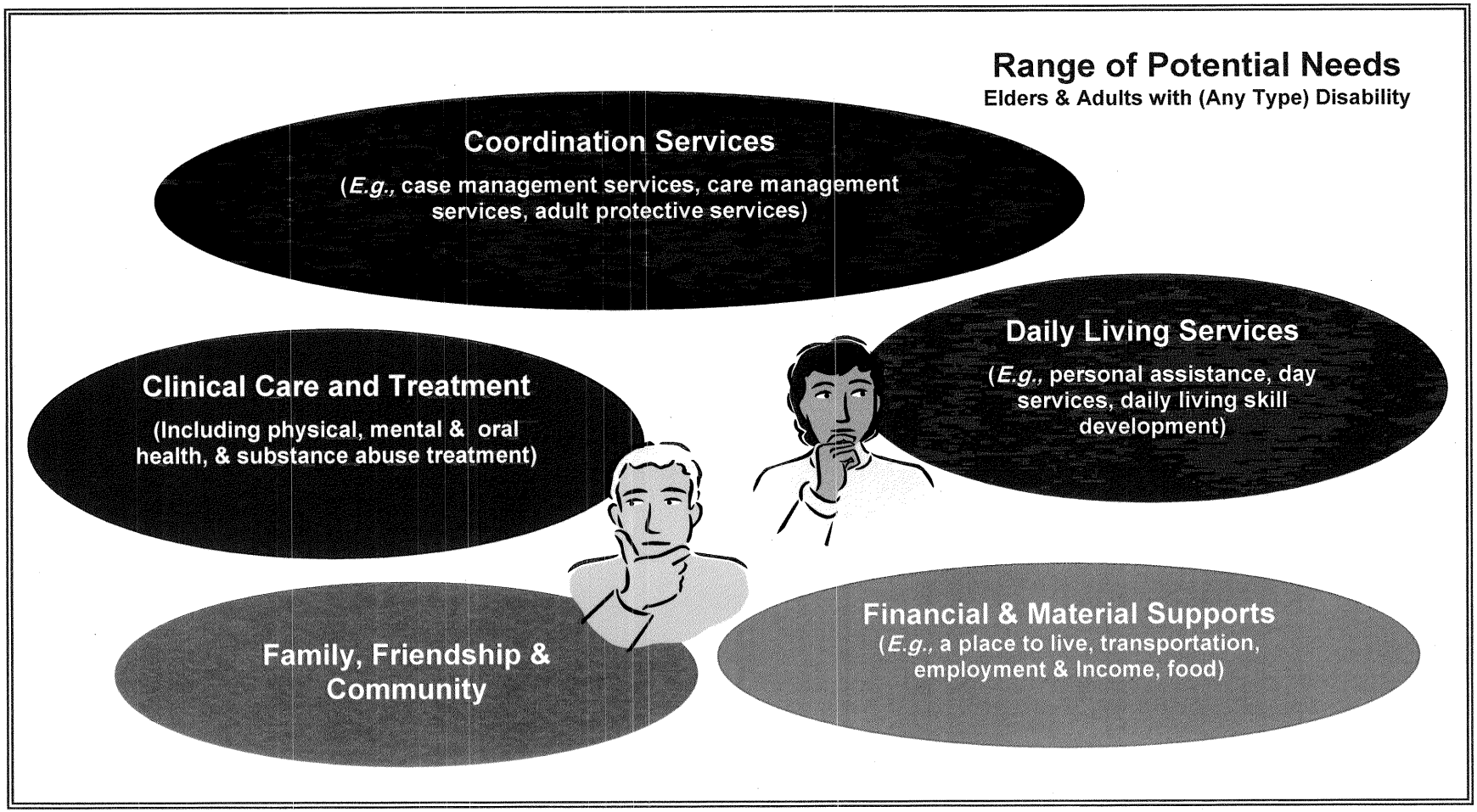
[1] CMS Policy Council Document. 9/28/06. Long-Term Care Reform Plan.

- Assistance will be available, when needed, to assemble and interpret the information provided through "single entry points."

4. *Coordinated, high quality care*
    - Care will be safe, effective, efficient, and timely, not only using the latest high-technology devices, but also providing care that prevents complication.
    - There will be coordinated discharge planning or end-of-life services.
    - There will be an assessment instrument.
    - There will be coordination of services, particularly of Medicare and Medicaid benefits.
    - Beneficiary quality of life, which depends to a great extent on the strength of relationships between patients and providers, will be improved by optimizing working conditions and job satisfaction for front-line staff.
5. *Financially sustainable*
    - Americans will recognize the importance of planning for their long-term care needs.
    - Private financing options will be available and affordable.
    - Additional supports will be made available to family caregivers.
    - Medicaid will continue to protect the most needy.
6. *Health information technology*
    - Health information technology systems will be implemented in all settings and fully operable across settings.
    - Systems will support the delivery of coordinated, higher quality care.
    - Personal health records will encourage beneficiaries to become more active in managing their care.
    - Information systems will include appropriate privacy protections.


Range of Potential Needs
Elders & Adults with (Any Type) Disability
Coordination Services
(E.g., case management services, care management services, adult protective services)
Daily Living Services
(E.g., personal assistance, day services, daily living skill development)
Clinical Care and Treatment
(Including physical, mental & oral health, & substance abuse treatment)
Family, Friendship & Community
Financial & Material Supports
(E.g., a place to live, transportation, employment & Income, food)

Categories of Long Term Care & Support Services

Across Population Groups

Coordination Services
- Case management services
- Community support services
- Care management services
- Protective services & guardianship

Daily Living Services (Home & Community Based)
- Performance of, or guiding, directing, or overseeing the performance of self-care and self-management
- Skill development services
- Peer support services
- Adaptive equipment

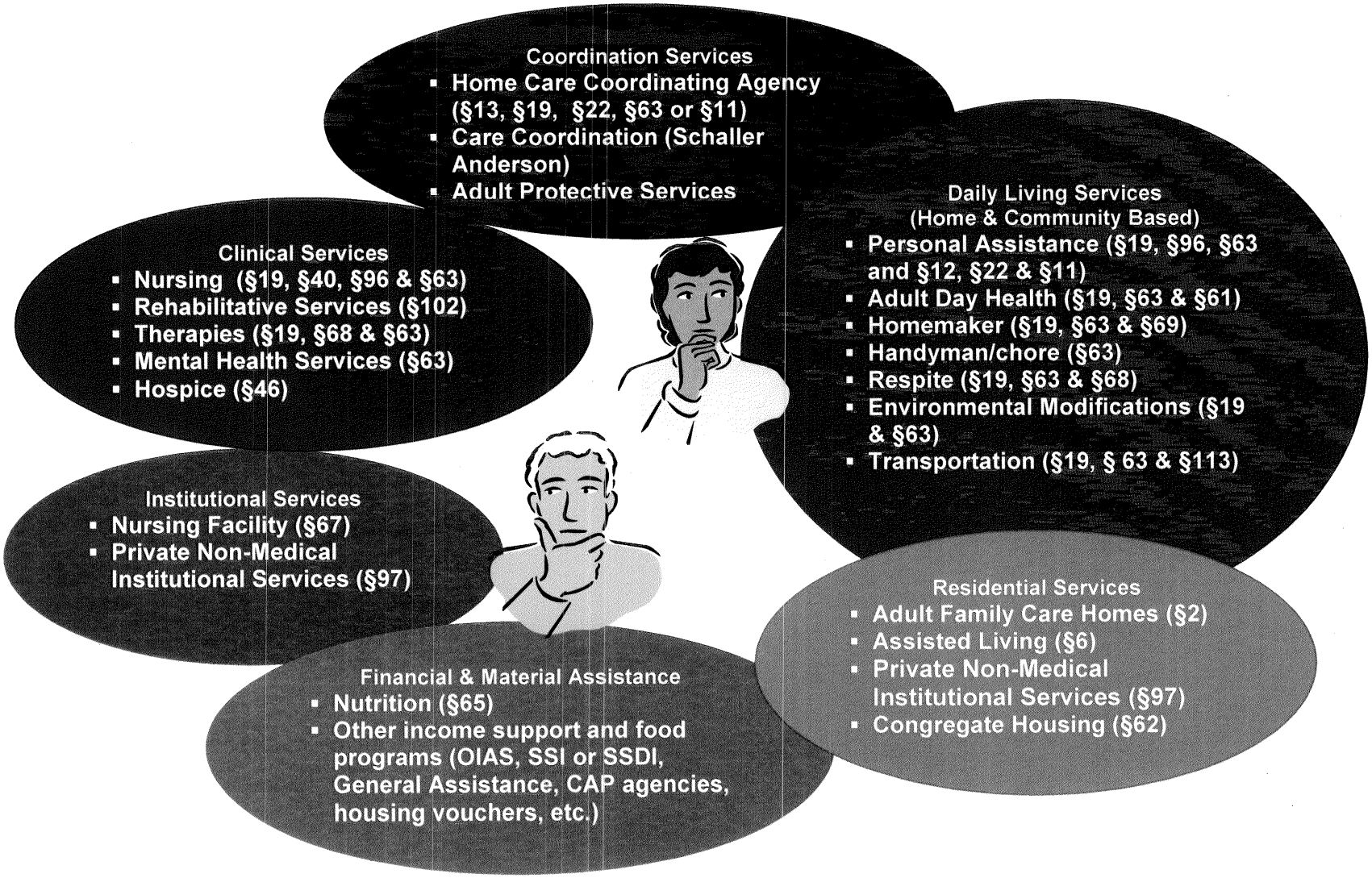
Related Clinical Services (Home & Community Based)
- Nursing services
- Physical, occupational, and speech therapies
- Rehabilitation services
- Mental health treatment
- Substance abuse treatment
- Medication management
- Etc.

Residential Services
- Supportive housing (daily living and clinical services tied to a provider-owned residence)

Hospital & Institutional Services
- General hospital
- Psychiatric hospital
- State-operated Hospital
- Nursing facility
- Intermediate care facility for persons with mental retardation

Financial & Material
- Rental assistance tied to an individual's home, apartment, etc.
- Income support programs
- Food programs

Elder and Adult Services



Error!Elder & Adult Services

Target Population: Older adults and adults with a disability. Eligibility is based on functional criteria, not a diagnosis, meaning that people not meeting the diagnostic criteria of other programs, or people not able to obtain services through other programs, may be served through these elder and adult programs.

Relevant Regulations and Programs

MaineCare Benefits Manual (MBM)
§2 Adult Family Care Homes
§6 Assisted Living
§12 Consumer Directed Attendant Services
§13 Targeted Case Management Services
§19 Home and Community Benefits for the Elderly and Adults with Disabilities
§22 Home and Community Benefits for the Physically Disabled
§26 Day Health Service
§40 Home Health Services
§43 Hospice Services
§67 Nursing Facility Services
§96 Private Duty Nursing and Personal Care Services
§97 Private Non-Medical Institutional Services
§102 Rehabilitative Services

State-Funded Programs via Office of Elder Services (OES)
§61 Adult Day Services
§62 Independent Housing with Services
§63 In-Home and Community Support Services for Elderly and Other Adults
§65 Nutrition Services
§68 Respite Care for People with Alzheimer's or Related Disorders
§69 Office of Elder Services Homemaker Program
Adult Protective Services
Public Guardianship
Evidence-Based Healthy Aging Program

State-Funded Programs via Office of Adults with Cognitive and Physical Disability Services (OACPDS)
§11 Consumer Directed Personal Assistance Services

Maine's Current Long Term Care System Compared to Selected Other States 2006

	Distribution of Medicaid LTC Expenditures For Older Adults and Adults w/Disabilities		
	Percent Institutional Services	Percent Community-Based Services	Rank in % Community-Based Services
Oregon	45.1%	54.9%	1
Idaho	59.7%	40.3%	9
New York	63.9%	36.1%	11
Vermont	72.8%	27.2%	18
Maine	75.0%	25.0%	22
Mass.	75.5%	24.5%	24
New Hampshire	86.6%	13.4%	42
Rhode Island	88.4%	11.6%	46

Monthly Average Number of MaineCare Service Users

COS	MaineCare Category of Service	SFY 1994	SFY 1995	SFY 2000	SFY 2004	SFY 2006	Percent Change 2000-2006
3	Nursing Facility	7,743	7,307	5,431	4,978	4,717	-13.14%
11	Home Health Services	2,478	2,545	1,673	919	741	-55.70%
21	Hospice	-	-	-	-	28	
22	Waiver for Physically Disabled	128	142	274	285	200	-27.12%
36	Day Health	6	20	79	88	56	-28.93%
39	Private Non-Medical Institutions	2,124	2,256	4,980	5,580	5,290	6.22%
55	Consumer-Directed Attendant Services	-	5	227	248	303	33.05%
57	Elder & Adults w/ Disabilities Waiver	692	620	1,043	846	716	-31.36%
58	Private Duty Nursing	92	88	488	806	743	52.44%
59	Personal Care Services	192	127	735	1,344	1,384	88.33%

Monthly Average MaineCare Expenditures

COS	MaineCare Category of Service	SFY 1994	SFY 1995	SFY 2000	SFY 2004	SFY 2006	
3	Nursing Facility	$19,333,701	$19,241,508	$15,487,249	$19,265,598	$18,621,579	20.24%
11	Home Health Services	$971,702	$1,116,978	$891,145	$508,840	$358,529	-59.77%
21	Hospice	-	-	-	-	$92,044	
22	Waiver for Physically Disabled	$139,706	$172,684	$605,737	$751,196	$499,427	-17.55%
36	Day Health	$1,815	$9,192	$49,727	$70,510	$34,389	-30.84%
39	Private Non-Medical Institutions	$2,182,116	$2,752,488	$11,632,002	$18,727,543	$19,953,232	71.54%
55	Consumer-Directed Attendant Services	-	$2,723	$281,133	$394,006	$245,920	-12.53%
57	Elder & Adults w/ Disabilities Waiver	$502,824	$599,654	$1,577,345	$1,414,622	$1,206,999	-23.48%
58	Private Duty Nursing	$132,661	$152,668	$290,089	$358,390	$367,323	26.62%
59	Personal Care Services	$214,088	$123,330	$378,125	$747,305	$897,845	137.45%

Average MaineCare Expenditures per Person per Month

COS	MaineCare Category of Service	SFY 1994	SFY 1995	SFY 2000	SFY 2004	SFY 2006	
3	Nursing Facility	$2,496.85	$2,633.27	$2,851.73	$3,870.15	$3,947.62	38.43%
11	Home Health Services	$392.18	$438.93	$532.74	$553.69	$483.79	-9.19%
21	Hospice	-	-	-	-	$3,326.90	
22	Waiver for Physically Disabled	$1,091.46	$1,216.08	$2,207.36	$2,632.70	$2,497.13	13.13%
36	Day Health	$302.54	$453.93	$630.13	$798.98	$613.18	-2.69%
39	Private Non-Medical Institutions	$1,027.28	$1,220.07	$2,335.70	$3,356.29	$3,771.94	61.49%
55	Consumer-Directed Attendant Services	-	$573.17	$1,236.20	$1,590.34	$812.73	-34.26%
57	Elder & Adults w/ Disabilities Waiver	$726.45	$966.92	$1,512.44	$1,671.64	$1,686.14	11.49%
58	Private Duty Nursing	$1,445.90	$1,736.50	$594.85	$444.93	$494.10	-16.94%
59	Personal Care Services	$1,114.07	$974.94	$514.46	$555.89	$648.61	26.08%

Source: MaineCare Claims Data

Long-term Care Expenditures FY2006

Monthly Average Number of MaineCare Service Users

COS	MaineCare Category of Service	SFY 2006
3	Nursing Facility	4,717
11	Home Health Services	741
21	Hospice	28
22	Waiver for Physically Disabled	200
36	Day Health	56
39	Private Non-Medical Institutions	5,290
55	Consumer-Directed Attendant Services	303
57	Elder & Adults w/ Disabilities Waiver	716
58	Private Duty Nursing	743
59	Personal Care Services	1,384

Monthly and Annual Average MaineCare Expenditures

COS	MaineCare Category of Service	SFY 2006	SFY 2006 Annual Cost
3	Nursing Facility	$18,621,579	$223,458,951.67
11	Home Health Services	$358,529	$4,302,349.12
21	Hospice	$92,044	$1,104,532.45
22	Waiver for Physically Disabled	$499,427	$5,993,118.49
36	Day Health	$34,389	$412,667.79
39	Private Non-Medical Institutions	$19,953,232	$239,438,780.79
55	Consumer-Directed Attendant Services	$245,920	$2,951,040.48
57	Elder & Adults w/ Disabilities Waiver	$1,206,999	$14,483,982.17
58	Private Duty Nursing	$367,323	$4,407,871.73
59	Personal Care Services	$897,845	$10,774,141.54

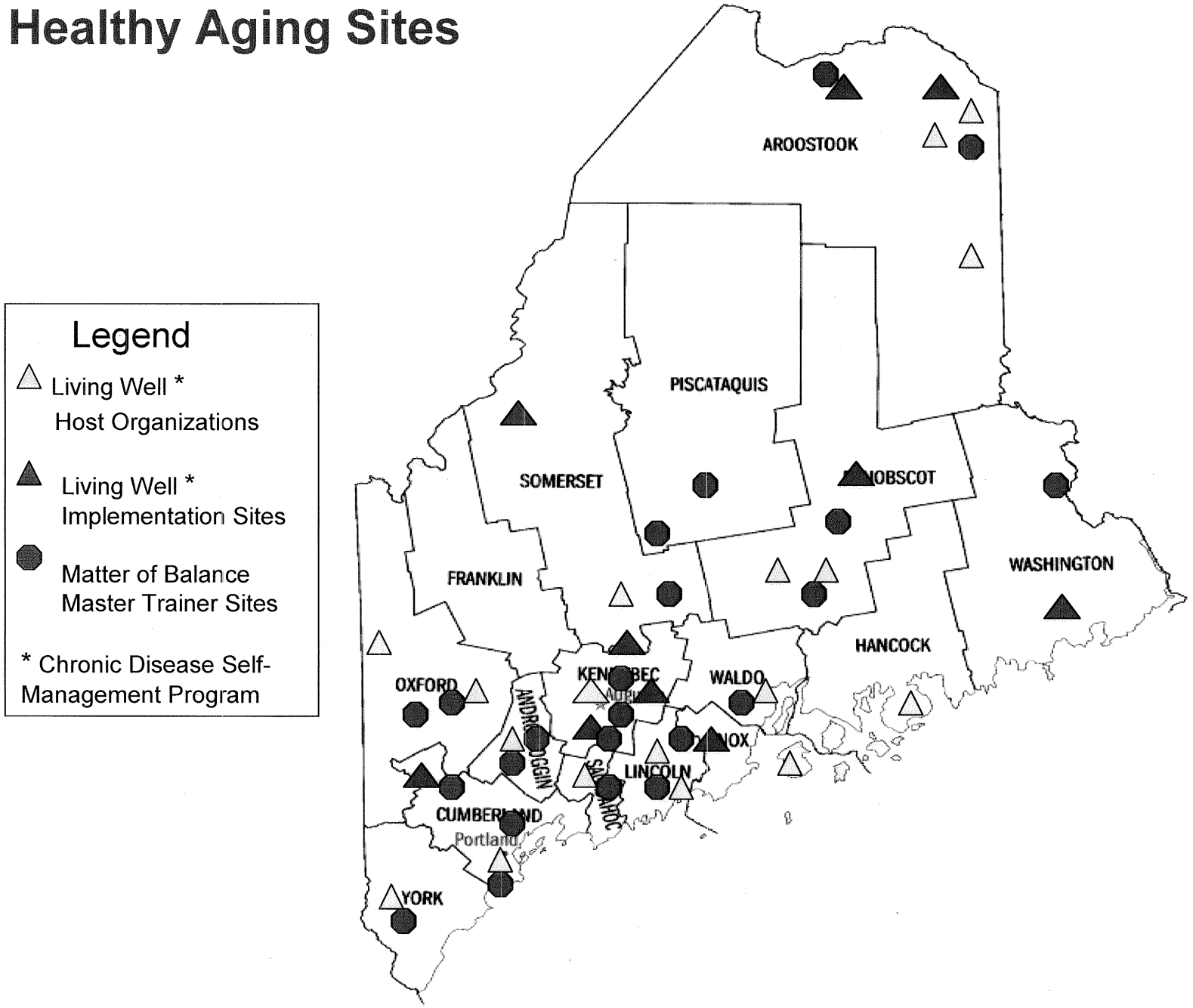
Average MaineCare Expenditures per Person

COS	MaineCare Category of Service	Average Monthly Cost Per Member
3	Nursing Facility	$3,947.62
11	Home Health Services	$483.79
21	Hospice	$3,326.90
22	Waiver for Physically Disabled	$2,497.13
36	Day Health	$613.18
39	Private Non-Medical Institutions	$3,771.94
55	Consumer-Directed Attendant Services	$812.73
57	Elder & Adults w/ Disabilities Waiver	$1,686.14
58	Private Duty Nursing	$494.10
59	Personal Care Services	$648.61

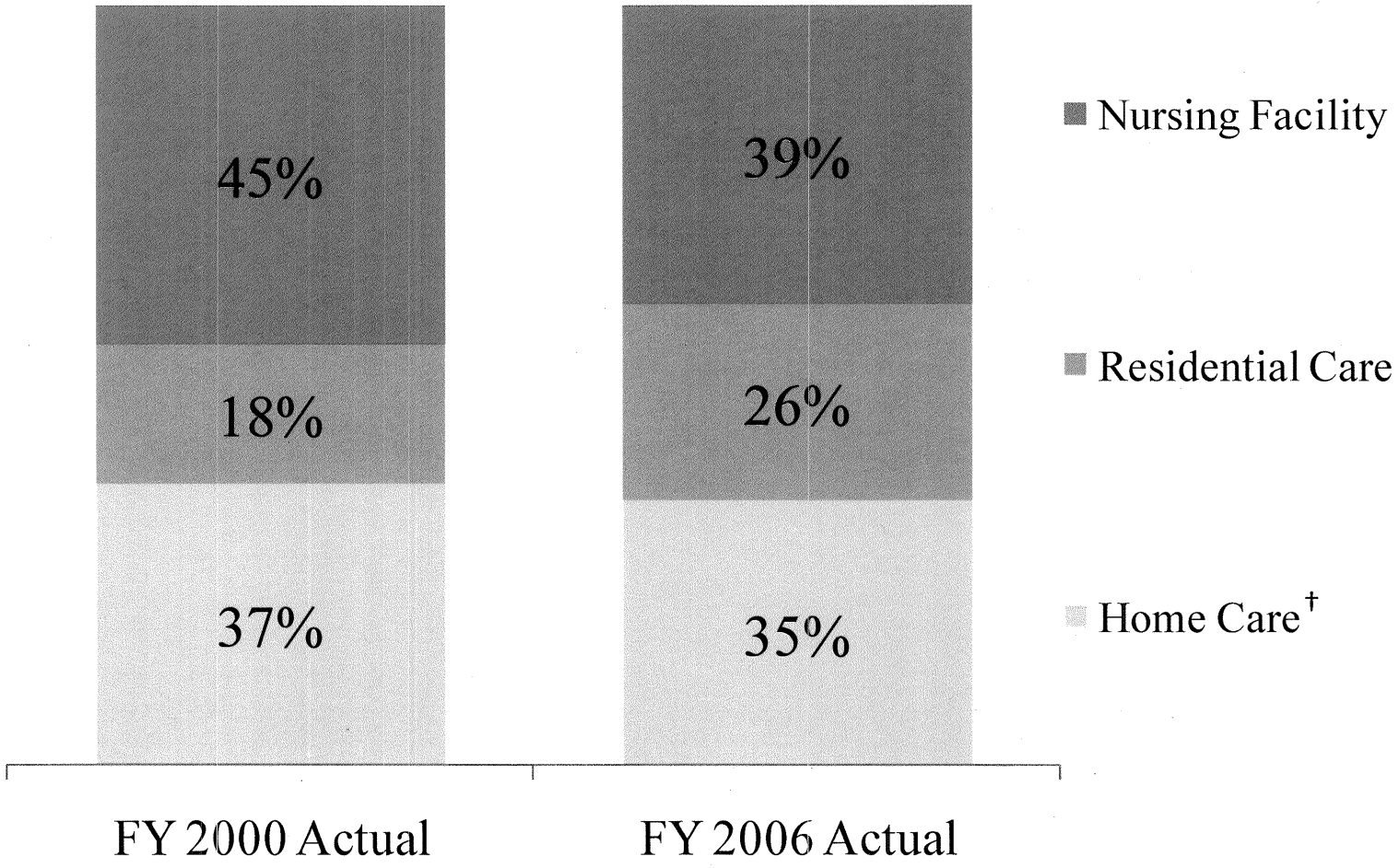
Source: MaineCare Claims Data

General Funded Services FY2006	Total Expenditure	# People Served	Per Capita Cost
Home Based Care: Elder & Adults	$6,932,627.00	2005	$3,458
Homemaker Program	$2,051,555.00	1636	$1,254

Healthy Aging Sites



Actual Distribution of MaineCare Long-term Care Users* Across Settings, 2000 to 2006



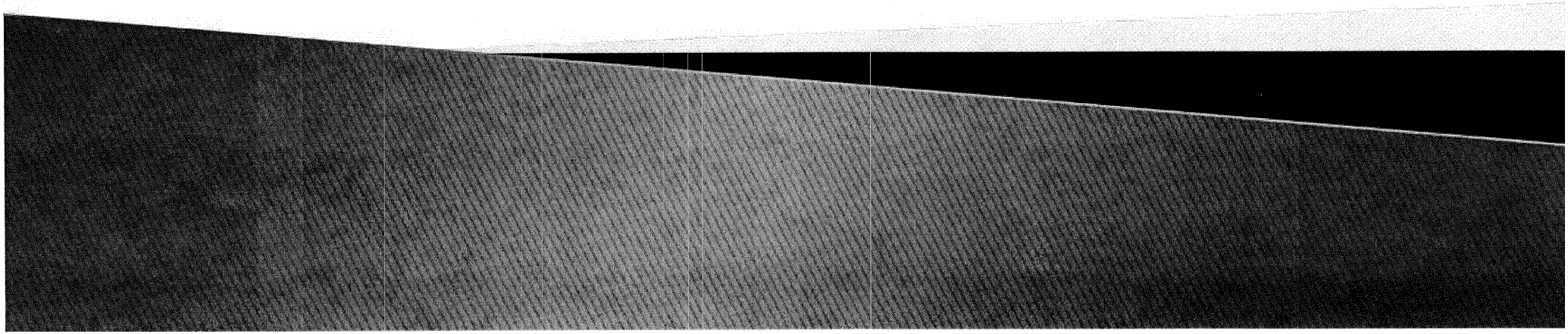
*Average monthly users

† Home Health Services, Waiver for Physically Disabled, Day Health, Consumer Directed Attendant Services , Elderly and Adult Waiver , Private Duty Nursing, Personal Care Services, and Hospice

Project 2020: Fulfilling the Promise of the Older Americans Act

NASUA
National Association of State Units on Aging

n4a
Advocacy. Action. Answers on Aging



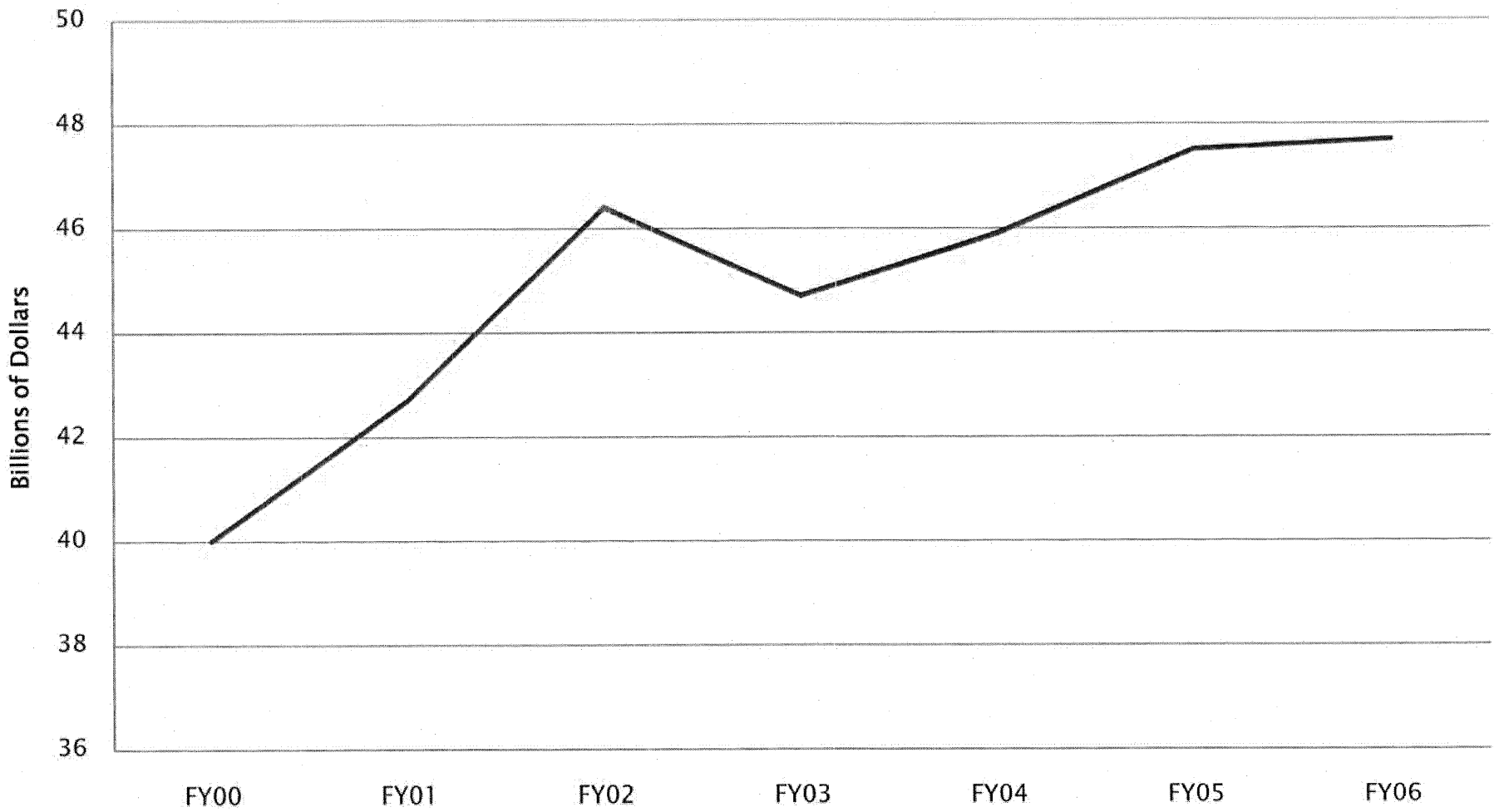
Background

- Winter meetings of NASUA and n4a
- Boards have met dozens of times to hammer out agreements
- Reauthorization of Older Americans Act language
- Seeking appropriations to match the authorizing language
- Using the past five years tested and proven best practices

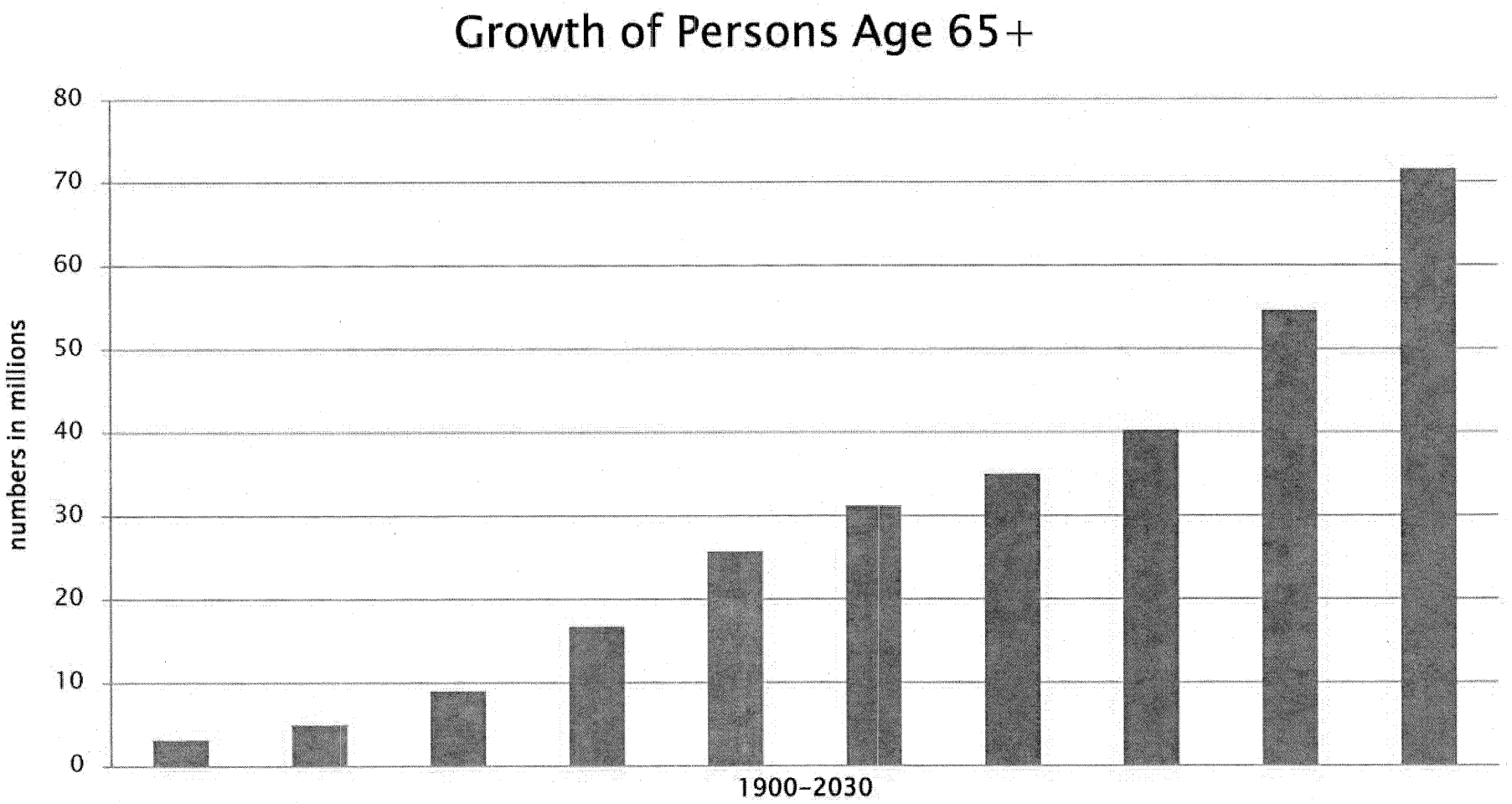
NASUA/n4a Principles

- First, do no harm.
- Build on current aging services network, not replace it.
- Encourage individuals ability to live independently.
- Continue to serve the unique needs of rural, poor, minority, and disabled and aging populations.
- Support consumer directed initiatives.
- Services should not be greater than the Medicaid waiver program.
- Encourage the increased use of technology to support efforts.
- Recognize that individuals, AAAs, SUAs, providers, and the federal government all have to contribute to make the program successful.

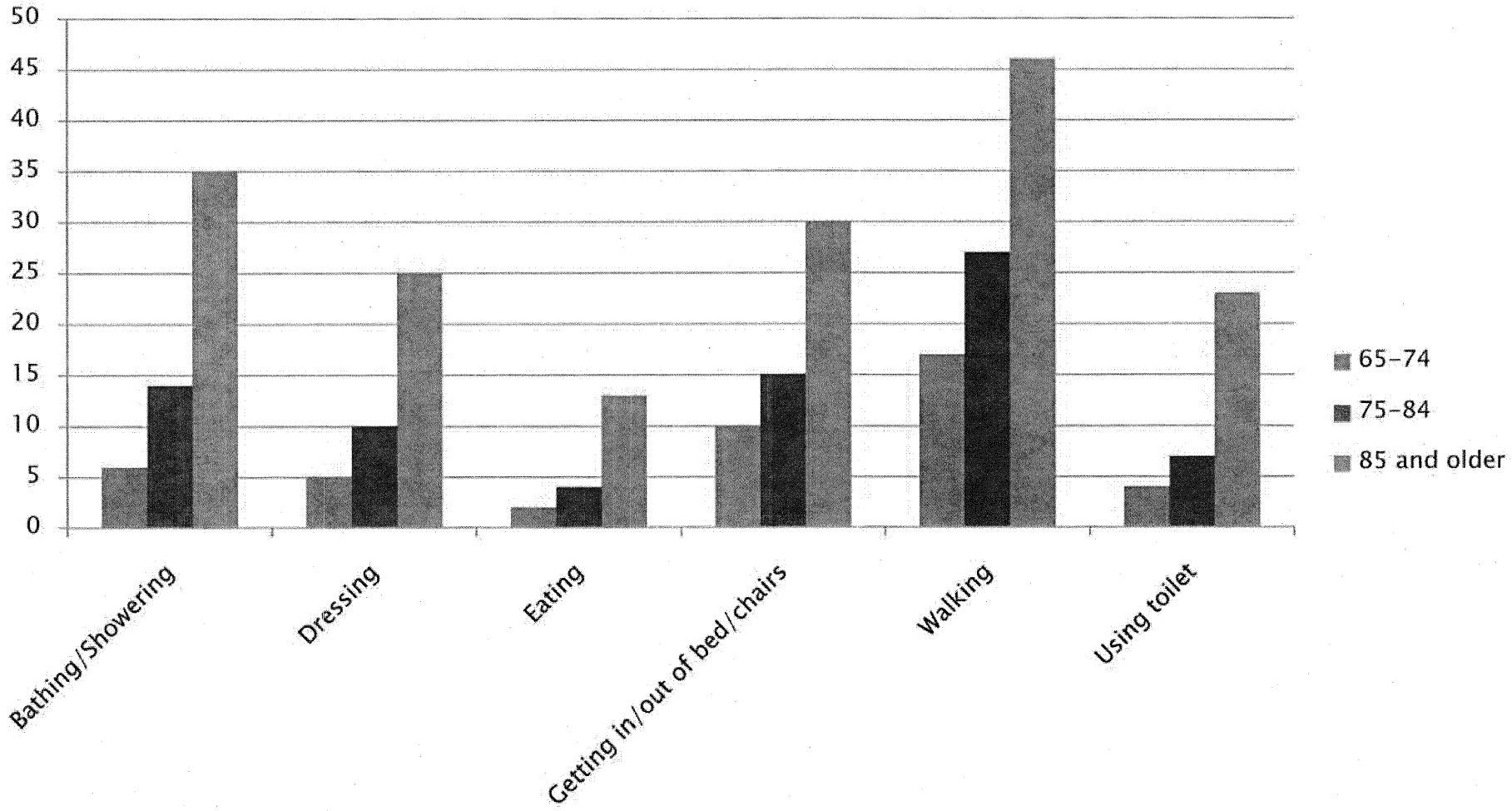
Medicaid Nursing Facility Spending



Need for Action



Percent of Individuals with Limitations in Activities of Daily Living by Age Group



The Aging Services Network

- Who We Serve?
  - 27% of consumers are poor
  - 33% of consumers live in rural areas
  - 20% of consumers are minority
  - 52% of older persons report having a disability
- Who Are We?
  - 56 State Units on Aging
  - 655 Area Agencies on Aging
  - Thousands of Service Providers

Components of the Proposal

1. Person-Centered Access to Information
2. Evidence-Based Health Promotion and Disease Prevention
2. Enhanced Nursing Home Diversion Services

Components of the Proposal

Component of Program	Service
Person-Centered Access to Information	Provides assistance, access, counseling and awareness of long-term care services and supports
Evidence-Based Disease Prevention and Health Promotion	Targets scientifically proven interventions to reduce chronic disease and disability to affected elderly individuals
Enhanced Nursing Home Diversion Services	Provides consumer directed community care to individuals at high risk of institutionalization

Number of Recipients

Component of Program	Eligibility Criteria	Estimated Number of Recipients (5 years)	Estimated Number of Recipients (10 years)
Person-Centered Access to Information	Anyone interested in Long-Term Care	39 million	105 million
Evidence-Based Disease Management and Health Promotion	Individuals 60 or older or who are at risk of falls	1.2 million	3.9 million
Enhanced Nursing Home Diversion Services	300 percent of SSI with assets in excess of $25,000	118,000	164,000

Federal Savings

Components of Program	Estimated Federal Savings (5 years)	Estimated Federal Savings (10 years)
Person-Centered Access to Information	$324 million	$1.2 billion
Evidence-Based Disease Prevention and Health Promotion	$308 million	$1.24 billion
Enhanced Nursing Home Diversion Services	$5 million	$159.4 million

Person-Centered Single-Entry Point Systems

	Federal	State	Total
Outlays	$582.7 million	$194.2 million	$776.9 million
Savings	$1.8 billion	$1.4 billion	$3.2 billion
Net Savings	$1.2 billion	$1.2 billion	$2.4 billion

**Over 10 years*

Evidence-Based Health Promotion and Disease Prevention

	Federal	State	Total
Outlays	$823.3 million	$145.3 million	986.6 million
Savings	$2.1 billion	$_____*	$2.1 billion
Net Savings	$1.2 billion	$145.3 million	$1.1 billion

**Over 10 years*

Enhanced Access to Home and Community Based Services

	Federal	State	Total
Outlays	$7.4 billion	$4.5 billion	$11.9 billion
Savings	$7.6 billion	$5.8 billion	$13.4 billion
Net Savings	$159.4 million	$1.4 billion	$1.5 billion

**Over 10 years*

Other Components

- Technology Grants (examples of some uses)
  - To build web portals for ADRCs
  - To develop on-line training programs for disease management
  - To build health information exchanges for community centers
- Technical Assistance
  - State and community level-specific, tailored technical assistance
- Evaluation

How would it work?

- Competitive Grant program
- Nursing Home Diversion Component rolled out in three phases
- Maximizes state flexibility in design of their program to best suit needs of their state
- State's match
  - 25 percent of ADRC program
  - 15 percent of evidence-based program
  - Difference between FMAP plus 5 for Nursing Home Diversion program

What's Next?

For additional information

Advocacy. Action. Answers on Aging.

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Prepared by Office of Elder Services 9/19/08

Respite and Other Services for People with Alzheimer's Disease and Their Families (FY 2007)

Section 69, OES Policy Manual

TYPE of SERVICE	AGENCY					TOTAL
	Aroostook	EAA	Spectrum	SeniorsPlus	SMAA	
In-home respite (agency)	67	56	7	18	17	165
Respite – family/friend/neighbor	4	53	65	43	37	202
Overnight respite	0	6	2	0	3	11
In-home respite assessment	96	38	58	35	30	257
Adult day	3	15	12	7	7	44
Information and support – no respite	297	186	374	329	48	1,234
Home modifications	5	0	2	0	0	7
Referral to mental health service	25	0	19	0	21	65
Referral to hospice	7	0	0	2	7	16
Referral to Dr. Laurel Coleman	1	2 consult	0	0	0	3

As of September 1, approximately 48 people were on the waiting list for respite services.

People Receiving Home Care Services

Respite Use by Setting and Program				
Community Program	Nursing Facility Respite	Residential Care Respite	In Home Respite # People	In Home Respite % People
Elderly	34	4	721	68%
Adults w/ Disabilities	15	2	260	63%
Home Based Care Level 1	0	1	67	16%
Home Based Care Level 2	4	1	97	18%
Home Based Care Level 3	6	1	117	30%
Home Based Care Level 4	10	1	116	62%
TOTAL	**70 (1.36%)**	**10 (0.19%)**	**1378**	**27%**

Office of Elder Services
Policy Section 63: In-Home and Community Support Services for Elderly and Other Adults
(100% State-funded)

Home Based Care Wait List Statistics - September 17, 2008

The waiting list information is provided by Elder Independence of Maine.

Total # Consumers on Wait List	**685***	**535**	**148**

The Wait List has been in place since August 2007. See below for information about the consumers removed from the Wait List to date. The longest length of wait time for a consumer currently on the Wait List is approximately 10 months (December 6, 2007).

The estimated cost to fund the plans of care for the current Wait List is $6.265 milliion.

Consumer Age	**Total**	**Full****	**Partial****
Over 60	614	484	130
59 and Below	69	51	18
# Consumers with Diagnosis of Dementia	161	137	24
Total by Home Based Care (HBC) Level	**Total**	**Full**	**Partial**
Total HBC 1 on Waitlist	212	194	18
Total HBC 2 on Waitlist	229	174	55
Total HBC 3 on Waitlist	154	112	42
Total HBC 4 on Waitlist (NF Level of Care - 13%)	88	55	33
Total by County	**Total**	**Full**	**Partial**
Aroostook	102	75	27
Androscoggin	35	25	10
Cumberland	99	86	13
Franklin	23	18	5
Hancock	22	18	4
Kennebec	75	54	21
Knox	11	9	2
Lincoln	16	15	1
Oxford	30	22	8
Piscataquis	15	12	3
Penobscot	79	65	14
Sagadahoc	6	4	2
Somerset	29	21	8
Washington	23	17	6
Waldo	24	22	2
York	94	72	22

		Full	**Partial**
Total Consumers Removed from Wait List	**470**	**276**	**194**
Full Wait List who Accepted Services	109	109	0
Partial Waitlist- Implemented Additional Services	101	0	101
Total Discharged from Waitlist with Other Reason	66	34	32
Total Deceased	62	40	22
Total Ineligible	8	6	2
Total Moved	4	2	2
Total who had Nursing Facility Placement	42	20	22
Total who had Other Facility Placement	36	28	8
Total who Refused Services	42	37	5

*Includes two consumers on hold
**Full means they are waiting for all services and are not a consumer.
**Partial means they are a current consumer but have been reassessed and found to need. additional

Wait List for Homemaker Services

Information Provided by Home Care for Maine as of 9/18/08

657 on wait list because of inadequate funding

209 on wait list because cases are unstaffed due to lack of staff

	Distribution of Medicaid LTC Expenditures For Older Adults and Adults w/Disabilities				
	Percent Institutional Services	Percent Community-Based Services	Rank in % Community-Based Services	Rank in % Age Group is of Total Pop.	
				Age 65-84	Age 85+
Oregon	45.1%	54.9%	1	32	16
Idaho	59.7%	40.3%	9	44	36
New York	63.9%	36.1%	11	22	17
Vermont	72.8%	27.2%	18	21	21
Maine	75.0%	25.0%	22	4	11
Mass.	75.5%	24.5%	24	23	10
New Hampshire	86.6%	13.4%	42	37	31
Rhode Island	88.4%	11.6%	46	13	5

Home and Community-Based Programs—Services, Eligibility, and Copayment Requirements

PROGRAM	SERVICES	HOW TO QUALIFY	CO-PAY
Medicare Home Health	Nursing, Therapy, Social Work	Homebound, nursing need, 65+ or disabled, doctor's order	No
MaineCare Home Health	Nursing, Therapy, Social Work	Financially eligible; meet medical requirements; doctor's order	$5 month
MaineCare Private Duty Nursing/Personal Care Services	Nursing, Homemaking, Personal care Family Provider Option	Financially eligible; meet medical requirements	$5 month
MaineCare Adult Day Health	Exercise, Health Monitoring, Socialization, Nursing	Financially eligible; meet medical requirements	$5 month
MaineCare: Consumer-Directed Attendant Services	Personal Care Services, Skills Training	Financially eligible; need help with daily activities; able to direct own care	$5 month
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
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
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
Home Based Care: Elders and Other Adults	Personal Care, Homemaking, Nursing, Therapy, Care Coordination	Age 18+; need help with daily activities	4% monthly income; 3% of assets over $15,000
Homemaker	Homemaking, chores, grocery shopping, laundry, transportation, some personal care	Age 18+; need help with daily activities; financially eligible	20% of cost of services
Alzheimer's Respite	In-home respite, institutional respite, adult day care	Diagnosis of dementia; caregiver needs respite; financially eligible	20% of cost of services
Adult Day Services	Socialization, exercise	Need help with daily activities; financially eligible	20% of cost of services

Maine's
2008-2009
State Health Plan

Issued by
The Governor's Office
of Health Policy and Finance
With
The Advisory Council
On Health Systems Development

April 2008

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Augusta, Maine 04333
Phone: 207-624-7442
GOHPF@maine.gov
www.maine.gov/governor/baldacci/cabinet/health_policy.html

Goal/Task: Evaluate the impact on the public's knowledge and ability to take appropriate action using the Behavioral Risk Factor Surveillance System survey. Maine CDC/DHHS - December, 2009.

The model of In a Heartbeat for community engagement and care standardization in emergency departments and hospitals has great potential and can be applied to the systematic approach to the care of other acute illnesses. Prominent among these is stroke. A statewide stroke program which builds on the lessons learned and the successes of In a Heartbeat is an initiative will be considered for inclusion in the next biennial State Health Plan.

2. Stroke Systems of Care

In 2005, the American Stroke Association (ASA) published "Recommendations for the Establishment of Stroke Systems of Care". This comprehensive document outlines the importance of a multi-dimensional team in providing effective and efficient, evidenced based, stroke care, as well as providing guidance around the roles of team members in the various settings involved.

For the past several years there has been an effort to develop a coordinated stroke system of care. "Stroke Care in Maine" a workgroup of state programs, advocacy organizations, health systems, and hospitals in Maine is actively engaged in promoting the establishment of stroke systems of care to transform what are often a fragmented collection of services, to a coordinated system of care that promotes a full range of activities and services associated with stroke prevention, treatment, and rehabilitation.

Goal/Task: Progress toward collective statewide initiatives surrounding stroke systems of care will be compiled and reported by the "Stroke Care in Maine" workgroup yearly with the goal of inclusion in the next biennial State Health Plan.

D. Finding the Right Place of Care for the Elderly and Disabled in Need of Assistance

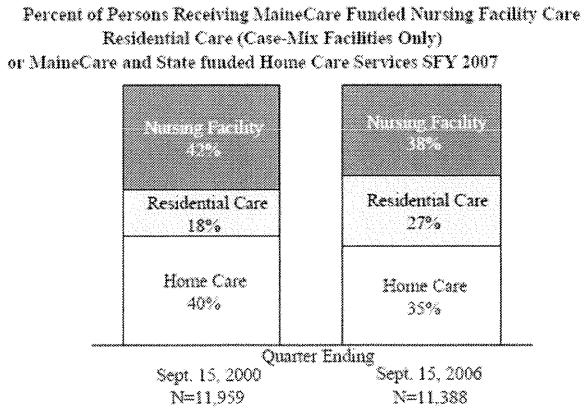
By the beginning of the 1980s, Maine was one of the first states to enact a state home-based care program in order to reduce institutional care for elderly persons and persons with disabilities. In the mid-1990s, Maine became a leader again by rebalancing its long term care (LTC) system by diverting people from nursing facilities to home and community-based services. However, in more recent years, due in large part to fiscal constraints, Maine's efforts to increase home- and community-based options has lost some momentum.

During 2007, the Department of Health and Human Services conducted an assessment of the LTC needs of Maine people and the types and locations of LTC services available. With the help of the Muskie School of Public Service at the University of Southern Maine and the national health and human services consultant, the Lewin Group, we have gathered baseline data and developed a projection model. Data is available by county. The model allows us to project for 2010 and 2015 the number of Mainers who will need services, types of LTC services they will need, and where services will be needed. Importantly, this model will enable the Department to estimate the impact of a change in one program on other programs providing long term care services.

As shown in the figure below, our needs-assessment documents that an increase in the use of residential care served to offset most of the decline in the use of nursing facility care between 2000 and 2006. In 2006, 38% of people using MaineCare or state-funded LTC services were in nursing facilities. This represents a decline from 2000 when 42% of LTC users were in nursing facilities. However, the proportion of MaineCare members in residential care increased from 18% to 27%. In addition, during this period, home care decreased from 40% of LTC users to only 35% of LTC users.

The needs assessment indicates that it is timely to determine the proper balance of home-based and facility-based services in Maine; that is - a balance based on the needs and choices of individuals who seek long term care services and supports.

The Department intends to expand the reach of evidenced-based programs for healthy aging to other community-based and LTC programs. Currently, there are a number of evidence-based programs offered in the community statewide including: A Matter of Balance, Chronic Disease Self Management, Enhance Wellness, Enhance Fitness and Healthy IDEAS. Individuals receiving long term care services can benefit from these programs as well.



Goal: Determine what services are needed where and that types of care available reflect the needs and choices of the people using those services.
Task: Use projection model developed by the Lewin Group, in collaboration with the Muskie School, to project need for and to plan for home care, community residential options, and nursing facility care. DHHS Office of Elder Services - December, 2008.
Task: Maine CDC/DHHS will compile a "Maine Elders Health Profile" by December, 2008.

Goal: Functional needs assessments for people needing any level of care.
Task: Establish/implement functional eligibility criteria for Private Non-Medical Institutions. DHHS Long Term Supports Leadership Team – July, 2009.

Goal: Make sure that options are in place that promote maximum choice and independence.
Task: Identify/implement strategies to strengthen home care and affordable, homelike living options for Maine's elders. DHHS Office of Elder Services – December, 2008.

Goal: Integrated planning, development and service delivery by comparing/contrasting information about long term care experience across all populations.
Task: Gather key common data elements across all populations with long term care needs. DHHS Long Term Supports Leadership Team – October, 2009.

Goal: Identify/implement strategies to support the direct care work force.
Task: Initiatives will be in place to honor and support direct care workers. DHHS Office of Elder Services – October, 2008.

Goal: Develop more sites in a variety of settings offering evidence-based programs: A Matter of Balance, Chronic Disease Self-Management, Enhance Wellness, Enhance Fitness and Healthy Ideas.
Task: Extend the reach of evidence-based programs throughout the state. DHHS Office of Elder Services – July, 2009.

Through the information/referral process at AAAs and ADRCs, people may hear about publicly funded programs that would provide services that meet their needs. These programs require functional or medical eligibility determination done by the state's Assessing Services Agency, Goold Health Systems (GHS). AAAs and ADRCs may help with referral process to GHS or consumer/family calls directly. Referrals to GHS also come from hospitals, nursing facilities, and other community agencies.

ADRC sites

Senior Spectrum **AAA**

Seniors Plus **AAA**

Eastern **AAA**

Alzheimer's Specialists

At each AAA

Goold Health Systems (GHS) Assessing Services Agency: Conducts assessment to determine functional/medical eligibility for publicly funded community programs. Outcome of assessment is forwarded to appropriate care management agency when person is found eligible for publicly funded home care program.

Home Care for Maine

Care Management for Homemaker Program

Alpha One Independent Living Center (ILC)

Care Management for Consumer-directed programs

Elder Independence of Maine (EIM)

Care Management for Traditional LTC home care programs (HBC, PDN, Waiver).

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

* Includes consumer-directed services.

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.

Maine's Long-term Supports and Services for Adults		
MaineCare Programs: (requires MaineCare financial eligibility determined by	**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

APPENDIX E

Historical and Projected Use of Long Term Care Services in Maine,
Presentation by Julie Fralich,
University of Southern Maine, Muskie School of Public Policy,
September 12, 2008

Historical and Projected Use of Long Term Care Services in Maine

Blue Ribbon Commission on Home and Community-Based Care

September 12, 2008

Julie Fralich

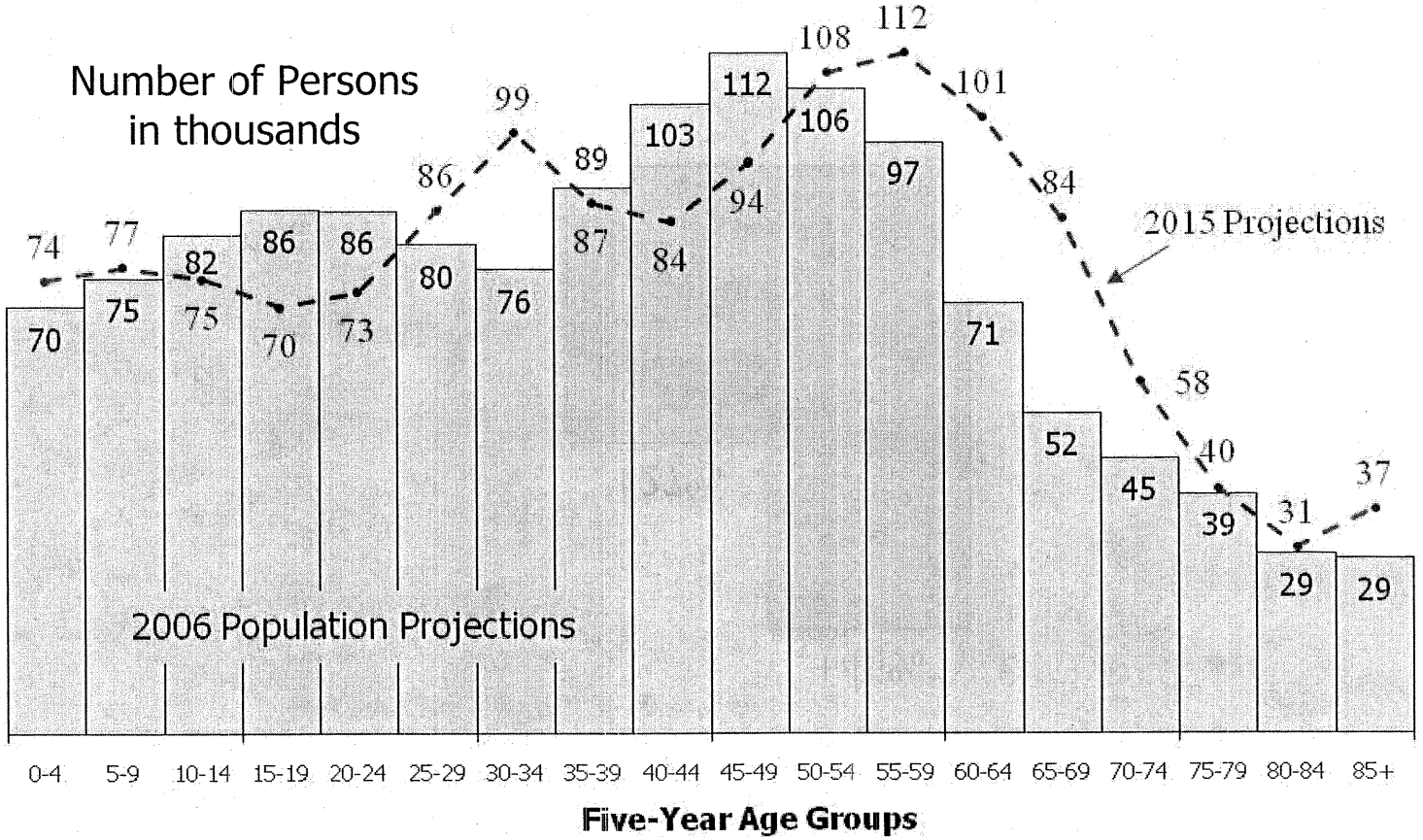
Muskie School of Public Service

UNIVERSITY OF SOUTHERN MAINE

Overview of Presentation

- Population and demographic trends
- Comparisons of Maine and National Trends
  - Nursing Facilities
  - Residential Care Facilities
  - Home Care
- Overview of LTC Projection Model
  - Methods and Results

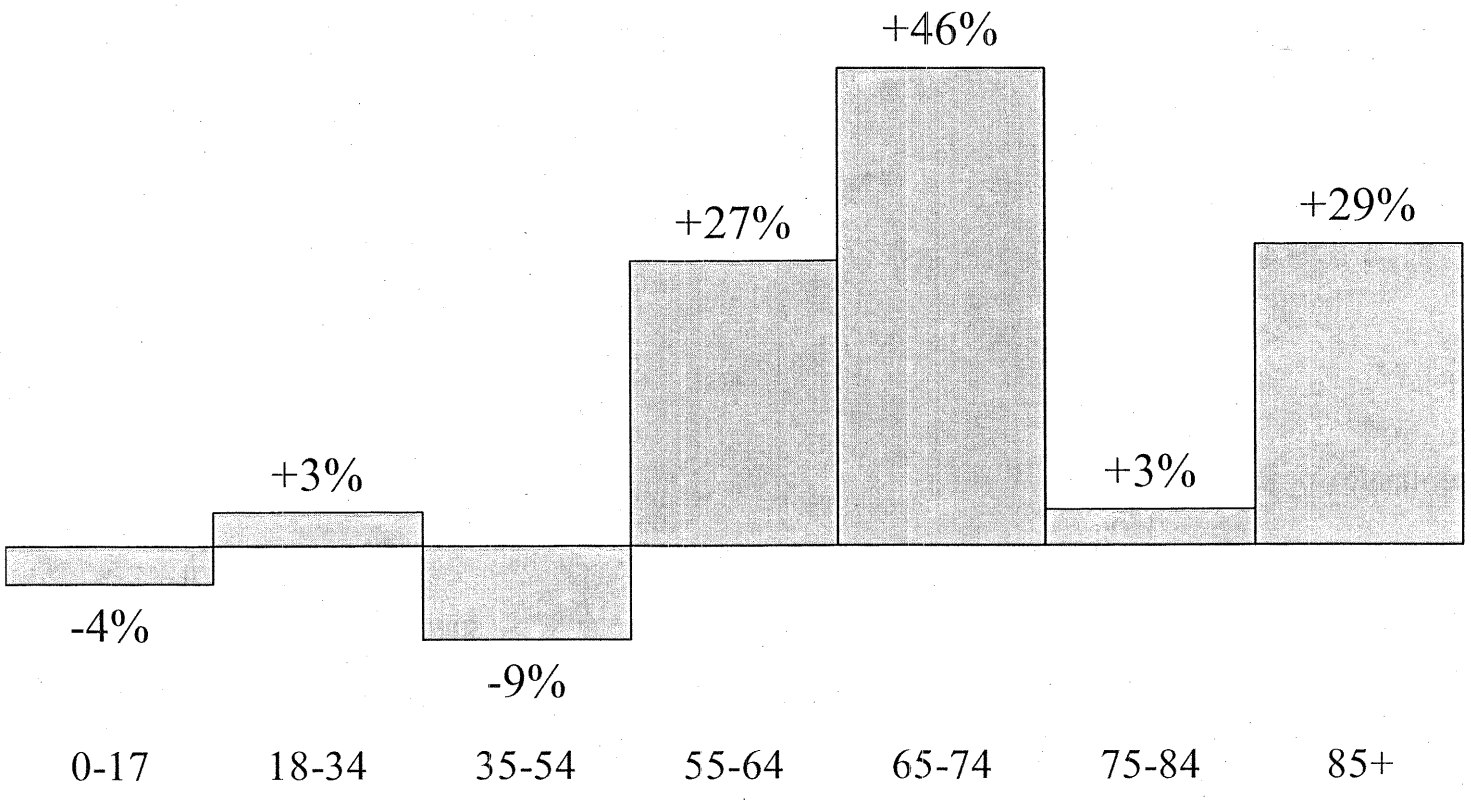
Maine population projection by age groups 2006-2015



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

9/30/2008

Percent Change in Maine's Population 2006-2015



Other Trends National

Persons Age 85+	1984	1994	2004
Percent of people with no disability	34%	42%	50%
Percent with IADLs only	9%	7%	4%
Percent in Institutions	26%	24%	15%

9/30/2008 Source: Manton, Gu and Lamb. Change in chronic disability from 1982 to 2004/2005 as measured by long-term changes in function and health in the U.S. elderly population. *Proceedings of the National Academy of Sciences*, November 28, 2006; 18374-18379.

Active Life Expectancy at Age 85

Year	Life Expectancy	Active Life Expectancy	ALE/LE
1999	6.4 years	3.0 years	46.9%
2015	7.0 years	4.1 years	58.6%

Source: Manton, Gu and Lamb. Long-Term Trends in Life Expectancy in the United States. Population and Development Review 32(1); 81-105. March 2006.

Nursing Facility Beds Per 1,000 Persons Over 65 in 2005

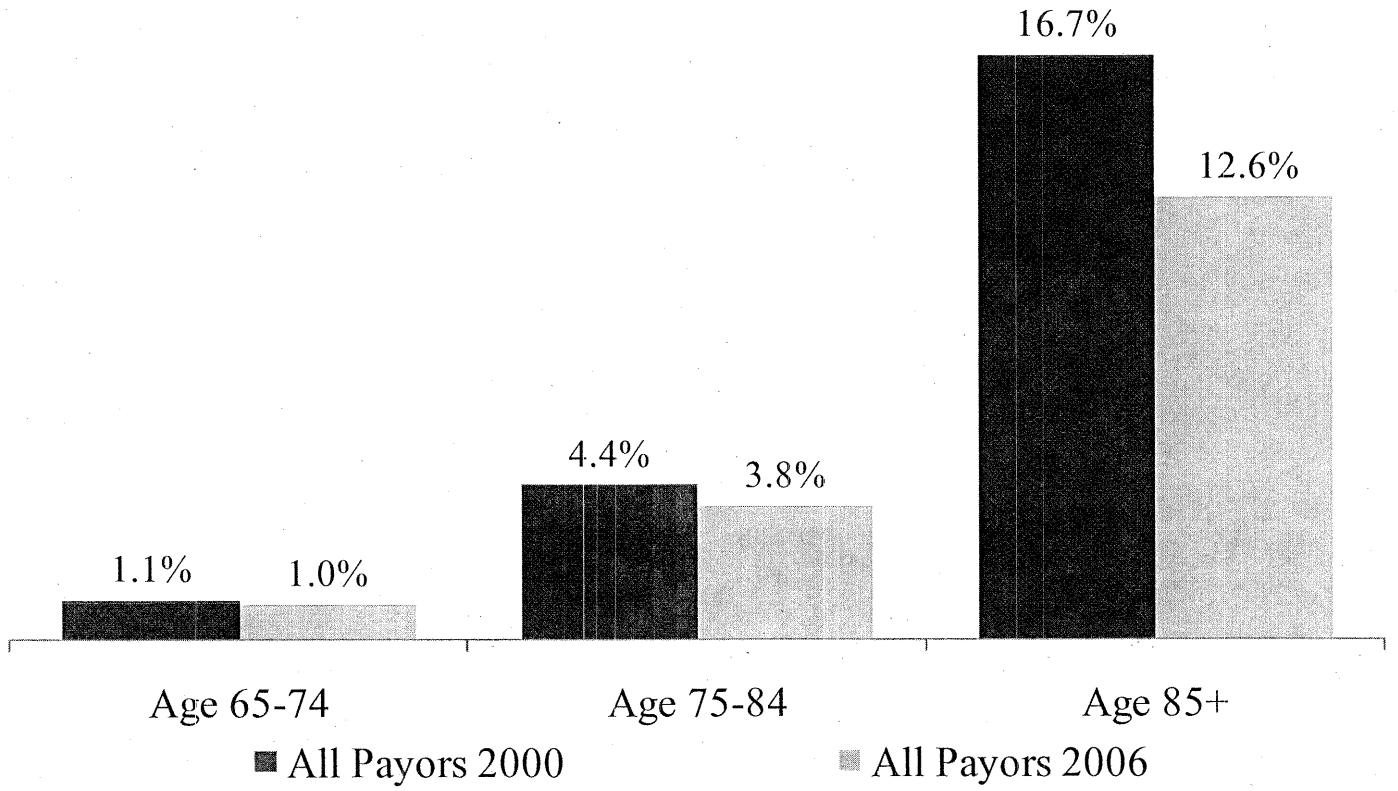
State	NF Beds	Rank
Iowa	80	*1st*
Connecticut	63	*10th*
Massachusetts	60	*14th*
Rhode Island	60	*14th*
New Hampshire	48	*25th*
Vermont	42	*33rd*
Maine	**39**	***36th***
Washington	27	*43rd*
Oregon	18	*48th*
Alaska	16	*51st*

Source: Houser, Ari, et. al., "Across the States: Profiles of Long-Term Care and Independent Living , State Data and Rankings Supplement", AARP (2006)

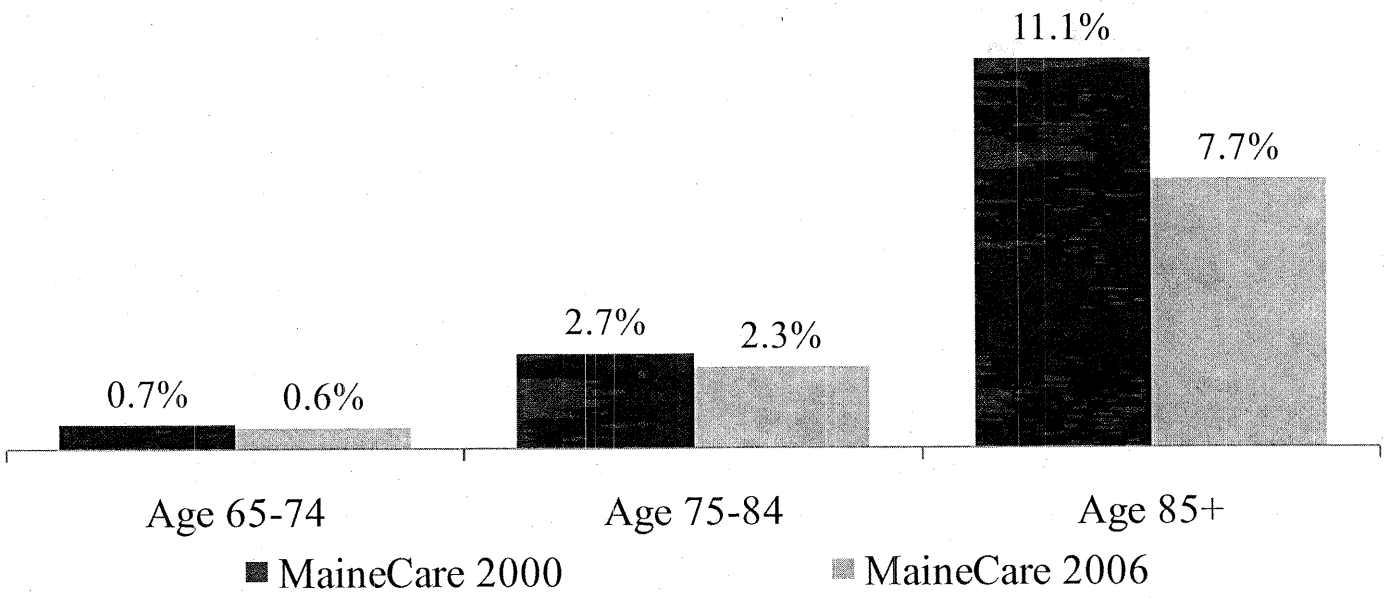
Number of Assisted Living/Residential Care Facility Beds per 1,000 Persons Age 65+ 2004

State	2004	
	Beds	Rank
Maine	**47**	**1st**
Oregon	46	2nd
Vermont	30	17th
New Hampshire	25	25th
Rhode Island	24	27th
Massachusetts	12	42nd
Louisiana	8	48th
Connecticut	6	49th

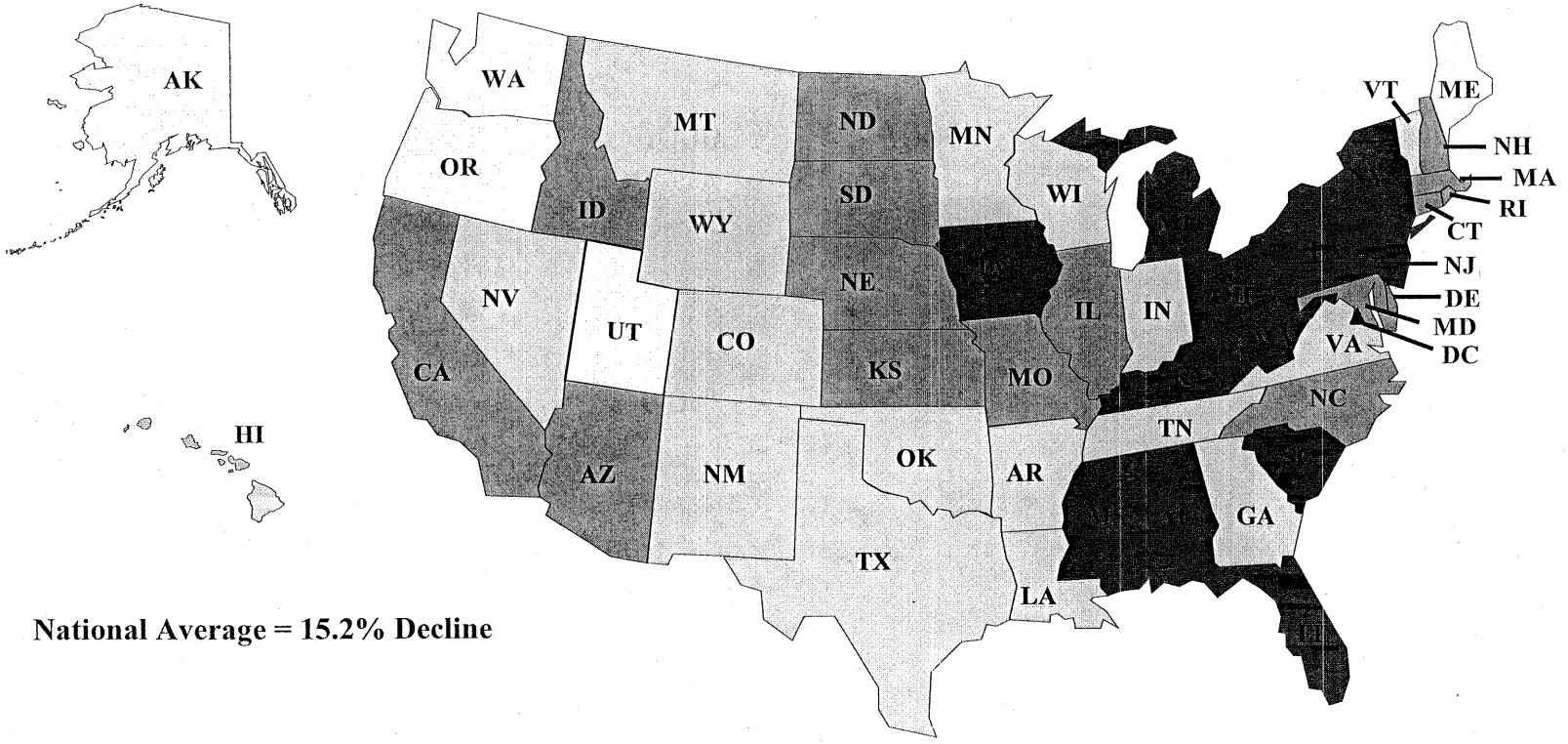
Maine All Payor Nursing Facility Use Rates by Age, 2000 and 2006



MaineCare Nursing Facility Use Rates by Age, 2000 and 2006



Change in Per Capita Medicaid NF Residents, 1995-2005

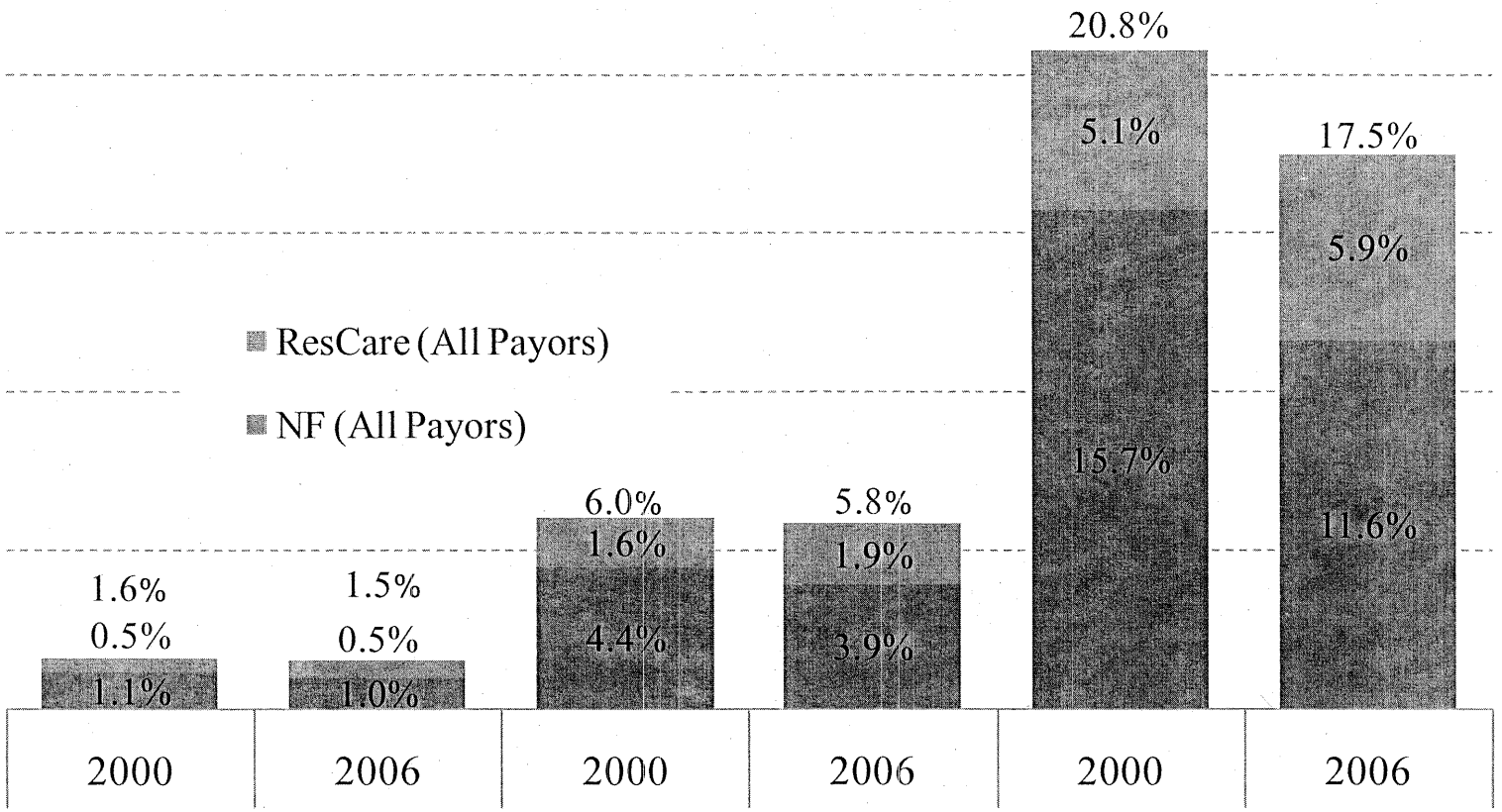


National Average = 15.2% Decline

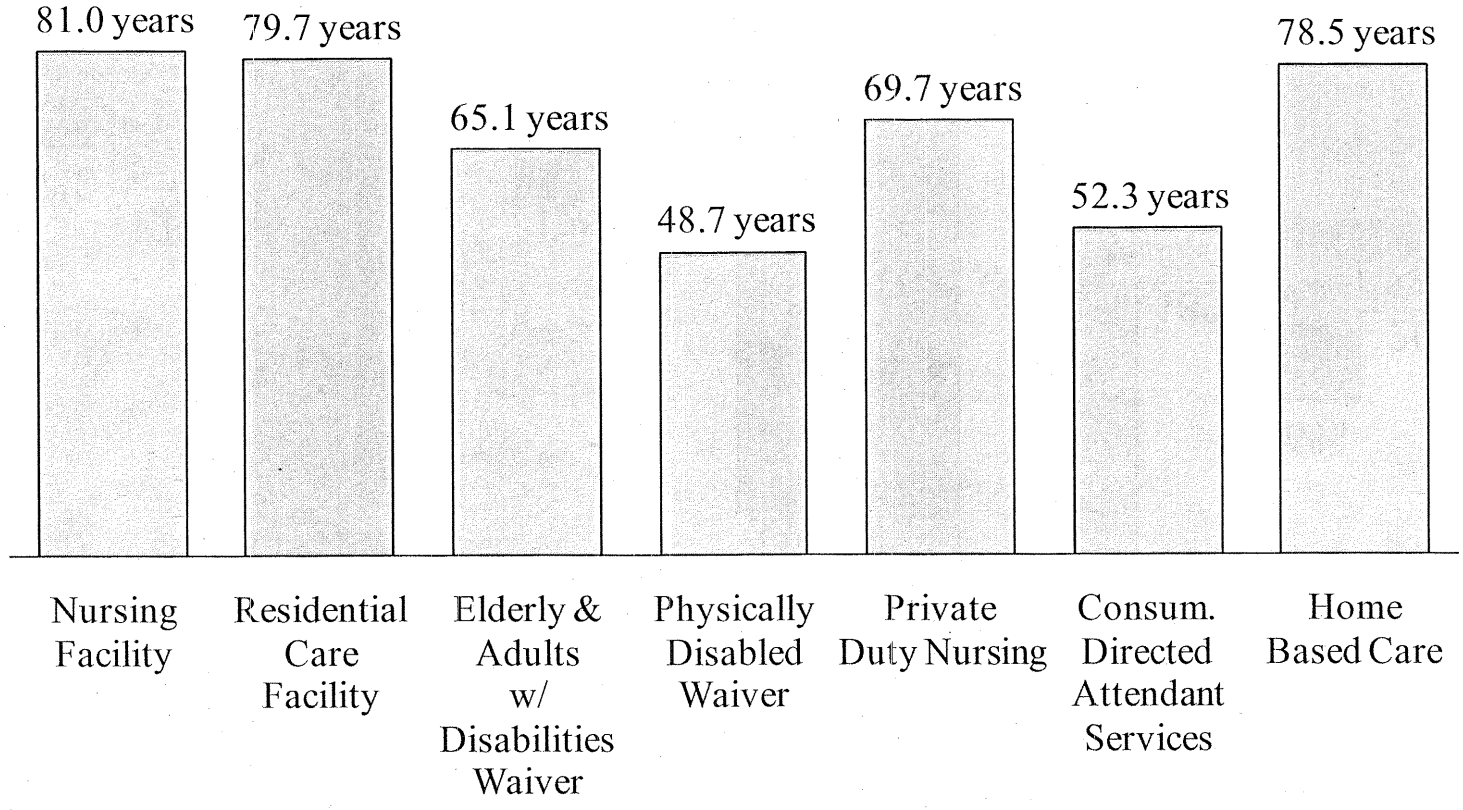
30% or More Decline		**20% to 30% Decline**		**10% to 20% Decline**		**Less than 10% Decline**	
Alaska	Washington	Arkansas	New Mexico	Arizona	Massachusetts	Alabama	Mississippi
Maine	Utah	Colorado	Oklahoma	California	Missouri	District of Columbia	New Jersey
Oregon		Georgia	Tennessee	Connecticut	Nebraska	Florida	New York
		Indiana	Texas	Delaware	New Hampshire	Hawaii	Ohio
		Louisiana	Vermont	Idaho	North Carolina	Iowa	Pennsylvania
		Minnesota	Virginia	Illinois	North Dakota	Kentucky	South Carolina
		Montana	Wisconsin	Kansas	Rhode Island	Michigan	West Virginia
		Nevada	Wyoming	Maryland	South Dakota		

Source: Mick Cowles 2006 Nursing Home Year Book for residents and Bureau of the Census for population.

The 2000 to 2006 Increase in Residential Care Offset Some of the NF Decline

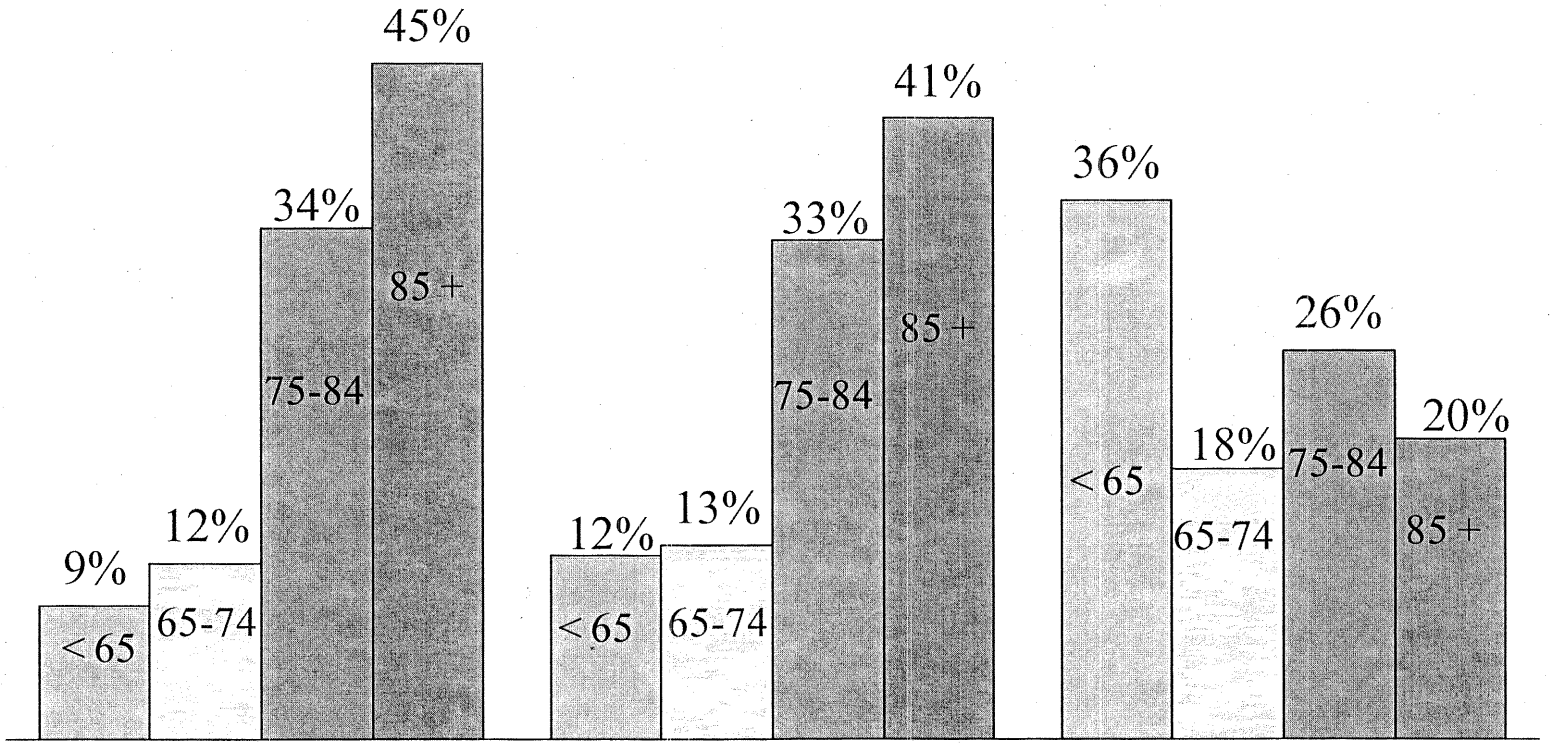


Average Age of Maine LTC Users by Setting in SFY 2006



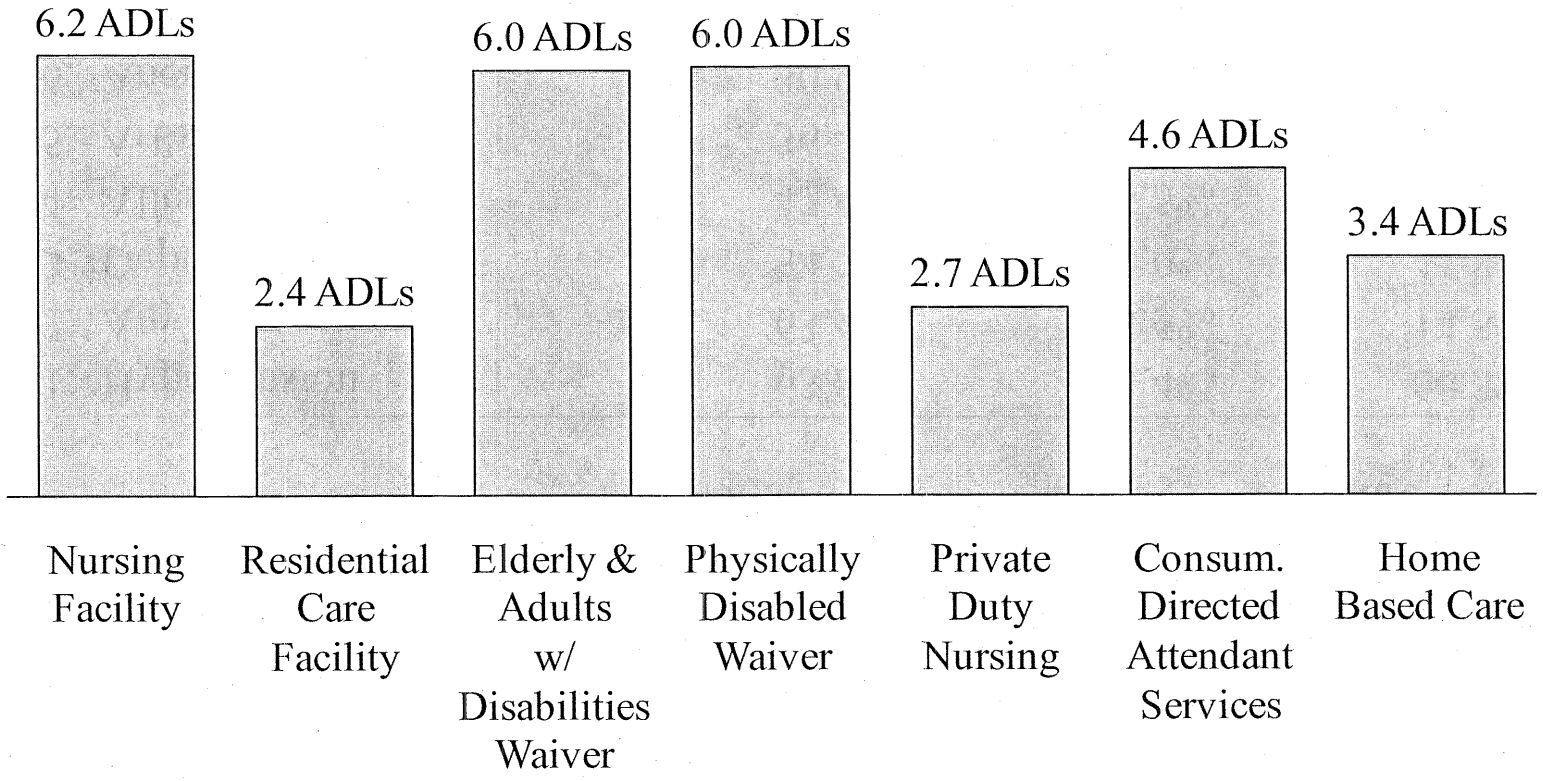
Source: MDS and MDS-RCA assessment data as of September 15, 2005 or most recent MED assessment completed in SFY 2006

Age Distribution of Maine Long-term Care Users by Setting in SFY 2006



Source: MDS and MDS-RCA assessment data as of September 15, 2005 or most recent MED assessment completed in SFY 2006

Average ADL Count (out of 7 ADLs) for Maine LTC Users, by Setting



The Activities of Daily Living (ADL) counts are based on the level of supervision, assistance and/or physical help a person needs with bathing, dressing, eating, toileting, bed mobility, transfer assistance or locomotion.

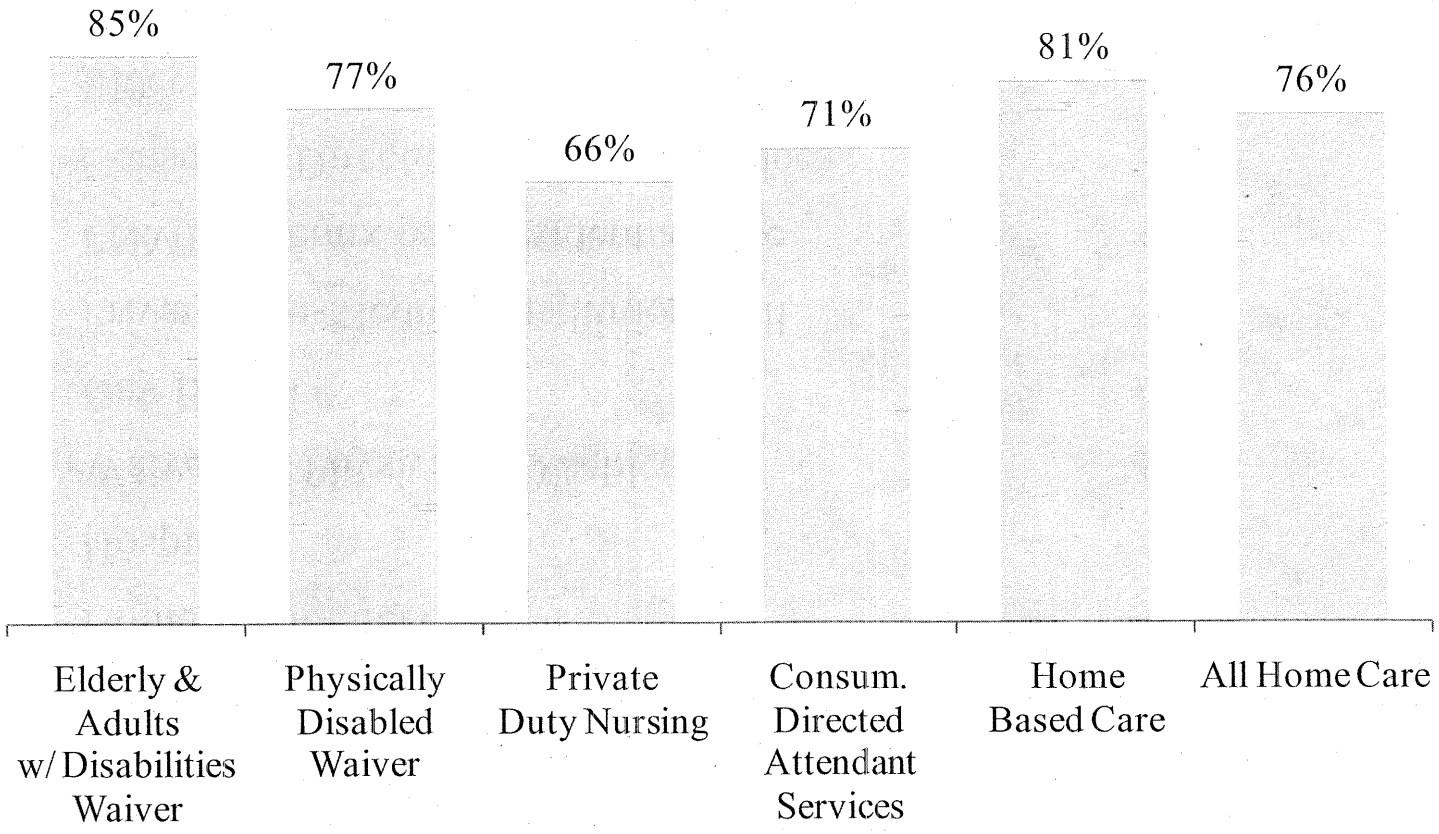
Source: MDS and MDS-RCA assessment data as of September 15, 2005 or most recent MED assessment completed in SFY 2006

Prevalence of Diagnoses among Maine LTC service users, by setting in SFY 2006

(listed in order by the nine most common diagnoses found among nursing facility residents)

Diagnosis	Nursing Facility	Residential Care	All Home Care
1. Hypertension	63.8%	63.4%	60.3%
2. Any Dementia	63.4%	43.5%	14.5%
3. Depression	54.7%	40.0%	44.8%
4. Allergies	47.4%	35.5%	43.0%
5. Arthritis	36.4%	26.0%	58.6%
6. Anemia	30.9%	19.6%	17.7%
7. Osteoporosis	30.2%	22.1%	22.8%
8. Diabetes	28.3%	27.5%	34.6%
9. Other cardiovascular	24.8%	22.2%	27.5%

Percent of Home Care Service Users with Caregiver Support in SFY 2006



Source: Most recent MED Assessment completed during SFY 2006

Changes in Use of LTC Services Average monthly number of MaineCare members 2000-2006

Category of Service	2000-2006
Nursing Facility	-13%
Home Health Services	-56%
Hospice	n/a
Waiver for Physically Disabled	-27%
Day Health	-29%
Private Non-Medical Institutions-All	6%
PNMI-Casemix only residential care	48%
Consumer-Directed Attendant Services	33%
Elder and Adults w/ Disabilities Waiver	-31%
Private Duty Nursing	52%
Personal Care Services	88%

Projections of LTC in Maine

- Model developed by Lewin Group
  - National consulting firm with special background and knowledge in LTC
  - Similar model developed for Vermont and for Health Care Association in Pennsylvania
  - Assistance from Muskie School of Public Service

LTC Model

- Estimates impact of changes in population and disability on long term care services to support planning and policy development
- Provides estimates of service users:
  - Statewide
  - By county
  - By age group
  - For 2006, 2010 and 2015

Services included in LTC model

- Nursing facility services
  - All Payors and MaineCare
- Private non-medical institutions
  - Elderly Residential Care Facilities
    - All Payors and MaineCare
- Waiver for elderly and adults with disabilities
- Waiver for physically disabled
- Day health services
- Home health services
- Consumer directed attendant services
- Private duty nursing services
- Personal care services
- Hospice services
- State funded home care services and homemaker services

Elements of LTC Model

Estimate Changes in:

- Population by age, sex, and county,
- Population with disabilities
  - IADLs
  - ADLs
- Use of services by people with disabilities, by income level
- 2006-2010 and 2015

Unit of analysis

- Average monthly users of services

Other Model Assumptions

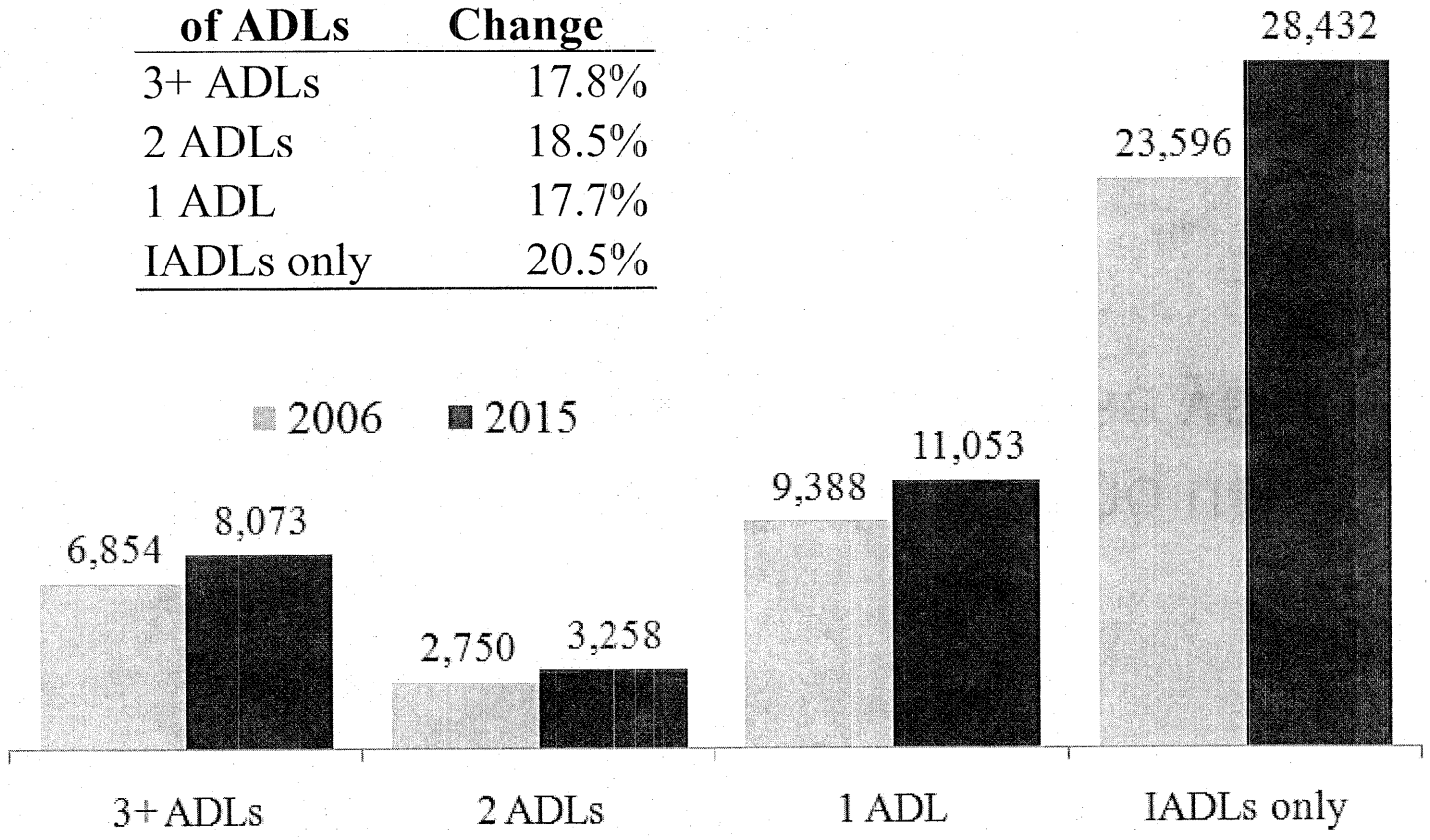
- Change in population rates of disability
  - Under 65 – increases
  - Over 65 -- decreases
- Continued decline in use of nursing homes
  - Rates of decline experienced from 2000-2006 will continue
  - Use by MaineCare and all payors will continue to decline
- Uses age specific use rates for home care programs (based on historical use and assumptions related to NF decline)

Model Assumptions can be changed

- Model allows for changes in assumptions
- Results presented here represent one set of assumptions – other assumptions can be tested

Growth in the Number of Persons in Maine w/ADL Needs Between 2006 & 2015

Number of ADLs	Percent Change
3+ ADLs	17.8%
2 ADLs	18.5%
1 ADL	17.7%
IADLs only	20.5%

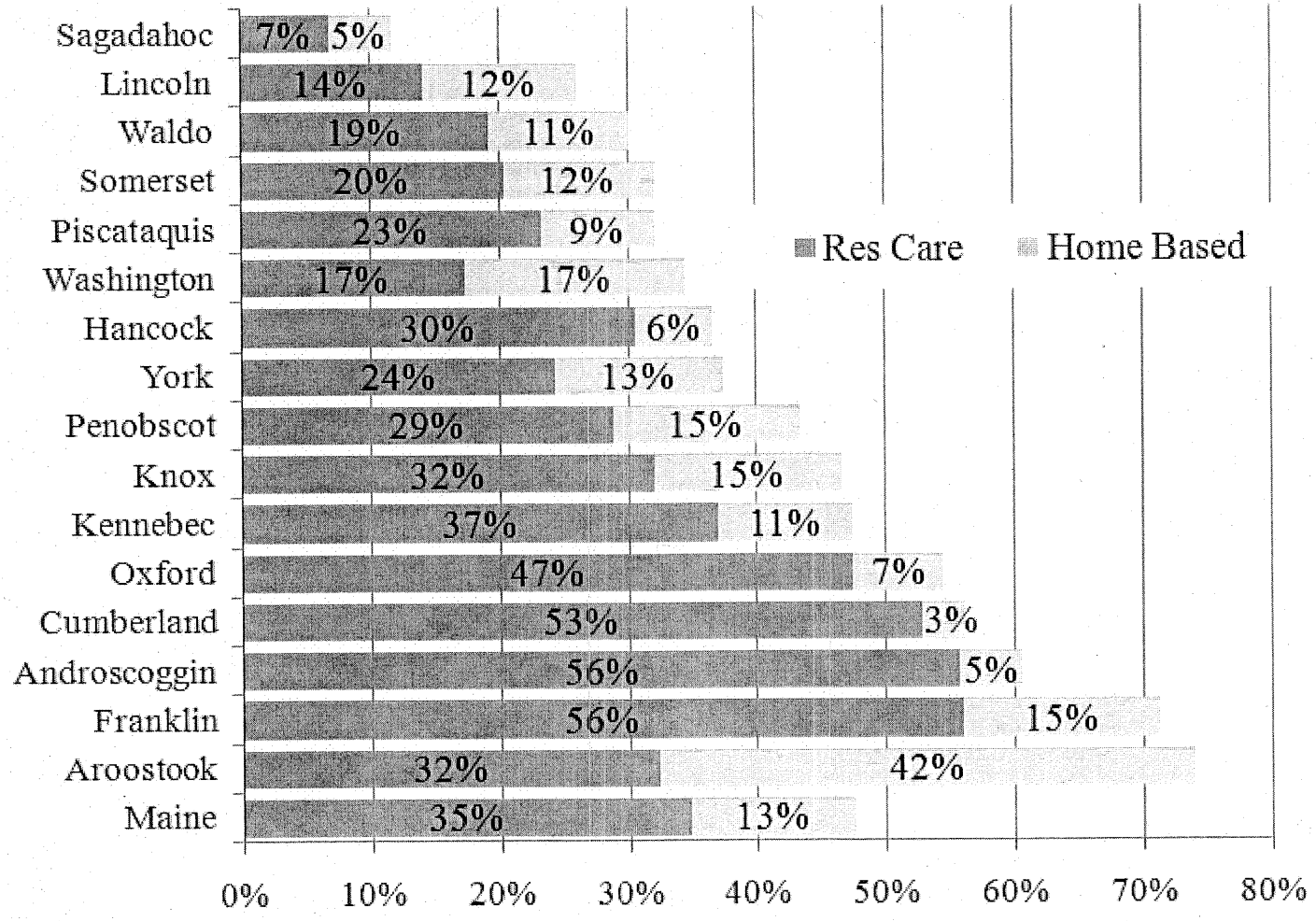


Use Rates

Numerator: Number of people who used the service in the base year (ave. monthly users)

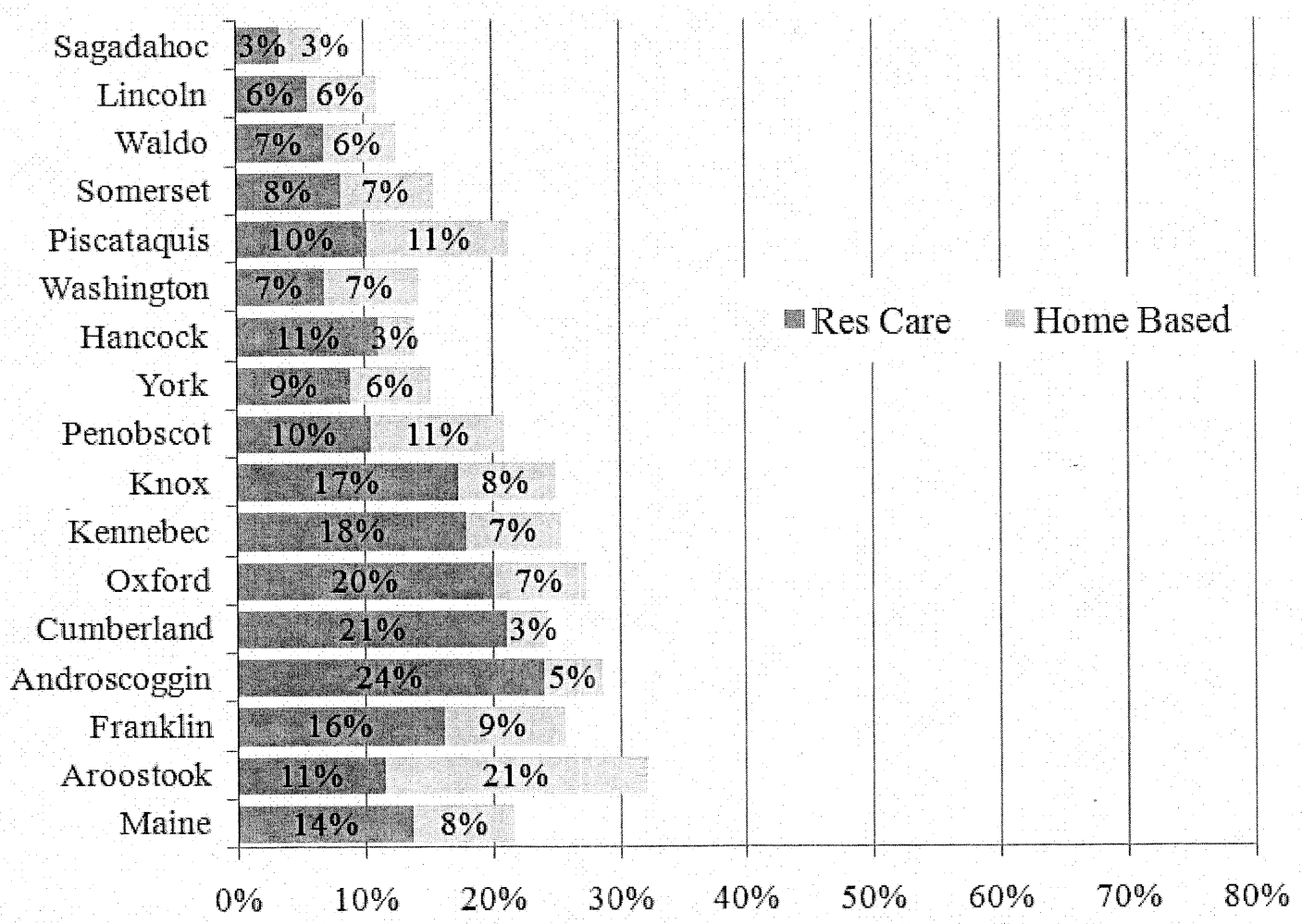
Denominator: Number of people in the general population, by age, income, by ADL level, as appropriate

MaineCare Users of ResCare or Home-Based Services* in 2006 as a Percent of Age 85+ Population Below Poverty Level



* Home Based Services include Home Health, Consumer Directed Attendant Services, Private Duty Nursing, and Personal Care Services

MaineCare Users of ResCare or Home-Based Services* in 2006 as a Percent of Age 65+ Population Below Poverty Level



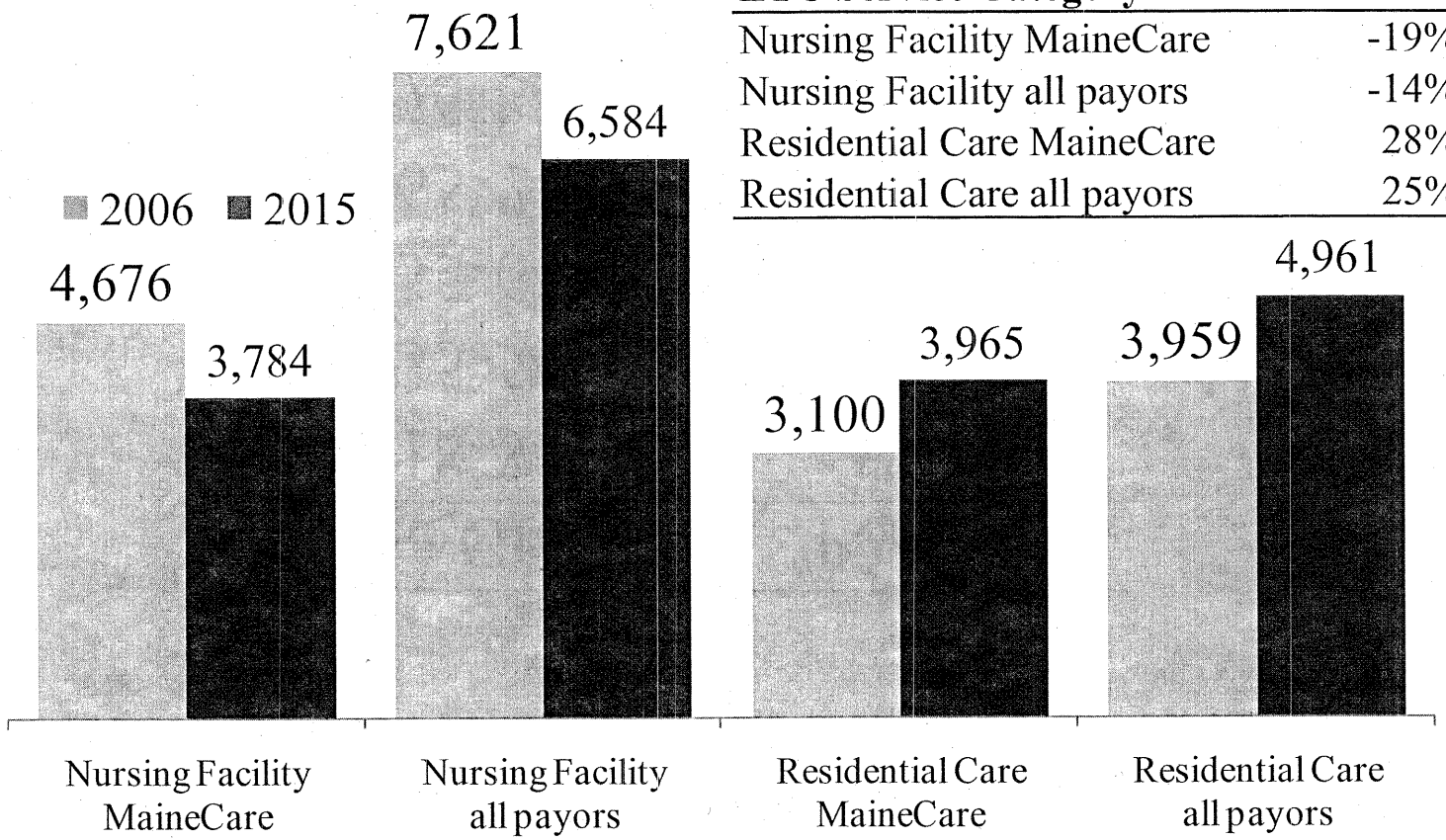
* Home Based Services include Home Health, Consumer Directed Attendant Services, Private Duty Nursing, and Personal Care Services

Maine 2006 Elderly and Adult Waiver Use Rates

(Number of people on the HCBS Waiver as a percent of Community Dwellers with 2+ ADLs and Incomes Below 225% of Poverty Level)

Age Group	Percent
18-34	18.2%
35-54	13.0%
55-64	12.3%
65-74	16.9%
75-84	11.8%
85+	9.7%

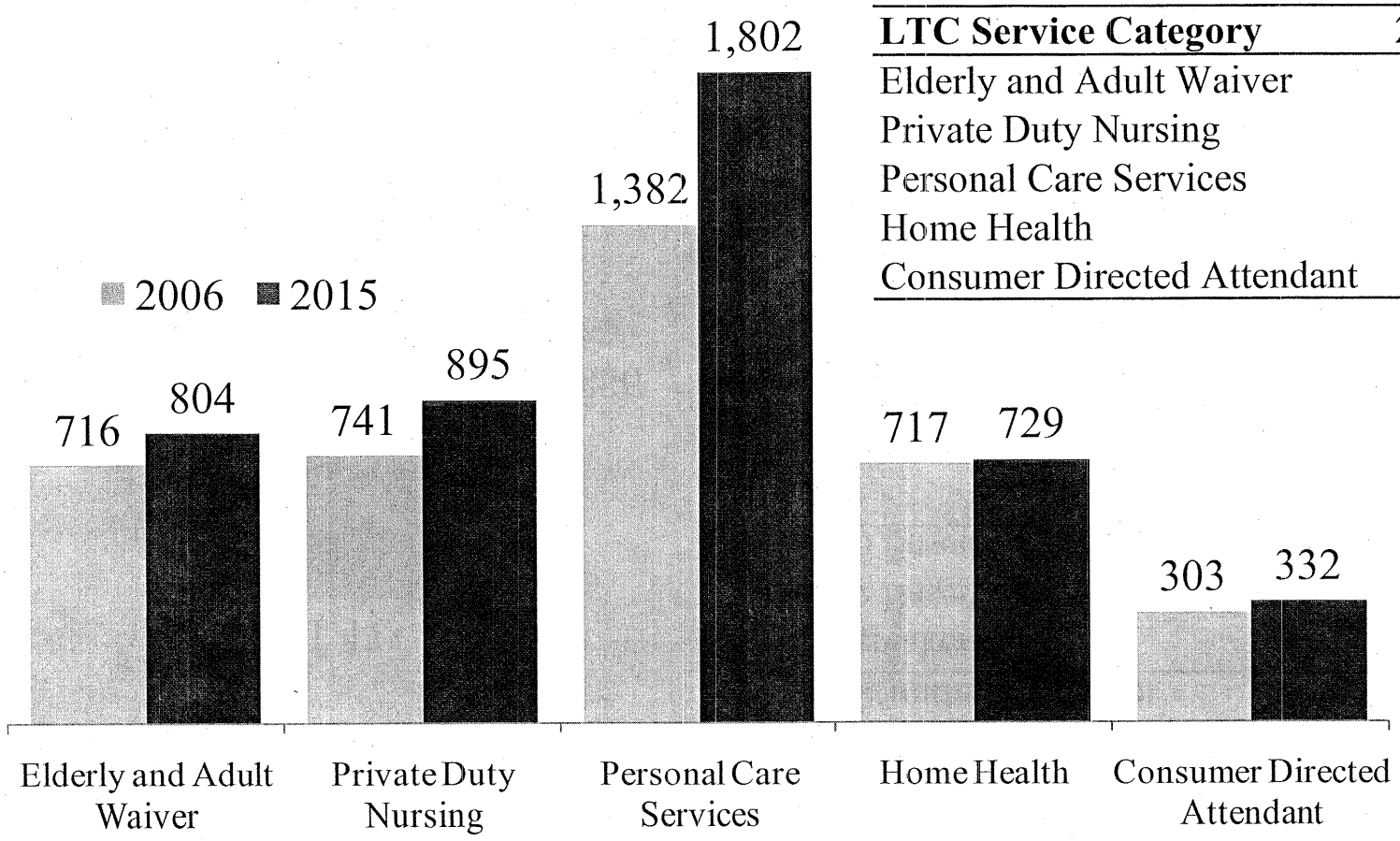
Projected Change in Major Programs using base assumptions 2006-2015



LTC Service Category	2006-2015
Nursing Facility MaineCare	-19%
Nursing Facility all payors	-14%
Residential Care MaineCare	28%
Residential Care all payors	25%

Based on a count of average monthly users

Projected Change in MaineCare Home Care Programs using base assumptions 2006-2015

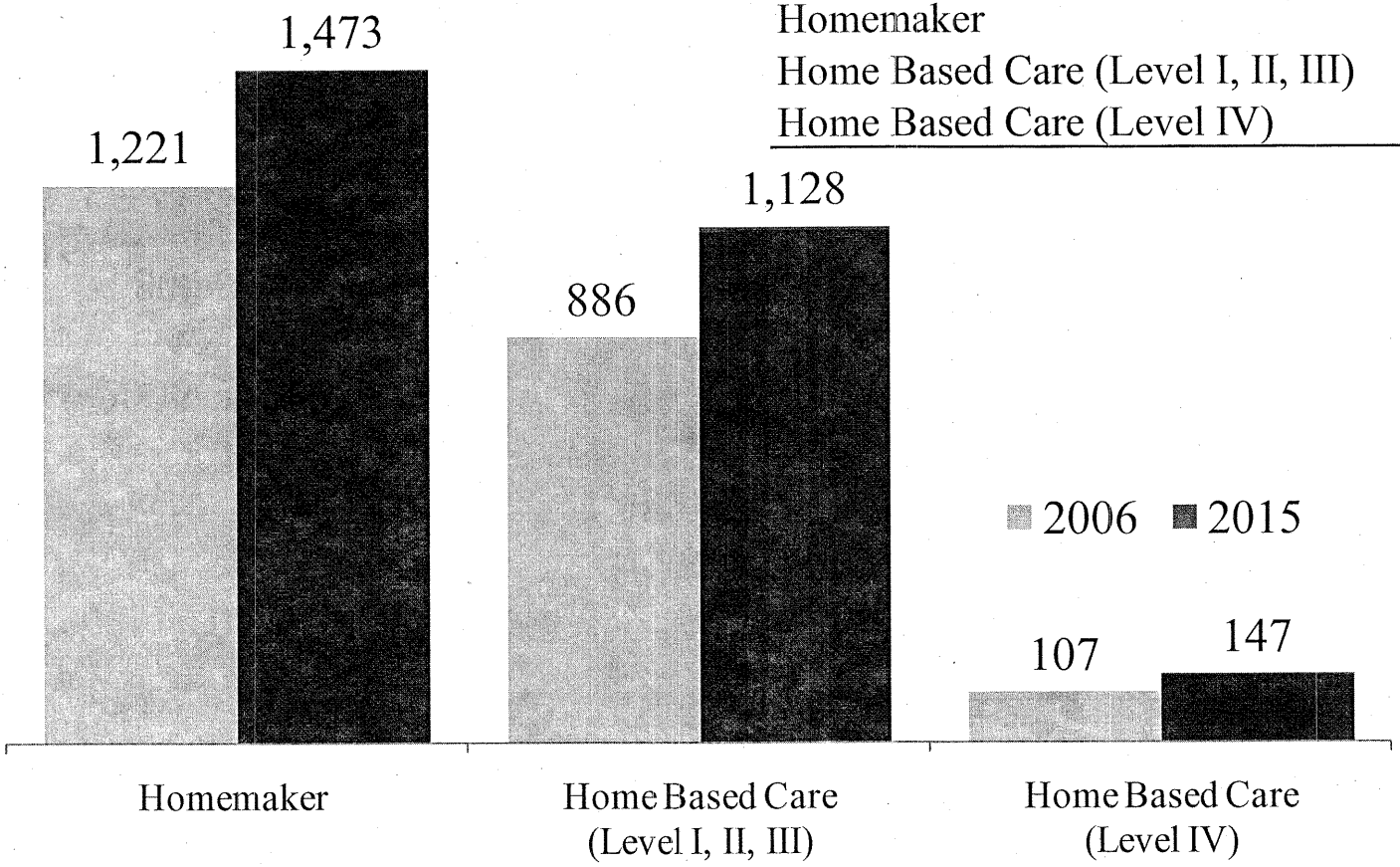


LTC Service Category	2006-2015
Elderly and Adult Waiver	12%
Private Duty Nursing	21%
Personal Care Services	30%
Home Health	2%
Consumer Directed Attendant	10%

Based on a count of average monthly users

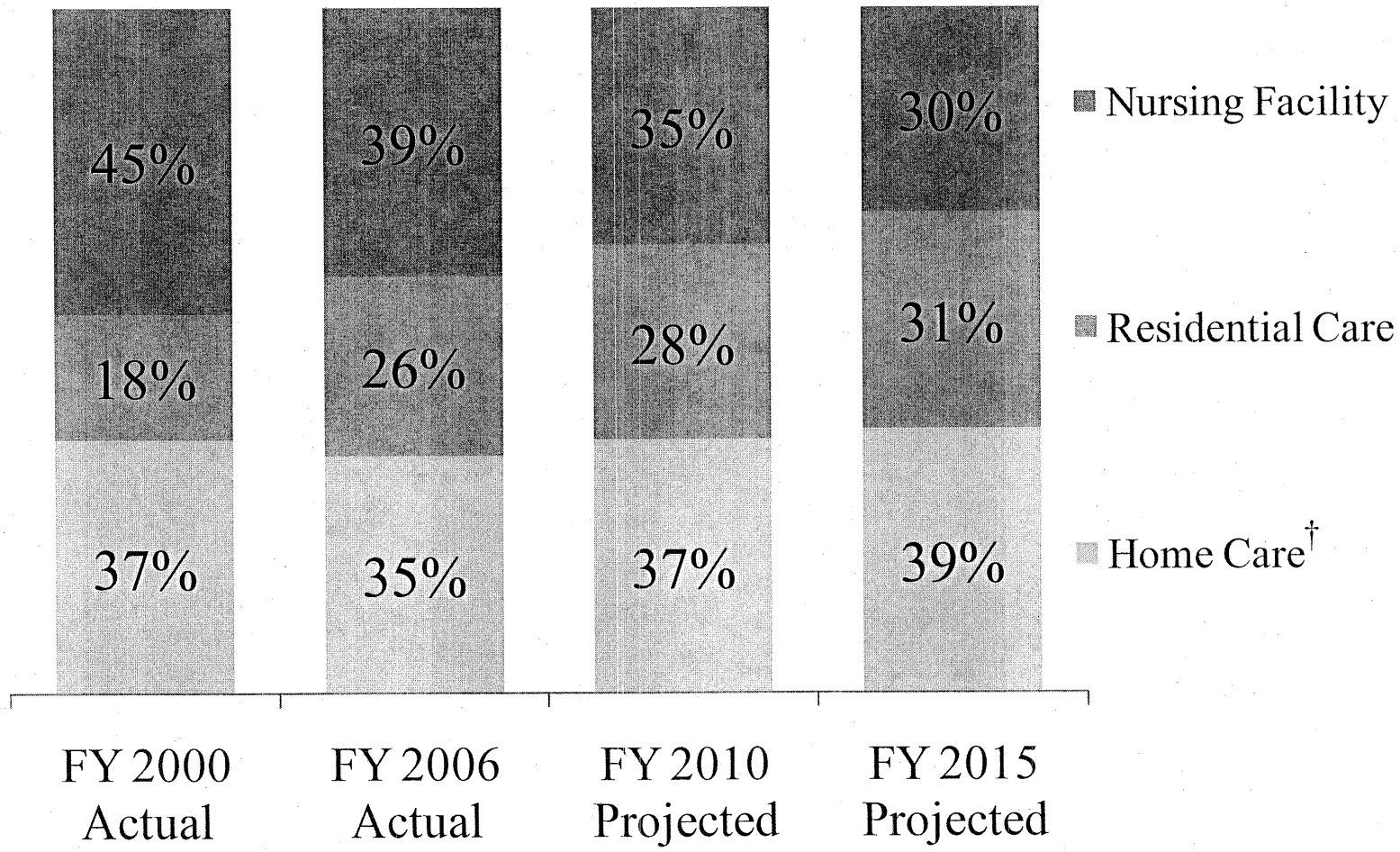
Projected Change in State-funded Programs using base assumptions 2006-2015

State-funded Program	2006-2015
Homemaker	21%
Home Based Care (Level I, II, III)	27%
Home Based Care (Level IV)	37%



Based on a count of average monthly users

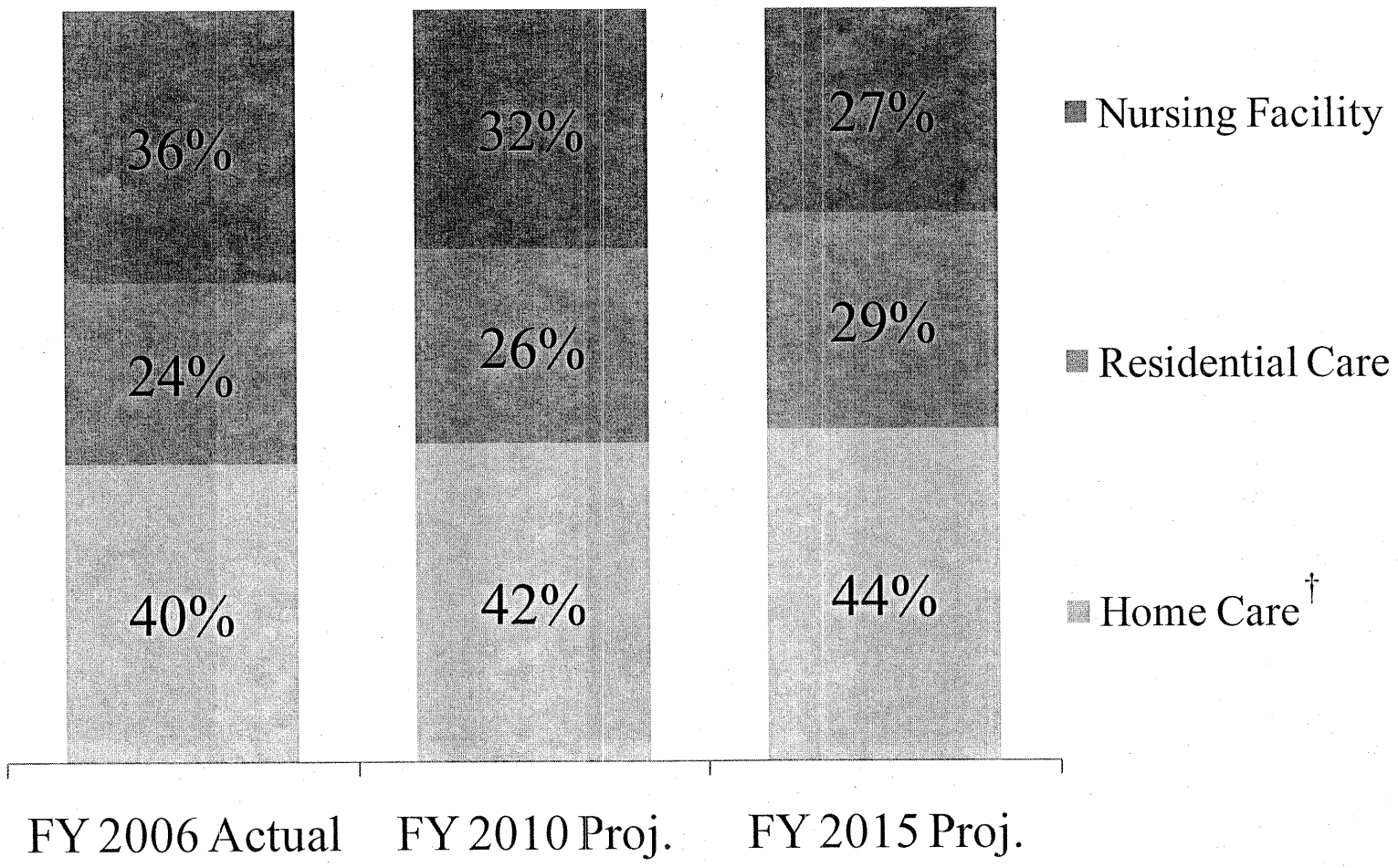
Actual and Projected Distribution of MaineCare Long-term Care Users* Across Settings, 2006 to 2015



* Average monthly users

† Home Health Services, Waiver for Physically Disabled, Day Health, Consumer Directed Attendant Services , Elderly and Adult Waiver , Private Duty Nursing, Personal Care Services, and Hospice

Actual & Projected Distribution of MaineCare & State-funded Long-term Care Users* Across Settings, 2006 to 2015



* Average monthly users

† Home Health Services, Waiver for Physically Disabled, Day Health, Consumer Directed Attendant Services , Elderly and Adult Waiver , Private Duty Nursing, Personal Care Services, hospice, Home Based Care (Level I, II, III, IV)

Uses of the LTC Projection Model

- Planning for Service and Resource Allocation
  - NF Beds
  - Residential Care Beds
  - Funding for HCBS Services
- Allocation of Resources by County
  - State funded services
  - Other services
- Mix of Services

APPENDIX F

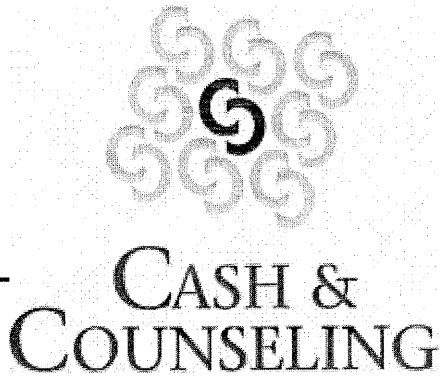
Home-based and Community-based Care: Cash and Counseling,
Presentation by Kevin Mahoney, PhD,
Boston College Graduate School of Social Work and National Program Director of the Cash and Counseling Demonstration and Evaluation Project, September 12, 2008.

CASH & COUNSELING

Blue Ribbon Commission to Study the Future of Long-term Home-based and Community-based Care: Cash & Counseling

Kevin J. Mahoney, PhD
National Program Director
September 12, 2008

Cash & Counseling: Program Overview



- Funders
  - The Robert Wood Johnson Foundation
  - US DHHS/ASPE
  - Administration on Aging
- Waiver and Program Oversight
  - Centers for Medicare and Medicaid Services
- National Program Office
  - Boston College Graduate School of Social Work
- Evaluator
  - Mathematica Policy Research, Inc.

Original Cash & Counseling Demonstration Overview

Demonstration States

- Arkansas, Florida, New Jersey

- Study Populations
  - Adults with disabilities (Ages 18-64)
  - Elders (Ages 65+)
  - Florida only: Children with developmental disabilities

- Feeder Programs
  - Arkansas and New Jersey: Medicaid personal care option programs
  - Florida: Medicaid 1915c Home and Community-Based long-term care waiver programs

Basic Model for Cash & Counseling

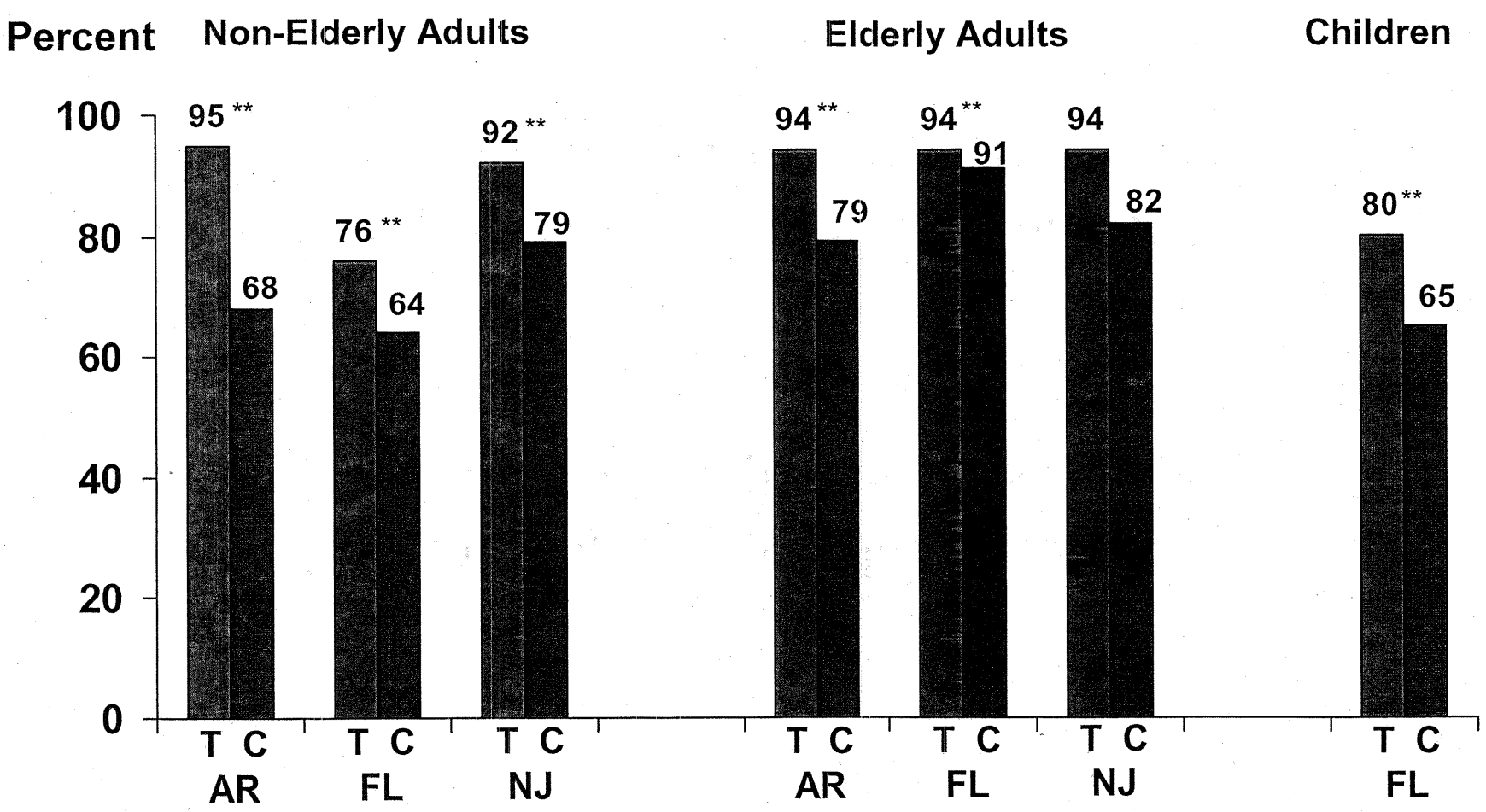
- Step 1: Consumers receive traditional assessment and care plan
- Step 2: A dollar value is assigned to that care plan
- Step 3: Consumers receive enough information to make unbiased personal choice between managing individualized budget or receiving traditional agency-delivered services

Basic Model for Cash & Counseling

- Step 4: Consumer and counselor develop spending plan to meet consumer's personal assistance needs

- Step 5: Cash allowance group provided with financial management and counseling services (supports brokerage)

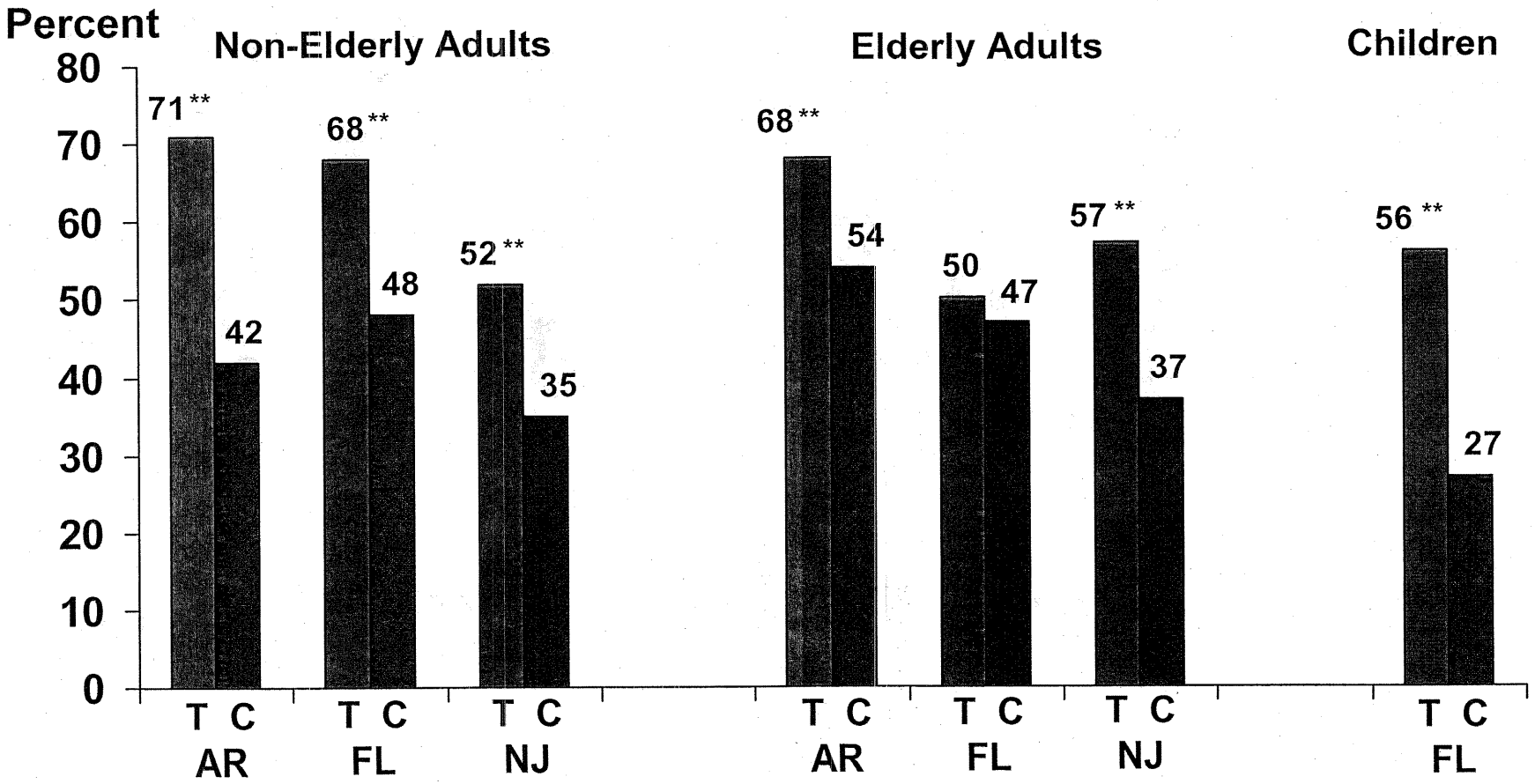
Receiving Paid Assistance at 9 Months



*, ** Significantly different from control group at .05, .01 level, respectively.

MATHEMATICA
Policy Research, Inc.

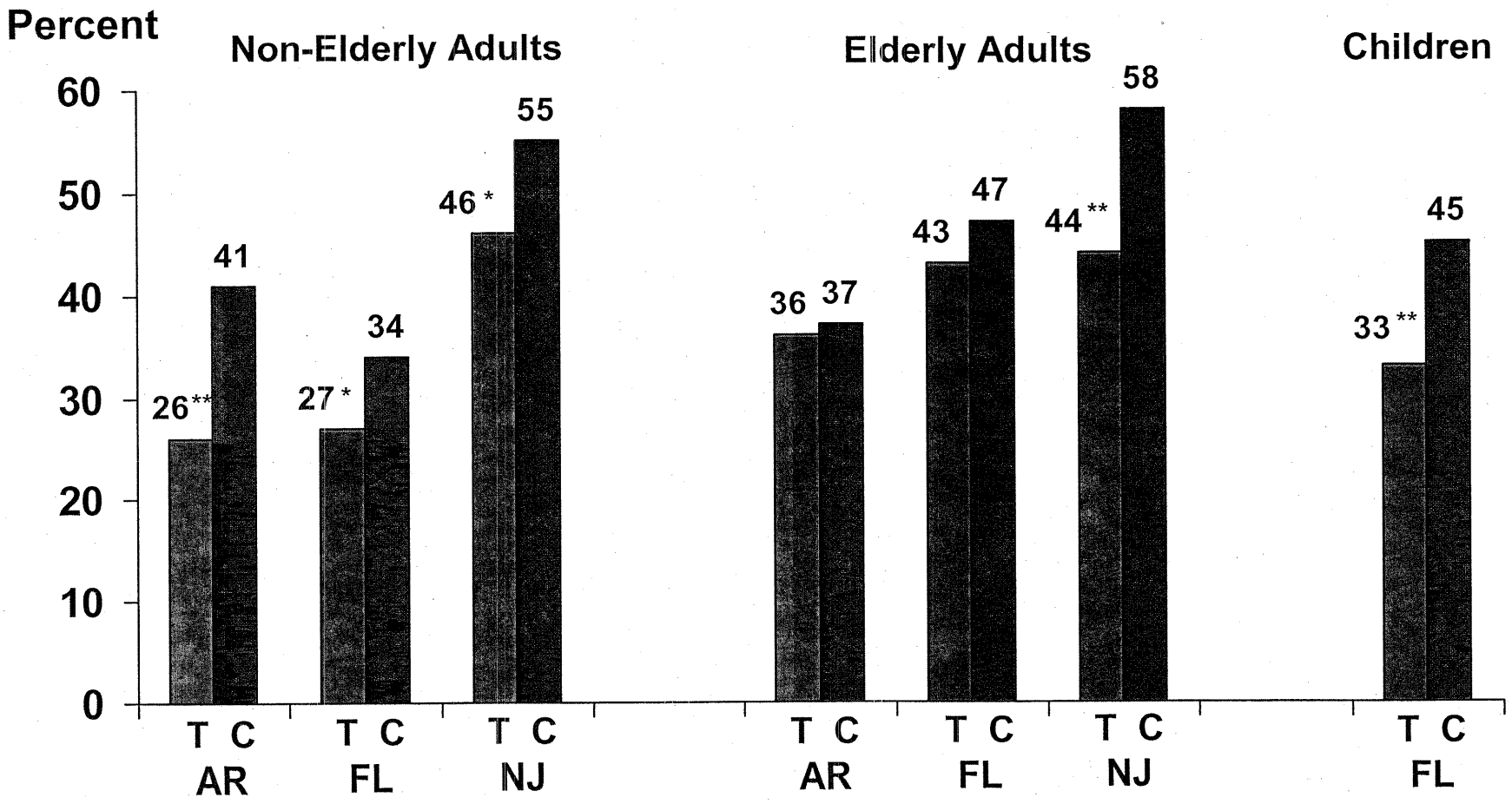
Very Satisfied with Overall Care Arrangements



*, ** Significantly different from control group at .05, .01 level, respectively.

MATHEMATICA
Policy Research, Inc.

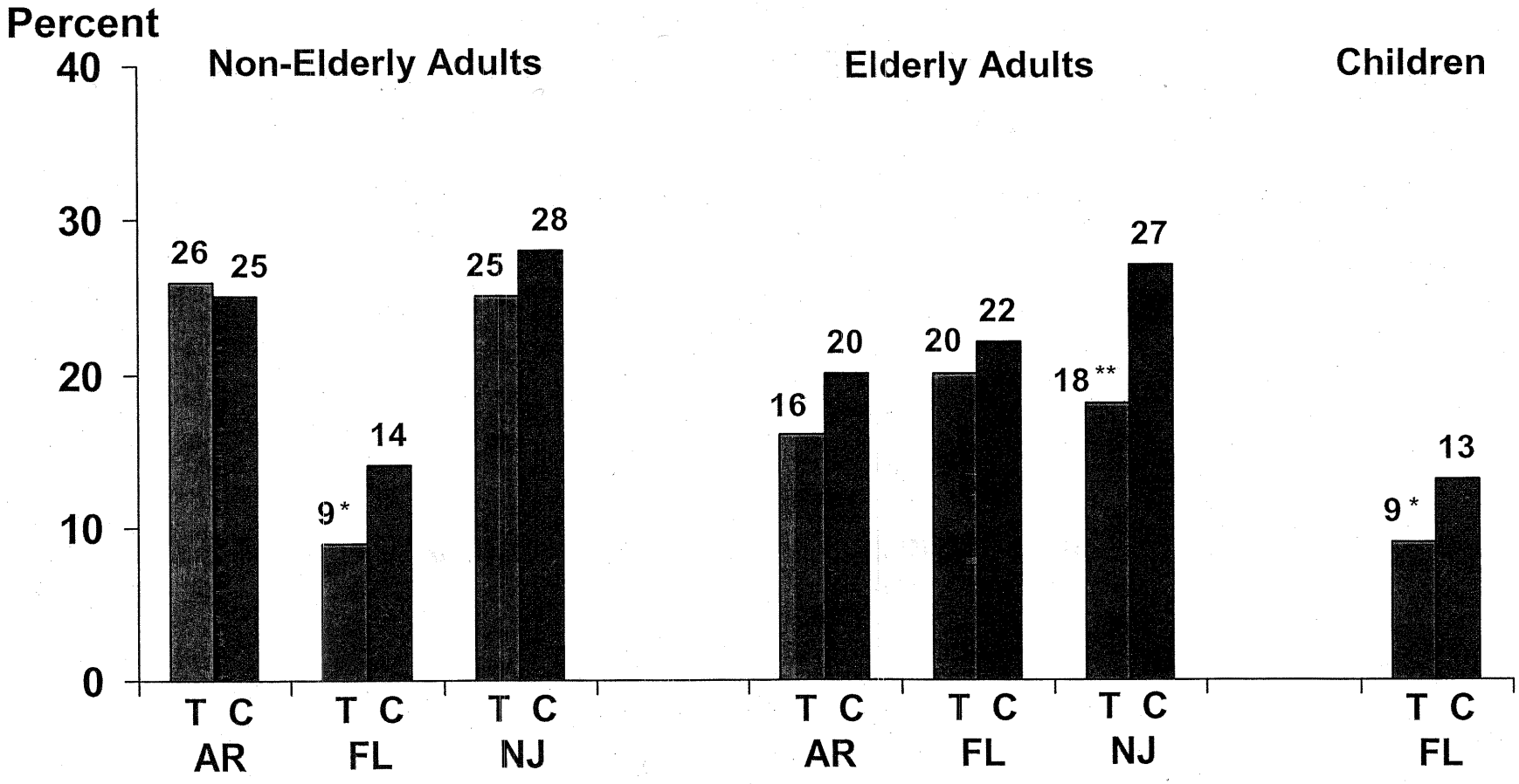
Had an Unmet Need for Help with Personal Care



*, ** Significantly different from control group at .05, .01 level, respectively.

MATHEMATICA
Policy Research, Inc.

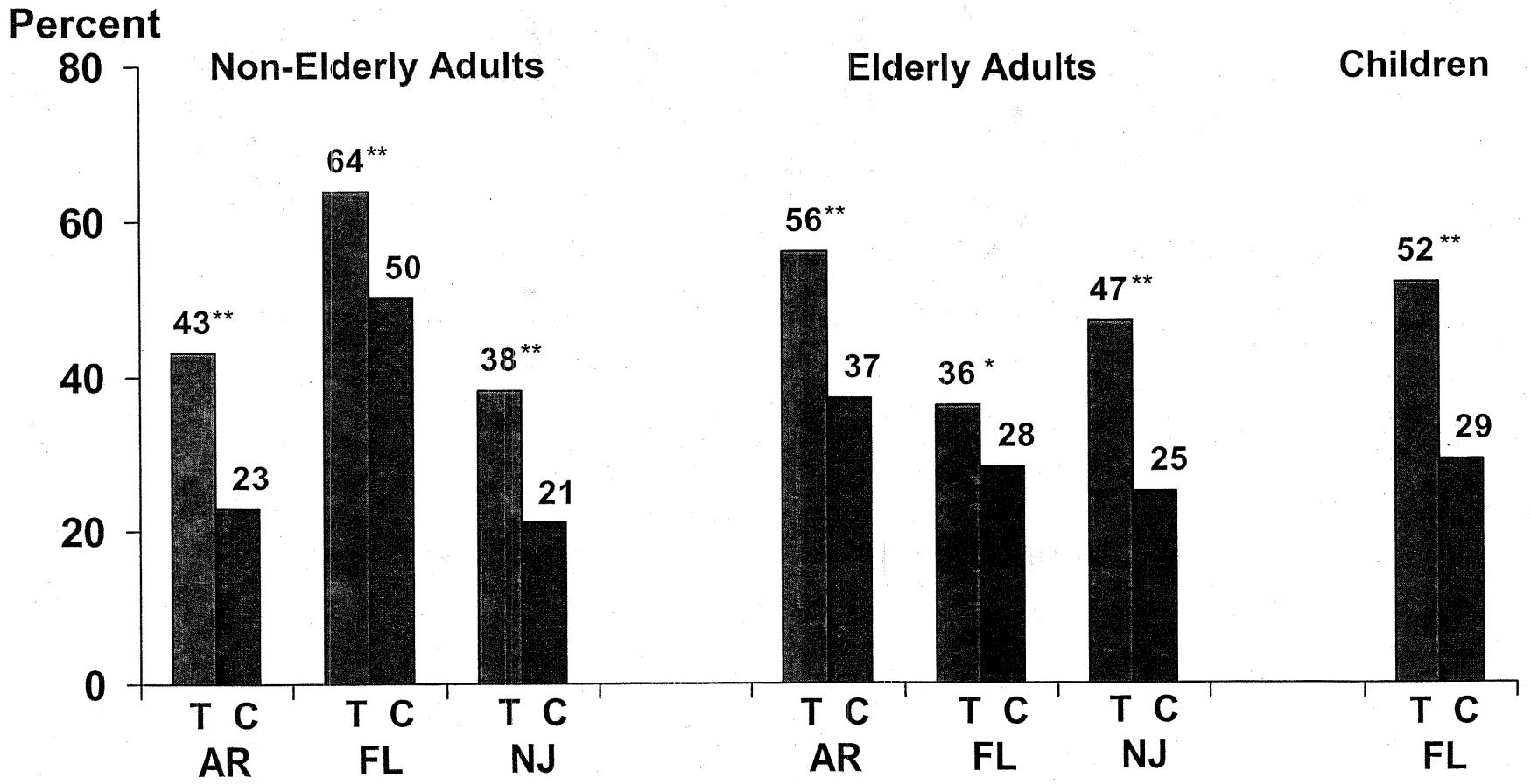
Contractures Developed or Worsened



*, ** Significantly different from control group at .05, .01 level, respectively.

MATHEMATICA
Policy Research, Inc.

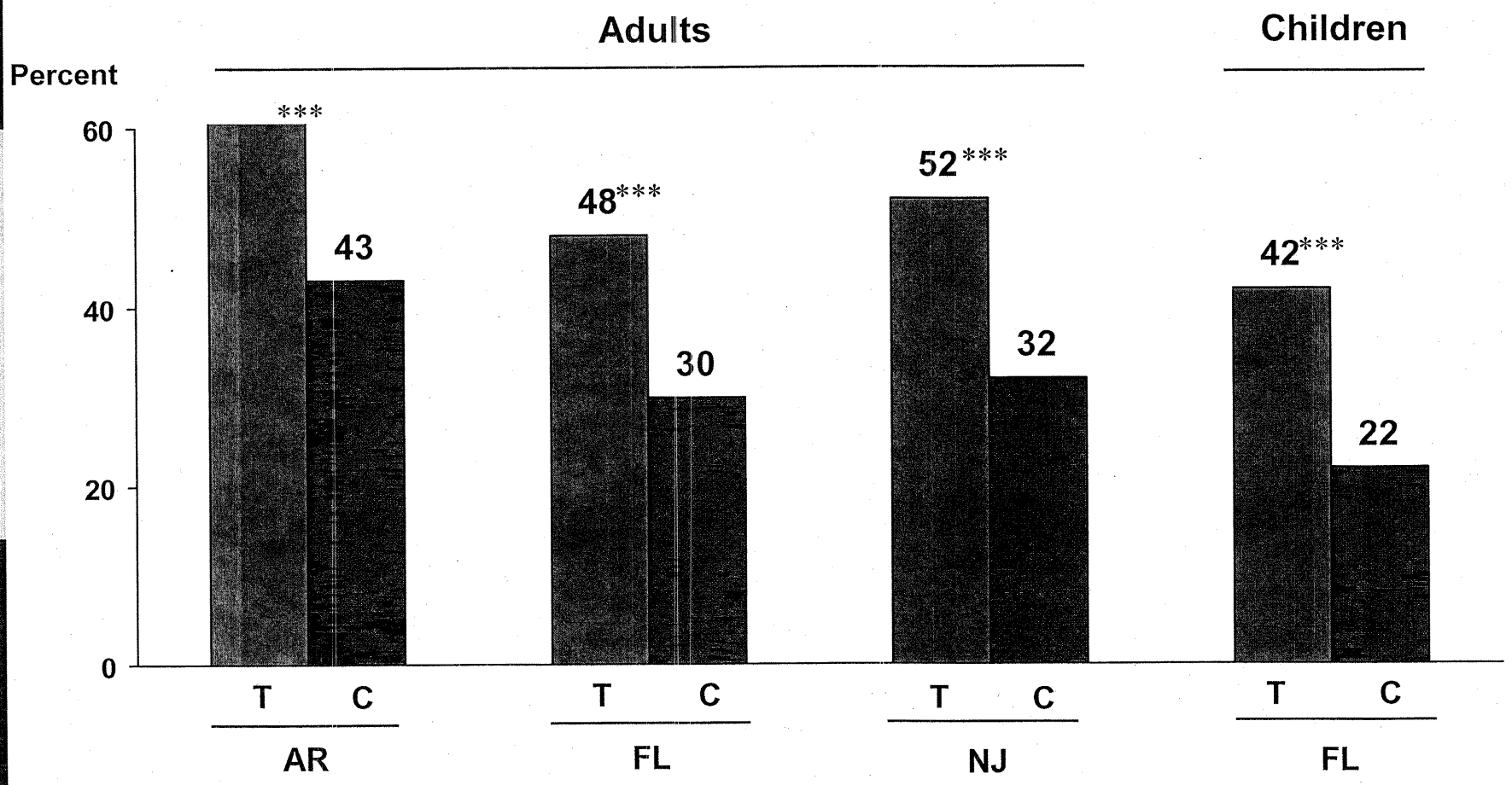
Very Satisfied with Way Spending Life These Days



*, ** Significantly different from control group at .05, .01 level, respectively.

MATHEMATICA
Policy Research, Inc.

Informal Caregivers Very Satisfied with Overall Care



*,**,*** Significantly different from control group at .10 (*), .05 (**), or .01 (***) level.

Effects on Medicaid PCS/HCBS Expenditures—Year 1

- Significantly Higher for Treatment Group in Each State
- In AR and NJ, Mainly Because Control Group Received Substantially Less Care Than Authorized
- In FL, Mainly Because Children and Adults With Developmental Disabilities Got Larger Benefit Increases After Assigned to Treatment Group

Effects on non-PCS Medicaid Expenditures

- Other Medicaid Costs Moderately Lower For Treatment Group in Each Age Group in All Three States

- The Best Example:
  - In AR , Compared to Control Group, Treatment Group Had 40% Fewer Admissions to Nursing Facilities in Second Year

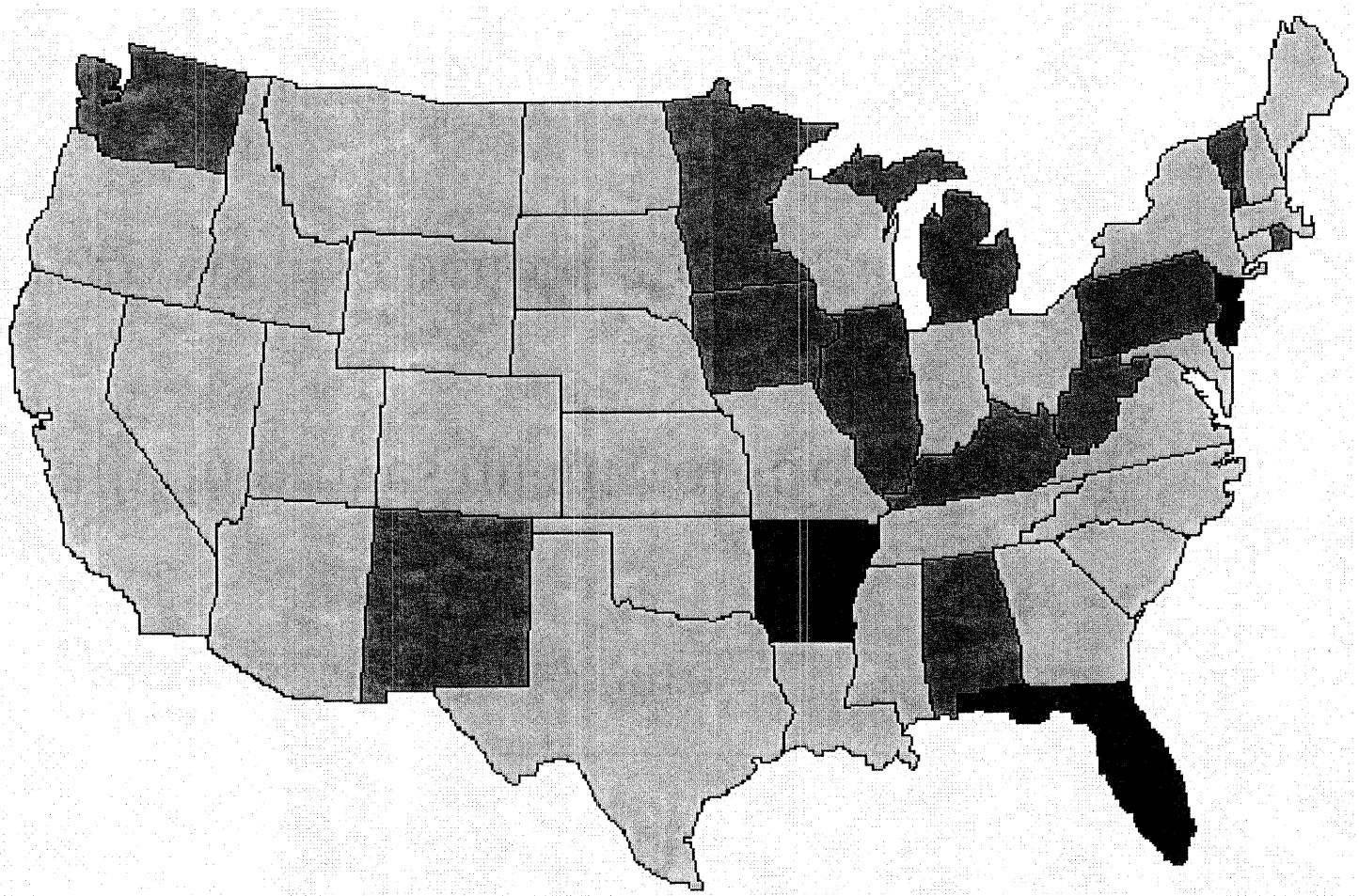
Effect on Total Medicaid Costs

- In AR, No Significant Difference by End of Year 2
  - Reductions in NF and other Waiver Costs Off-Set Increase in Personal Care Costs
- In NJ and FL, Costs Up 8-12%, But States Learned How to Control Costs
- Higher Costs in AR and NJ Due to Failure of Traditional System

Policy Implications

- Can increase access to care
- Greatly improves quality of life (all ages)
- Caregivers also benefit greatly
- States may be concerned about costs
  - But have learned how to control them

Original and Expansion Cash & Counseling States



Cash & Counseling Enrollment June 30, 2008

State	First Enrollment Date	Number of Cash & Counseling Enrollees*	Enrollees in December 2007
Alabama**	October 07	23	2
Illinois**	October 07	195	58
Iowa	December 06	562	310
Kentucky	September 06	1,509	1,092
Michigan**	December 06	327	163
Minnesota	November 04	565	434
New Mexico	December 06	1,003	301
Pennsylvania**	November 08	-	-
Rhode Island	March 06	277	207
Vermont	July 06	125	40
Washington**	February 07	134	48
West Virginia	May 07	215	83
TOTALS		4,935	2,685

** Program is not state-wide

New Opportunities (Federal Legislation)

- DRA
  - 1915(j)
  - 1915(i)

- Revised Older Americans Act

New Resources

- Handbook
- Lessons Learned from Replication States
- National Center on Consumer Direction
- Enhanced website: cashandcounseling.org

Long Term Care Partnership Program

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Background

Federal Legislative Material

Federal Guidance

State Plan Amendments

What's New

Implementation Issues

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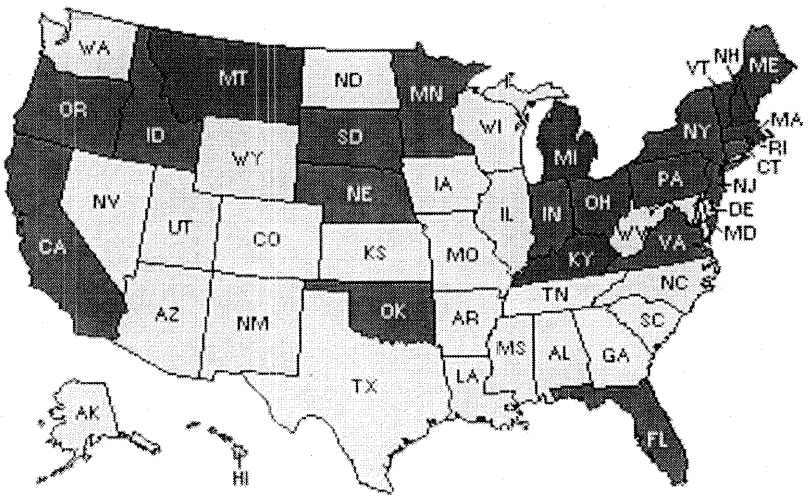
Long Term Care Partnership State Tracking Map

To see a list of available documents for a state, either choose a state from the dropdown list below and click on GO, or click directly on a state in the map below.

ALABAMA GO



Approved State Plan Amendment

State Documents Available

Policies for Sale

State Plan Amendment Submitted

No documents available for these States

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APPENDIX G

Quality Oversight of Federal HCBS Waivers,
Presentation by Maureen Booth,
University of Southern Maine, Muskie School of Public Service,
September 22, 2008.

Quality Oversight of Federal HCBS Waivers

September 22, 2008

Maureen Booth
Muskie School of Public Service

HCBS Waiver: Section 1915(c)

- Established in 1981
- Provides community based long-term care and support as an *alternative* to institutional placement.
- Costs cannot exceed what Medicaid would have paid in an institution
- More than 300 waivers approved by CMS;
- More than 1M participants; over $23B
- Represents 7.5% of total Medicaid spending; 37% of all Medicaid LTC spending

Maine HCBS Waivers

- Adults with Disabilities and the elderly (1188/$16M))
- Persons with Mental Retardation and Developmental Disabilities (2635/$226M))
- Persons with Physical Disabilities (217/$6M)

Context for HCBS Quality

- GAO report, 2002 – "Federal Oversight of Growing Medicaid Home and Community-based Waivers must be Strengthened"
- Letters to Secretary Thompson from Senators Grassley and Breaux
- ***CMS Action Plan for HCBS Quality***

Principles behind CMS Action Plan

1. The State has primary responsibility for continuous quality management and improvement of its waiver programs.

2. CMS expects states to
    1. identify problems
    2. correct problems
    3. continuously improve waiver programs

Principles behind CMS Action Plan

3. CMS judges whether the State meets quality requirements based on evidence of a continuous quality improvement process

4. CMS accepts the State's evidence and analysis of data as true (CMS oversight is not a "look behind"

D-D-R-I

- **Design:** Programs are designed to delivery high quality care
- **Discovery:** States have mechanisms for identifying problems when they happen
- **Remediation:** Individual problems are resolved as soon as possible
- **Improvement**: System changes are made to prevent problems from reoccurring

Design

- *Greater specificity* in waiver applications to assure safeguards and protections exist upfront.

- *More rigorous review by CMS* all features of a waiver program are adequately documented and in place before approval is given

Discovery

- Continuous methods of discovery
  - Complaint systems
  - Critical incident reports
  - Routine communication between case manager and consumers
  - Routine oversight by case manager of service providers

- Use of Performance Measures
  - Use program data to assess performance
  - Measure performance over time, providers, participants
  - Identify areas for improvement

Remediation

- Notifying right person
- Determining the right action
- Documenting what was done
- Checking to see that remedial action worked

System Improvement

- Determine if problems are individual-level or require system solutions
- Analyze and trend data (e.g., complaints, incidents, quality indicators)
- Establish priorities
- Root cause analysis (don't jump to first solution)
- Review system change options and implications
- Make system change
- Monitor to make certain change has the desired effect

Quality Improvement Strategy

- Documented and systematic process for D-D-R-I
- Required in application or subsequent renewal
- Clear articulation of roles and responsibilities for quality oversight
- Specification of quality indicators to track performance
- Process for establishing priorities
- Workplan for quality improvement initiatives

Waiver Assurances

- Level of Care
- Service Plans
- Qualified Providers
- Health and Welfare
- Administrative Authority
- Financial Accountability

Level of Care

- Participants meet federal eligibility requirement before being enrolled in program.
- Level of care is reevaluated at least annually
- There is a consistent process for determining that participants meet eligibility criteria

Service Plans

- Service Plans address participants' needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- The state monitors plan development in accordance with its policies and procedures.
- Service Plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Service Plans
(Continued)

- Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

- Participants are afforded choice:
  - Between waiver services and institutional care;
  - Between/among waiver services and providers.

Qualified Providers

- The state verifies that providers initially and continually meet required licensure and/or certification standards

- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Health and Welfare

The state, on an on-going basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

- Desired outcomes are achieved
- Evidence-based care is provided
- Participants are satisfied with the waiver

Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.

Administrative Authority: What Does It Mean?

- There is designated one State Medicaid Program with uniform requirements §1902(a)(5).
- Per 42 CFR §431.10, all policies must be developed or approved by the SMA and be in writing;
- The 1915(c) waiver is an agreement between the SMA and CMS.

Financial Accountability

State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

What does all this mean for Maine?

- Waivers are a small but growing part of State's HCBS program.
- Waivers may meet basic CMS quality requirements but still miss the big picture
  - Use of evidence-based practices
  - Sustaining a qualified HCBS workforce
  - Coordinating care with other services
- As people shift from institutional care to home care, how to re-balance oversight of quality

APPENDIX H

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

Office of Elder Services

Department of Health and Human Services

State of Maine

State Plan on Aging

October 1, 2008 – September 30, 2012

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Verification of Intent

The State Plan on Aging is hereby submitted for the State of Maine for the period October 1, 2008 through September 30, 2012. The plan includes goals, objectives, strategies, and performance measures to be conducted by the Office of Elder Services, Maine's State Unit on Aging, during this period. The Office of Elder Services has been given the authority to develop and administer the State Plan on Aging in accordance with the requirements of the Older Americans Act. The Office of Elder Services is primarily responsible for the coordination of all state activities related to purposes of the Act, such as development of comprehensive and coordinated systems for the delivery of supported services, including health, housing, social and nutrition services; and to serve as the advocate for Maine's older adults.

The Plan is hereby approved by the Governor and constitutes authorization to proceed with the activities under the Plan upon approval by the Assistant Secretary for Aging.

The State Plan hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements. The State Agency assures that it will comply with the specific program and administrative provisions of the Older Americans Act.

7/31/08
(Date)

(Signed) Diana Scully
Diana Scully, Director
Office of Elder Services

7/23/08
(Date)

(Signed) Brenda Harvey
Brenda Harvey, Commissioner
Department of Health and Human Services

7/29/08
(Date)

(Signed) John Baldacci
John Elias Baldacci, Governor
State of Maine

Executive Summary

The Office of Elder Service's (OES) is required by federal law to develop a "State Plan on Aging" to receive federal funds under the Older American's Act of 1965, as amended. Maine's plan is for a four year period beginning October 1, 2008 and concluding on September 30, 2012. The plan was developed through internal OES planning, examining Area Plans from Area Agencies on Aging, hosting two public hearings, sending the plan to interested parties for review, and posting the plan online for comment. A valuable tool used to project the needs of Maine's older adults was the "Long Term Care Needs Assessment" developed in partnership with the Muskie School of Public Service, University of Southern Maine. This plan was built on the Area Plans developed by Maine's five Area Agencies on Aging.

Much has happened since Maine's last plan was written. The "Bureau of Elder and Adult Services" became the "Office of Elder Services", and the "Department of Human Services" (the organizational home of OES) merged with the Department of Behavioral and Developmental Services to become the "Department of Health and Human Services." Maine now has three Aging and Disability Resource Centers covering 13 of Maine's 16 counties. Maine also has been a leader in implementing evidence-based healthy aging programs and working with diverse public and private partners on civic engagement initiatives to connect older people to employment and volunteer opportunities. The use of nursing facility care has continued going down, though the use of residential care has increased. Baby Boomers have begun to retire.

Maine's population of older adults aged 60+ is increasing dramatically. Maine is the oldest state in the nation when measured by median age, and it's a population that has a higher rate of poverty than the U.S. and New England average, ranking as the 18th highest state in the nation for persons aged 65+ at or below the Federal Poverty Level (FPL). The 2000 Census reports that 54% of Mainers 65+ below the FPL also reported a disability, compared to 40% of the same age group reporting a disability if incomes were higher than the FPL. This leaves those most in need of assistance least able to pay for it.

Maine's population is also aging at a faster rate than most other states, because the percent of Maine's older adults is increasing, but also because the percent of Maine's younger persons is decreasing. The cresting older population wave will create greater demands for services. More people will need information services and resources. This trend will pose challenges as fewer younger persons will be available to fill a growing demand for service positions. Employers in all sectors will need to adapt to a changing workforce as those with experiential knowledge leave.

The next generation of older adults will have greater interest in healthy aging and active retirement. This interest, if supported, should delay an older adult's need for physical assistance or institutional care. Maine must redouble its long-time efforts to support older

people to remain in their homes for as long as possible through the provision of in-home care, home modifications, and caregiver assistance.

Maine's aging network is made up of the OES, Area Agencies on Aging, Long-term Care Ombudsman Program, Legal Services for the Elderly and community providers. The network is well-positioned to meet the needs of older adults. The OES is comprised of four units: 1) Community Services, which is supported primarily with Older Americans Act funds, manages a variety of programs from senior employment to home delivered meals; 2) Adult Protect Services, which accepts referrals, investigates allegations of abuse, neglect or exploitation for adults age 18+; 3) Long-term Care, which manages programs involving home and community-based services for older and disabled adults; and 4) Policy, Planning and Resource Development, which supports the work of OES, providers and advocates in planning for and responding to the needs of Maine's aging population. The Area Agencies on Aging offer a variety of services to Maine's older adults, supported largely through Older Americans Act funds. The Long-term Care Ombudsman Program serves as an advocate and mediator for consumers receiving long-term care through nursing homes and home and community based services. Legal Services for the Elderly provides free legal services to individuals age 60 and older statewide. Community providers are the backbone of service delivery, advocating on their behalf.

There are a variety of issues and trends affecting Maine's older adults. Perhaps the greatest trend in services has been the progress made toward reducing the use of nursing facilities. In 2001, Maine had 52 nursing facility beds per 1,000 people, ranking Maine 19th in the nation for the most beds per capita. By 2005 Maine ranked 36th with 39 beds per 1,000 people. Supporting people in their home, where they overwhelmingly want to remain, is the next step toward reducing the need for institutional care. The changing population will also present an employment challenge for the direct care workforce and for employers. There will be a greater role for family caregivers as Baby Boomers age, and this group must be supported. Aging and Disability Resource Centers will having a growing role in creating a single-point of contact for information and assistance to older adults and adults with disabilities. Energy costs may impede, and re-focus service delivery as people focus more on meeting basic needs like food and heat. Maine's new Blue Ribbon Commission to study home and community-based services will present one opportunity for effective planning.

OES' planned activities for the next four years reflect the Administration on Aging's vision, tailored to Maine's unique resources, needs, and population. OES adopted, to a large extent, the Administration on Aging's 2007-2012 strategic goals, because they spoke not only to national needs, but also to Maine's, and they were broad enough to permit Maine specific objectives and strategies. These activities are detailed on the following page. In addition to the following objectives, there are plans to continue long-term care reform, further assist with implementation of the Medicare Modernization Act, address transportation needs, and promote and ensure emergency preparedness plans.

Maine Office of Elder Services Goals and Objectives for 2008-2012

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.***

Objective 1.1: Increase the amount of information and training available to family caregivers.
Objective 1.2: Continue outreach and advocacy efforts to older adults for assistance with health insurance issues, prescription drug programs, and health care programs.
Objective 1.3: Increase the reach and function of Aging and Disability Resource Centers.

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.***

Objective 2.1: Promote aging in place.
Objective 2.2: Enhance consumer home environments to support aging in place.
Objective 2.3: Promote and encourage use of Adult Day Services as an approach to reduce institutional care and to reduce caregiver stress.

Goal 3 – ***Empower older people to stay active, healthy and connected to their communities through employment, civic engagement, and evidence-based disease and disability prevention programs.***

Objective 3.1: Create opportunities for older adults to stay healthy and active in their communities.
Objective 3.2: Foster community connections for older adults through employment and civic engagement.
Objective 3.3: Enhance and expand evidence-based disease and disability prevention programs.
Objective 3.4: Promote and ensure inclusion of Maine's diverse populations in the aging network and communities.

Goal 4 – ***Protect the rights of older adults, and enhance the response to elder abuse.***

Objective 4.1: Increase awareness of elder abuse, neglect and exploitation and the role of mandated reporters.
Objective 4.2: Promote the rights of older and incapacitated adults.
Objective 4.3: Increase availability of emergency services for people abused, neglected or exploited.

Introduction

The federal Older Americans Act of 1965 requires all states to prepare a periodic "State Plan on Aging" in order to receive federal funds under the Act. The Maine Office of Elder Services (OES) developed this plan to detail and guide their work to meet the needs of older adults. OES' goal is to assist elders and adults with disabilities to maintain their independence and to participate in the life of the community. Maine's plan is for a four year period beginning October 1, 2008 and concluding on September 30, 2012. The plan reflects the collaborative efforts of the OES, public and private groups, service providers, employers, advocacy groups, volunteers, and others. The people of Maine have a long history of working together, and that cooperation is one of Maine's greatest assets.

Since Maine's last state plan was written, the State Unit on Aging was changed from the "Bureau of Elder and Adult Services" to the "Office of Elder Services." The proposed merger between the Department of Human Services and the Department of Behavioral and Developmental Services is complete. OES was housed within "Department of Health and Human Services" (DHHS) in 2004, but the work associated with this merger is ongoing as the department finds more ways to improve services to Maine's population through enhanced cooperation between offices. DHHS personnel are seeing their work as part of a larger structure rather than within silos. This creates a more positive consumer experience as access to services is simplified and services are better coordinated. The positive effects are being realized. New initiatives include examining information systems across the Department to determine the best methods to collect, share and use information in the most efficient, least duplicative manner possible.

The demographic information presented in this plan underscores the growing importance of the work the OES performs. While the goals, objectives, and strategies within this plan are intended to map our work and focus for the next four years, the plan is intended to be a working document. Development of this plan presented an opportunity to step back from our daily tasks and examine our direction to make certain we are aligned according to the needs of Maine's older population. Given the rapidly changing world in which we live, where political, economic, and societal changes present new challenges, we expect the objectives and strategies to change with the times. The plan will be reviewed annually to determine if our work stays aligned with the needs of the people we serve.

This plan, in accordance with AoA requirements, builds on the Area Plans developed by Maine's five area agencies on aging. While those plans reflect the needs specific to the regions they serve, this plan focuses on statewide issues. The public has had opportunities to comment on the plan through public hearings, e-mail and phone. The notice was published in multiple newspapers, interested parties were notified, and the draft plan was available for download from the OES website. Public comments were incorporated in the final plan. Additional public comment details can be found in Appendix A.

Who are Maine's older adults now and in the future?

The Muskie School of Public Service, University of Southern Maine, under a Cooperative Agreement with OES, developed a "Long Term Care Needs Assessment" report in 2007 to define Maine's older adult population as it exists today and project what the future of this population will look like. This information is being used for long term care policy and planning purposes. The report incorporated data from the U.S. census and consumer service use information within Maine state government. What makes the assessment particularly useful, beyond its baseline data, is the projection model developed in partnership with a national health and human services consultant, the Lewin Group. The model allows for need projections for 2010 and 2015 to predict what services will be needed where and when. The model is not fixed, meaning it can be adapted to incorporate new and/or unexpected changes as they develop. The information provided within the Needs Assessment was used to shape this plan, and it was the source for the charts and graphs that follow.

The U.S. Census Bureau estimates that in 2006, Maine had 193,000 people aged 65 and over. **Maine is the oldest state in the nation when measured by median age.** When measured by the percent of population aged 65+, Maine was the 7th oldest state in the nation in 2000, and projected to become the 2nd oldest state by 2020 just below Florida (see following chart).

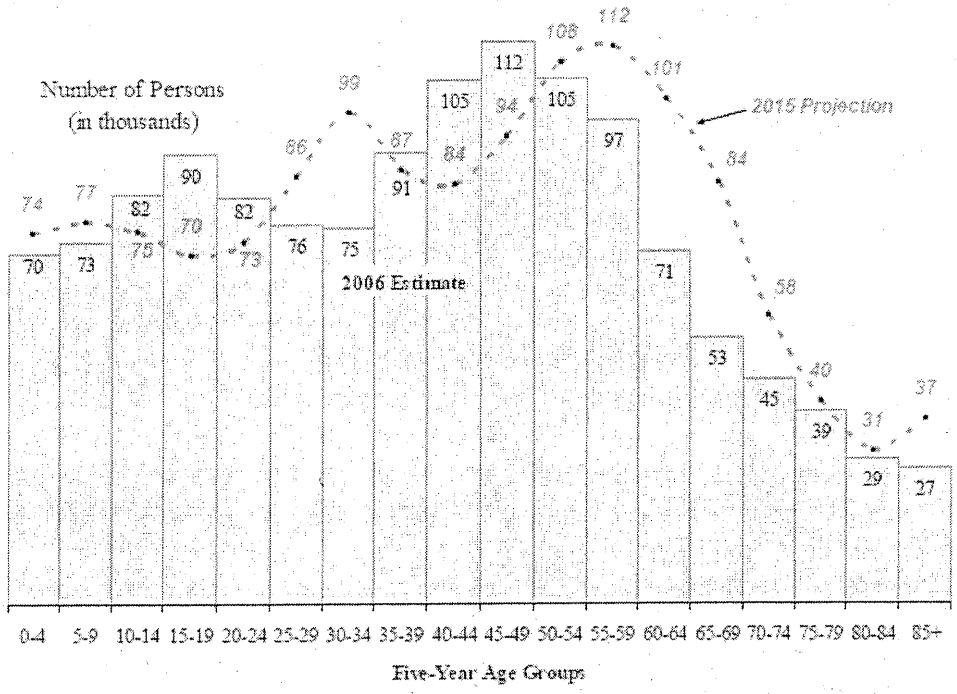
Percent of Population Age 65+ and *State Rank* Based on U.S. Census Bureau Projections for 2000 to 2030 *(Sorted by rank in 2030)*

State	Census 2000		Census Bureau Projections											
			2005		2010		2015		2020		2025		2030	
Florida	18%	*1*	17%	*1*	18%	*1*	19%	*1*	22%	*1*	25%	*1*	27%	*1*
Maine	14%	*7*	15%	*6*	16%	*3*	18%	*3*	21%	*2*	24%	*3*	27%	*2*
Vermont	13%	*26*	13%	*22*	14%	*11*	17%	*7*	20%	*8*	22%	*8*	24%	*8*
Connecticut	14%	*10*	14%	*11*	14%	*9*	16%	*14*	17%	*17*	20%	*18*	22%	*16*
New Hampshire	12%	*37*	12%	*35*	13%	*32*	15%	*28*	17%	*19*	20%	*17*	21%	*17*
Rhode Island	15%	*6*	14%	*8*	14%	*15*	15%	*19*	17%	*20*	19%	*20*	21%	*18*
Massachusetts	14%	*12*	13%	*19*	14%	*23*	15%	*23*	17%	*24*	19%	*24*	21%	*21*
Utah	9%	*50*	9%	*50*	9%	*50*	10%	*51*	11%	*51*	13%	*51*	13%	*51*

Source: *Interim Projections of the Population by Selected Age Groups for the United States and States: April 1, 2000 to July 1, 2030*, U.S. Census Bureau (released April 2005)

Maine's population is aging at a faster rate than most other states. This is happening on two fronts: 1) the percent of Maine's older adults is increasing over time, and 2) the percent of Maine's younger persons is decreasing over time, as seen in the following five-year age group chart.

Age Profile of Maine's Population by Five-Year Age Groups Based on Census Bureau Estimates for July 2006 and Projections for 2015



The 60-69 age group represents the most significant increase in population, those persons facing retirement age. These persons are expected to have an interest in healthy, active aging. The 85+ age group is expected to increase by 10,000 people during this time frame, which suggests greater demands for long-term care services. What also stands out in this graph is the decrease in population for those aged 15-24 and 40-50. The decrease in these age groups may create difficulties in maintaining a workforce that is able to meet the needs of older adults.

Maine's older adult population is not well positioned financially. In 2005, 10.6% of Maine's population aged 65+ was at or below the Federal Poverty Level (FPL). Maine ranked as the 18th highest state in the nation with this statistic, where the U.S. average was 9.9%, and the New England average at 8.8%. Mainers within this population group and FPL were also more likely to have a disability. The 2000 Census reports that 54% of Mainers 65+ below the FPL also reported a disability, compared to 40% of the same age group reporting a disability if incomes were higher than the FPL. This leaves those most in need of assistance least able to pay for it, creating a greater need for publicly funded assistance.

What is Maine's Aging Network?

Maine's Aging Network is comprised of four major components: The Office of Elder Services, five Area Agencies on Aging, the Long Term Care Ombudsman Program, Legal Services for the Elderly, and community providers.

The Office of Elder Services (OES) is housed within the Department of Health and Human Services (DHHS). The OES receives federal and state funds to support programs and services to older and incapacitated adults. Appendix B is a view of the OES organizational structure, and Appendix C shows where the OES fits within the DHHS. OES works closely with providers, government agencies, elected officials, advocacy groups, and older adults.

There are four units within OES:

- **Community Services** manages programs that involve congregate and home delivered meals, outreach, information and assistance, family caregiver assistance, transportation, senior employment, public education, independent support services, adult day services, independent housing with services, evidence based programs for healthy aging, Senior Medicare Patrol, Aging and Disability Resource Center, federal demonstration grants for Alzheimer's services, legal services and SHIP (State Health Insurance Assistance Program). The unit is supported primarily with Older Americans Act funds, and served over 41,000 people in FY07 through the five Area Agencies on Aging, service providers and Legal Services for the Elderly, Inc.

- **Adult Protective Services** accepts referrals, investigates allegations of abuse, neglect or exploitation of adults age 18+. The program's purpose is to accept referrals, assess the adult and reported dangers and to provide and arrange for services to protect dependent or incapacitated adults who are unable to protect themselves from abuse, neglect or exploitation. The program petitions Probate Court to become public guardian or conservator for incapacitated adults when no private person is available, willing or suitable to assume responsibility; manages assets of public wards and protected persons; and provides training on mandatory reporting and recognizing and reporting abuse, neglect or exploitation to health care, law enforcement and social service agencies. The program received over 3,500 protective referrals in FY 07, and was the active public guardian and/or conservator for over 900 adults. It is administered by the OES with staff persons in 12 district offices throughout the state.

- **Long-term Care** manages programs involving home and community-based services for older and disabled adults in order to avoid or delay nursing home placement. The programs include services related to home based care, Medicaid waiver for elders and adults with disabilities, nursing facility care, residential care facilities, assisted living facilities, home health services and adult family care homes. The unit manages pre-admission functional assessment of applicants for

nursing facility care and those seeking home and community-based services through a contract with a single statewide assessing services agency. The unit also manages case management and a provider network for home and community-based services through a contract with one of the Area Agencies on Aging.

- **Policy, Planning and Resource Development** supports the work of the OES, providers, and advocates in planning for and responding to the needs of Maine's aging population. The unit assesses the needs of older and incapacitated adults, and those with long-term care needs. It identifies and develops resources to meet those needs. The unit collects and maintains the OES data and statistics for dissemination to policy makers, government agencies, service providers, advocates, and the public. The unit develops and implements the State Plan on Aging and provides staff support to study committees established by the Legislature and internal DHHS committees as needed.

- **Community Providers** are the backbone of services to Maine's aging population. They provide services that range from adult day services, long-term care services, and transportation services. Beyond providing services, Maine's provider community is actively engaged in advocacy efforts.

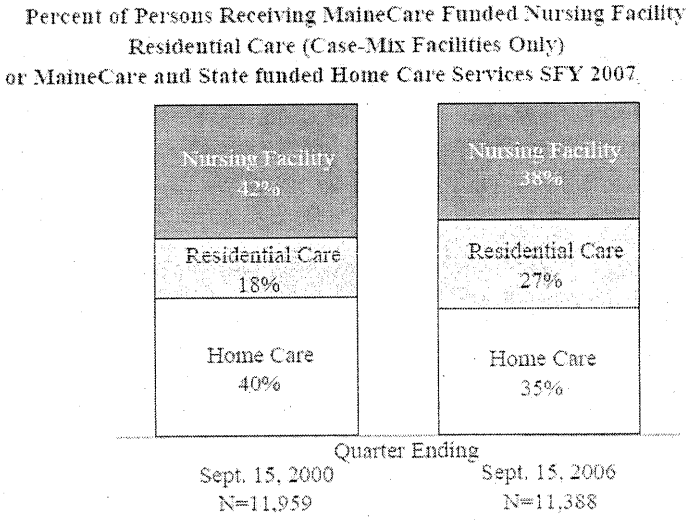
Area Agencies on Aging in Maine offer a variety of services to Maine's older adults, including, but not limited to: congregate and home delivered meals, information and assistance, health insurance counseling, Medicare education regarding fraud, errors and abuse, Alzheimer's respite, employment training, and adult day services. Maine has five AAAs: Aroostook Agency on Aging, Eastern Area Agency on Aging, SeniorsPlus, Spectrum Generations, and Southern Maine Agency on Aging. The agencies serve all regions of the state (see Appendix D for a map of their service areas). Three of these agencies have become Aging and Disability Resource Centers.

Long-term Care Ombudsman Program is a private non-profit agency designated by the State to serve as an advocate and mediator for consumers receiving long-term care through nursing homes and home and community based services. The program receives and investigates complaints from individuals and agencies regarding issues that affect the care, health safety or rights of recipients of long term care. The Ombudsman Program is mandated by federal law and is further defined by Maine state enabling legislation (22 MRSA §5106 and 5107-A), which requires the Office of Elder Services to assure that Maine has an Office of the Ombudsman.

Legal Services for the Elderly is a private non-profit agency designated by the State and mandated and funded under the Older Americans Act to provide free legal services to individuals age 60 and older statewide. The agency receives state funding as well as other funding from other organization and private individuals to support its activities.

What are the issues and trends? What are the challenges and opportunities?

Perhaps the greatest Maine trend in services to older adults has been the progress made toward reducing the use of nursing facilities. In 2001, Maine had 52 nursing facility beds per 1,000 people, ranking Maine 19th in the nation for the most beds per capita. In 2005, that number decreased to 39 beds per 1,000 people, ranking Maine 36th in the nation for most beds per capita. In 2000, 42% of MaineCare or state funded LTC consumers were in nursing facilities, compared to 38% in 2006. This has, however, come with an increase in the use of residential care beds, as seen in the following graph:



Source: MDS and MDS-RCA Assessment data as of September 15, 2000 and 2006 where MaineCare is identified payer source. MED Assessment - most recent completed in SFY 2000 and 2007.

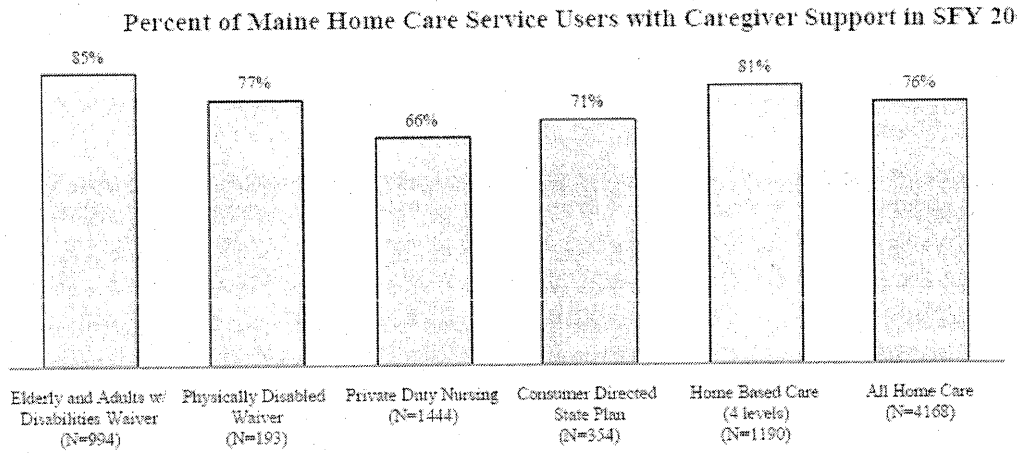
The increase in residential care use following a decrease in nursing facility use may not come as a surprise, but during the same 2000-2006 time period, the use of home care decreased by 5%. **Supporting people in their home, where they overwhelmingly want to remain, will help reduce the need for institutional care in any form.** This supports their choice, their independence, and the finances of the both the consumer and the public. Accordingly, the objectives and strategies built into this plan are a reflection of OES' intent to support people in their homes. The strategies are not limited to the provision of physical assistance for activities of daily living, however. **Prevention remains the easiest, least costly method to reduce reliance on care.** Safety and prevention are proven methods to reduce the chance of experiencing the effects of a disease, a disability or injury.

The changing population, with more older adults projected and fewer younger persons, will present an employment challenge for the direct care workforce. This field of work has already experienced difficulties in attracting and retaining employees,

particularly for publicly funded services. Home care providers that serve individuals receiving MaineCare (Medicaid) often have a difficult time competing with the pay given to those serving individuals who pay privately. The rise in fuel costs compounds the problem as workers must drive from residence to residence, often at their own expense. Maine is a very rural state, and many who need assistance are geographically isolated. This adds importance to the need to reach these persons, but also creates a challenge as economies of scale are broken down.

The growing role of the Aging Network in serving persons with disabilities through the development of Aging and Disability Resource Centers is a direction the OES expects to continue. This development helps create a single-point of contact for information and assistance to older adults and adults with disabilities on a wide range of resources regardless of income. There is value here as consumers can more easily identify the source for information on a whole host of services. The personnel serving these consumers also gain the benefit of expanded training on consumer services they may have not previously been exposed to. This knowledge gives the worker a wider view of the services available to assist consumers. Because OES expects the move toward ADRCs to continue, objectives and strategies have been planned that seek to solidify and expand the role of ADRCs in Maine.

There will be a greater role for family caregivers as Baby Boomers age. Family members will increasingly need to step forward, in the face of a challenged direct care workforce, to provide assistance for loved ones. Maine's Aging Network has already recognized the importance of the family caregiver role in caring for older adults, but caregiver support must be maintained and expanded. Part of this expansion includes encouraging others to support caregivers as well. Employers in particular must be educated on the importance of supporting employees that are stretched between work and care giving demands. Following is a chart that underscores the important, active role Maine caregivers play in helping keep their loved ones in their homes as long as possible.



Source: Most recent MED Assessment completed during SFY 2006

A state funded demonstration project may be continued that provides demonstration funds to support caregivers by providing limited financial assistance to address self-

identified needs such as the purchase of chair lifts, medical equipment, and heating assistance.

Caregivers do more than just provide help like physical assistance and meal preparation, however. They help make decisions. They look for resources. They need information. Caregiver support must focus on meeting all their needs.

The Baby Boomers' exodus from the workforce will present economic challenges, but the extent to which this will happen remains unknown. There are indications that many will remain in the workforce as a way to stay active and engaged, but also as a way to maintain income levels as life expectancy rates continue to climb. Some may retire completely, some may work part-time, and others may stay fully employed.

Employers must prepare for these changes if they wish to keep a qualified workforce, but there are other advantages to employing older adults. Working longer helps financial security. It keeps people active and engaged. OES' role in the National Governor's Association Civic Engagement initiative has created an opportunity for OES to partner with other public and private agencies to address this issue.

Economic conditions could change the focus of the Aging Network dramatically as people focus on meeting basic needs like food and heat. Maine has long winters and old homes, 80% of which rely on heating oil to get through the winter months. Energy costs have risen exponentially. Food costs have risen greatly. This is a hardship for all Maine citizens, but particularly for those on fixed incomes – Maine's older adults. Government's ability to meet their needs becomes compromised as operating costs increase for everyone. Service providers also become squeezed. Meals on Wheels programs suffer. Public transportation costs increase. Fewer volunteers are willing to drive their cars.

The aging population will require greater protection efforts. Whether it is fraud, abuse or neglect, older adults are often the target of crimes. The larger the older population gets, the more prevalent the crimes. Whether it's the older adult, the caregiver, law enforcement, or the judiciary, there must be a focus on education, advocacy and enforcement.

The Maine Legislature has created a Blue Ribbon Commission to study home and community-based services. It is comprised of several legislators, a representative of the Governor's Office, a consumer, and three experts (one of whom is the Director of the Office of Elder Services). This is a tremendous opportunity to increase understanding by lawmakers about the desirability and cost-effectiveness of home and community based services

How will Maine's Aging Network meet the needs of older adults?

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.*

- ***Objective 1.1: Increase the amount of information and training available to family caregivers.*** Providing caregivers with information is a critical part of the decision making process for many instances in long-term care planning. Access to this information helps ensure informed decision making and reduction in caregiver stress.

  Strategies:

  1. Ensure that Independent Support Services staff; Home and Community Based care program staff; and health, long-term care facilities, social service providers are knowledgeable about the Family Caregiver Program, Alzheimer's respite, other resources, and the importance of making consumer referrals to programs and support groups that offer assistance.
  2. Increase Family Caregiver Coordinator education about new technologies that assist older people to reside in their own homes longer so this information can be shared with individuals referred for assistance.
  3. Continue the "Best Friends Training" program despite funding challenges through grants and other opportunities. Determine if trainings should be made available to support group leaders, embedded in other programs, etc.
  4. Consistent with the intent of the Family Caregiver Program, work with providers and the public to ensure the definition of "family caregiver" includes grandparents caring for grandchildren, and create awareness of the challenges this populations faces while working to ensure the needs of these persons are being met in the best ways possible.
  5. Collaborate with interested organizations to develop and deliver caregiver training sessions.
  6. Continue and expand Healthy Ideas program for caregivers of individuals with dementia to improve their quality of life by reducing depressive symptoms.

- ***Objective 1.2: Continue outreach and advocacy efforts to older adults for assistance with health insurance issues, prescription drug programs, health care programs, and mental health assistance.*** Continuation of such efforts assures people facing these decisions for the first time have the information needed to make sound choices and those who have issues or concerns know where to turn for help.

Strategies:

1. Work with the five area agencies on aging and Legal Services for the Elderly to increase the number of eligible people who enroll in the Medicare Savings Program and receive those benefits, as well as deemed eligibility status for Medicare Part D Low-Income Subsidy (LIS) assistance.
2. Educate more people about Medicare benefits, and empower them to identify and report health care errors, fraud, and abuse through programs like the SMP (Senior Medicare Patrol).
3. Work with the Maine Center on Aging and others to assist in their efforts to educate the public on the dangers of improper prescription drug disposal and to implement a system for better, more ecologically sound methods.
4. The SHIP (State Health Insurance Assistance Program) will continue to provide information, assistance and counseling to people with Medicare, their family members and others in the community through the SHIP network and will strengthen relationships with Maine Medicare Workgroup members and other community agencies by developing Memoranda of Understanding to clearly define roles.
5. Provide staff support to the Joint Advisory Committee on Select Services for Older Adults, and assist the group to clarify its mission and have meaningful impact.
6. Work with Mental Health Services over 2009 to develop an RFP for the provision of geriatric mental health services.
7. Designate an OES staff person to work with Adult Mental Health to identify additional methods for addressing the mental health needs of older adults.

- ***Objective 1.3: Increase the reach and function of Aging and Disability Resource Centers (ADRCs).*** A single entry point for information and assistance for older adults and adults living with physical disabilities, cognitive impairments, mental illnesses and substance abuse disorders creates a less cumbersome, easier-to-navigate source for information and resources.

Strategies:

1. Continuously work toward becoming fully functioning ADRCs based on AoA criteria.
2. Seek funding to develop new ADRCs for Aroostook, Cumberland and York Counties.
3. Sustain existing ADRCs by securing additional funding through grant opportunities.
4. Continue expanding and enhancing the ADRC partner network by including additional providers and partners in the databases used to refer clients to services.

5. More effectively transfer consumer information between ADRCs and Maine's Office of Integrated Access and Support (OIAS) to reduce layers and redundancy in connecting people with services.
6. Enhance the consumer experience through the transfer of information between the statewide assessing agency and ADRCs by developing a mechanism that includes a release of confidential release of information.
7. Promote sensitivity training and approaches for ADRC personnel in dealing with people who have mental health conditions.

Goal 1 – Outcomes / Performance Measures

Objective	Outcome / Performance Measure	Target Date
1.1	2,800 will receive information, assistance and education through the Family Caregiver Program.	Annually
	Best Friends training will be delivered to 250 individuals.	July 2010
1.2	200 education and outreach events will be provided to Medicare beneficiaries/consumers through SMP.	2009-2012
	3,000 will be determined eligible for the Medicare Savings Program/Part D Low-Income Subsidy.	Annually
	Six MOUs will be in place between the SHIP and partners like the Bureau of Insurance, Social Security Administration, Maine Primary Care Association, and others.	2010
1.3	Establish baseline ADRC assistance figures.	2009
	ADRC assistance to consumers will increase by 3%.	2009
	92% of people will report "very satisfied" or "satisfied" ADRC surveys.	Annually

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.*

- ***Objective 2.1: Promote aging in place.*** Older adults wish to live in their own homes for as long as possible, a wish that saves the consumer and the public money.

  Strategies:

  1. Increase participation in evidence based programs developed for in-home use by providing opportunities for homebound older adults to participate in these, including promoting the online Living Well program and piloting one of the programs to be used in-home.
  2. Foster better cooperation and coordination between hospital discharge planners and ADRC/AAA staff to make certain those that can use home and community based services are connected with services upon discharge.

3. Collaborate with hospital emergency departments through linkages with AAAs to increase the cooperation and coordination of services to older adults who are not admitted.
4. Use Maine's Long-term Care Needs Assessment and projection model in planning and policy to arrive at the appropriate balance of long-term care services that will meet the population's needs now and in the future.
5. Participate in the development of eligibility criteria for residential care facilities to determine if placement is appropriate and funds are being used as effectively as possible. Establish a stakeholder group to accomplish this and ensure that consumers will have access to support services should they not qualify under new criteria.
6. Identify sustainable methods of financing for affordable assisted living, adult family care homes, Independent Housing with Service Program (IHSP), and/or other models.
7. Collaborate with public and private stakeholders to inform decision makers about compensation and retention issues for direct care workers so that older adults have access to consistent, quality in-home help.
8. Explore ways to make nutrition programs more cost-effective, and assist in other means of financial support such as March for Meals.

- ***Objective 2.2: Enhance consumer home environments to support aging in place.*** The physical environment within one's home should not be a barrier to aging in place. Enhancing home environment to support those wishing to live in their homes represents a cost-effective approach to long-term care services.

Strategies:

1. Encourage use of a home safety assessment by AAAs, direct care providers, and others to identify safety threats.
2. Increase knowledge and use of consumer directed services.
3. Assess the success of the LD 519 demonstration project, *An Act to Provide Assistance to Family Members, Friends and Neighbors Who Provide Home Health Care for Senior Citizens*, which allotted state funds for use to support caregivers including home modification, assistive technology, personal care, and others. Report to the Commissioner on the findings and make recommendations for the project should it continue.
4. Educate and identify potential resource for older adults and their families around the advances in technology which can support older adults in their homes.
5. Work with other Department of Health and Human Services offices, AAAs, Community Action Programs, Maine State Housing, and others to address challenges resulting from rising energy costs.

- ***Objective 2.3: Promote and encourage use of Adult Day Services (ADS) as an approach to reduce institutional care and to reduce caregiver stress.*** Adult Day Services assists older adults age in their homes, experience community inclusion, gain access to services, and provides respite to caregivers.

  Strategies:

  1. Improve distribution of state funded ADS services for older adults that do not meet eligibility requirements for other funding sources, while better monitoring and analyzing consumer use of funds to permit the best use of limited funds.
  2. Build a state web page specific to Adult Day Services for consumers and providers to find licensed adult day providers, programs that offer funding assistance, links for additional information, etc.
  3. Provide training about policies, procedures, and approaches for addressing needs of people receiving services to ADS staff and facilities through a partnership with the Maine Adult Day Services Association (MADSA).

Goal 2 Outcomes / Performance Measures

Objective	Outcome / Performance Measure	Target Date
2.1	Establish baseline participation figures for evidence based programs.	2009
	Increase participation in evidence based programs developed for in-home use by 3%.	Annually beginning 2010
	Maintain the number of individuals utilizing home and community based services.	Annually
	Maintain the number of persons receiving home delivered meals.	Annually
2.2	Adopt a home safety assessment process for use by AAA staff, service providers, caregivers, and older adults.	2010
2.3	More service providers will access Section 61 ADS funds to assist consumers.	December 2009
	At least one training session will be provided to ADS providers through MADSA and other groups.	Annually

Goal 3 – *Empower older people to stay active, healthy and connected to their communities through employment, civic engagement, and Evidence-Based Disease and Disability Prevention programs.*

- ***Objective 3.1: Create opportunities for older adults to stay healthy and active in their communities.*** OES seeks to expand awareness of, and opportunities for, older adults to maintain quality of life through the aging process through access to healthy aging initiatives and community inclusion.

  Strategies:

1. Work with other Department of Health and Human Services offices, state departments, AAAs, Community Action Programs, transportation providers, and others to address challenges in transportation resulting from high energy costs.
2. Work with the Maine Community Foundation and the Maine Development Foundation to establish an older adult leadership training program that will train older adults on community leadership issues and directly involve them in municipalities to assist in the planning for an aging population.
3. Engage older adults through involvement a Blaine House Conference on Aging (Maine's version of the White House Conference on Aging), through regional forums in different parts of the state, and by including a civic engagement breakout session in the conference.

- ***Objective 3.2: Foster community connections for older adults through employment and civic engagement.*** Projections on the needs for aging populations to stay gainfully employed as a benefit both to older adults and employers necessitates the need to foster environments that are conducive to an aging workforce. Staying or becoming engaged in one's community also promotes benefits for both the older adult and the community.

  Strategies:

  1. Continue progress made under National Governors' Association (NGA) Policy Academy to develop and expand state strategies on the civic engagement of seniors.
  2. Work with the Maine Department of Labor (DOL) to assemble information that will assist elder worker planning and policy development, such as establishing benchmarks to measure success in retaining older workers, assessing demographic information to determine need, etc.
  3. Partner with the DOL to develop and promote an "EngageME" conference that will focus on employers, older workers, and minority populations on issues surrounding employment.
  4. Expand relationships with Senior Community Service Employment Program , the Work Force Investment Boards, and other state and private organizations to promote the value of older workers.

- ***Objective 3.3: Enhance and expand evidence-based disease and disability prevention programs.*** Evidence-based disease and disability prevention programs are an effective, low-cost approach to reduction in disease, disability, and injuries in older adults.

Strategies:

1. Increase the reach of Living Well chronic disease self-management and other evidence-based programs through expansion of the community based and practice based models.
2. Develop public/private partnerships to create long-term sustainable systems for evidence-based programs.
3. Work with insurance companies, employers, and retiree associations to promote understanding of the importance of evidence-based programs and offer them as a service.
4. Examine the feasibility of including Living Well as a benefit under the MaineCare (Medicaid) program.

- ***Objective 3.4: Promote and ensure inclusion of Maine's diverse populations in the aging network and communities.***

Strategies:

1. Ensure access to interpreter and translation services and aging related literature in different languages as needed.
2. Promote opportunities for employment of older adults within minority populations.
3. Explore existing outreach efforts to various racial, ethnic, and cultural communities, and find opportunities to collaborate.

Goal 3 Outcomes / Performance Measures

Objective	Outcome / Performance Measure	Target Date
3.1	Realize the completion of a senior leadership program through partnership with Maine Community Foundation and Maine Development Foundation.	2011
	Host a Blaine House Conference on Aging.	Biennially
3.2	Establish benchmarks for elder workers	2009
	97 people will utilize Senior Community Service Employment Program and 21 people will find gainful employment after accessing service.	Annually
3.3	Three thousand older adults will have participated in evidence based programs through the Healthy Choices for ME program.	May, 2011
	400 additional leaders and Master Trainers will have been trained in evidence based program delivery.	May, 2011
	Three private partners will contribute to sustainability of evidence based programs.	May, 2011
3.4	Complete at least one collaborative initiative.	Annually

Goal 4 – *Protect the rights of older adults, and enhance the response to elder abuse.*

1. ***Objective 4.1: Increase awareness of elder abuse, neglect and exploitation and the role of mandated reporters.*** Approximately 5% of older adults in Maine are victims of abuse, neglect, and exploitation. Older adults are often the targets of abuse, fraud, neglect, and exploitation. Protecting this population is a high priority.

   Strategies:

   1. Hold mandated reporters who do not fulfill reporting requirements accountable.
   2. Develop a Memorandum of Agreement between Adult Protective Services (APS) and Licensing and Regulatory Services on reporting abuse, neglect or exploitation in licensed facilities.
   3. Provide mandatory reporter training to facility staff and state employees.
   4. Maintain partnership with the Maine Attorney General's Office in conducting training and educational opportunities on elder abuse, and assist with investigations of financial exploitation and abuse.
   5. Support the efforts of the Maine Association of TRIADS (a partnership of police, AARP, senior leaders, and interested agencies) and Elder Abuse Task Forces across the state to deliver information and training for older persons and community leaders to recognize and prevent abuse, neglect and exploitation.
   6. Partner with Maine Domestic Violence Coalition, Maine Sexual Assault Coalition, state and private groups to develop services and resources that support individuals who experience abuse in later life.
   7. Enhance data collection and reporting capability from Maine Adult Protective Services Information System (MAPSIS).
   8. Maintain elder abuse hotline (1-800-624-8404).
   9. Examine the systems of protecting persons from abuse, neglect and exploitation for ways to improve protection through changes of statutes, rules and law enforcement training.

2. ***Objective 4.2: Promote the rights of older and incapacitated adults.***

   Strategies:

   1. Educate probate court, attorneys and APS workers on alternatives to guardianship and conservatorship.
   2. Maximize the independence of incapacitated individuals by promoting alternatives to guardianship and conservatorship.

3. Provide funding and monitor service contract with the Long Term Care Ombudsman Program.
4. Provide funding and monitor service contract with Legal Services for the Elderly to provide free legal services for Mainers sixty years or older on such issues as consumer protection, public benefits, health insurance counseling, housing, financial exploitation, abuse, neglect and age discrimination.

3. ***Objective 4.3: Increase availability of emergency services for people abused, neglected or exploited.***

Strategies:

1. Better identify unmet needs of adults being served by APS.
2. Work within existing structures to make funds available for services to meet specialized temporary needs including emergency housing.

Goal 4 Outcomes / Performance Measures

Objective	Outcome / Performance Measure	Target Date
4.1	Deliver 6 trainings across Maine on elder abuse.	Annually
4.2	Develop educational resources on the role of a guardian / conservator and alternatives to guardianship/conservatorship for use by probate courts, private and public entities.	Sept. 2010
	Train Department staff persons on alternatives to guardianship.	Sept. 2010
	Develop online guardianship and conservatorship training curriculum.	Sept. 2010
	Develop outreach campaign to educate court visitors, probate judges, health and social service professionals, consumers, and families on when least restrictive alternatives to guardianship and conservatorship are appropriate.	Sept. 2010
4.3	Access to emergency services for APS clients in place.	2010
4.1 - 4.3	MAPSIS changes completed and implemented.	2011

Continuing Long-Term Care Reform

OES plays an active role in the implementation efforts related to rebalancing long-term care. Beyond the long-term care objectives outlined within this plan, Maine's 2008-2009 State Health Plan incorporates objectives to address this subject. These objectives include:

- Establishing and implementing functional eligibility criteria for Private Non-Medical Institutions for people needing any level of care.
- Identifying and implementing strategies to strengthen home care and affordable, homelike living options for Maine's older adults to make sure options are available that promote choice and independence.
- Extending the reach of evidence-based programs throughout the state by developing more sites in a variety of settings to offer the following programs: A Matter of Balance, Chronic Disease Self-Management, Enhanced Wellness, Enhanced Fitness and Healthy Ideas.

As mentioned under Issues and Trends, Maine has made progress in reducing reliance on, and use of nursing facilities, but this has come with an increase in the use of residential care. We must redouble our efforts to support older adults to remain in their in homes.

Medicare Modernization Act

Through the implementation of the Medicare Modernization Act, the SHIP (State Health Insurance Assistance Program) network, administered by the State Unit on Aging (SUA), assists to coordinate the efforts of other state offices, including the development of an appeals unit to assist low-income consumers with the Medicare Part D appeal process. The SUA provides counseling on consumer benefits, helps enrollment in Part D plans, and application assistance for the low-income subsidy assistance. The SHIP also educates consumers on Medicare Advantage and other Medicare health care plan options, and helps them understand and access their preventive benefits.

Transportation

Maine is a rural state, and transportation issues are consistently mentioned as a factor that inhibits consumer access to services. Couple this with the fact that most of Maine's low-income older adults reside in the most rural counties, and the problem of reaching consumers that need services is even greater. Couple this further with the dramatic rise in transportation costs, and what was an inhibiting factor quickly becomes a roadblock.

State leaders, government agencies, service providers, and individuals have long grappled with this problem, and there is no reason to expect a solution in the near future. Area Agencies on Aging have done their best to combat the problem through the use of volunteer drivers and partnerships with Community Action Programs, but as costs rise further, the challenge grows greater.

The rising cost of energy is also a serious issue for Maine's Older Adults. Maine is the most reliant state on home heating oil with an old housing stock. The Governor has formed a task force to develop strategies to address the issue. This problem is particularly problematic for older adults on fixed incomes. The OES will give the issue attention at the Blaine House Conference on Aging, and look for ways to assist older adults remain safe and warm during winter months.

Emergency Preparedness Plans

OES is actively engaged in preparedness planning for the population it serves. Our most notable accomplishment was our partnership with the Maine Center for Public Health, the Maine Center for Disease Control and Prevention, the Maine Emergency Agency, and the Harvard School of Public Health Center for Public Health Preparedness to develop an online course addressing emergency preparedness planning for older adults. While the course was designed for government officials, service providers, older adults, caregivers, and emergency personnel, any person can access and complete this course in the comfort of their home. It addresses the knowledge necessary to plan and prepare for emergencies and disasters. The course can be accessed at this site: www.maine.gov/dhhs/beas/working_for_future.shtml.

The Director of the OES is involved in the State's Emergency Preparedness and Response Plan through her participation on the Integrated Management Team of the Department of Health and Human Services. She has delegated lead responsibility for work within the Department to the Director of Adult Protective Services and for coordination with the Administration on Aging and Area Agencies on Aging to the Director of Community Services.

The OES also has a staff person that sits on Maine's Disaster Behavioral Health Response Team, which is mobilized when disasters strike. Participants are trained on the psychological, psychosocial, and psycho-spiritual impacts on individuals and communities, and the role of behavioral health and spiritual care personnel in disaster planning, response, and recovery. This person is well-positioned to assist with the needs of older adults when disaster strikes.

The Office of Elder Services assisted the Department develop a comprehensive pandemic flu plan in 2007 entitled "Continuity of Operations Plan for Pandemic Influenza." The intended audience for the plan is DHHS staff, contractors, clients, agencies and local and county pandemic planning groups. The plan's purpose is to:

1. identify the critical functions that the Department must continue to support during a flu pandemic and resulting loss of staff capacity;
2. detail plans for continuing those operations;
3. describe how communications and decision-making will occur during a pandemic, and;
4. outline plans for post-pandemic period and the restoration of DHHS operations that may have been suspended during the pandemic.

The pandemic influenza plan details the work flow for OES and others should staffing levels decline, and it details responsibility sharing to help ensure services continue when they are most needed.

The Older Americans Act Amendments of 2006 also requires state and local Area Agencies on Aging to develop long-range emergency preparedness plans. Area Agencies on Aging are now required, through their contracts, to develop such plans.

Intrastate Funding Formula

There have been no changes to Maine's Intrastate Funding Formula (IFF) since Maine's last State Plan on Aging. Details of the IFF are found in Appendix E.

State Plan Assurances

The Older Americans Act as amended in 2006 stipulates that all State Plans must address specific assurances and informational requirements. Assurances can be found in Appendix F.

APPENDIX A – PUBLIC COMMENT SUMMARY

Public hearings were held at two different locations in the state, one at an Area Agency on Aging in Eastern Maine on July 21, and another at a state office building in Central Maine on July 22. These locations were chosen, because they allowed for easy commutes from virtually all regions of the state. For those unable to attend, comments could be submitted by e-mail, phone or mail. The plan was placed on the OES website for download, and a notice of the plan and public hearing locations was placed in Maine's major newspapers. A local news station also attended a public hearing and provided television coverage of the plan's development.

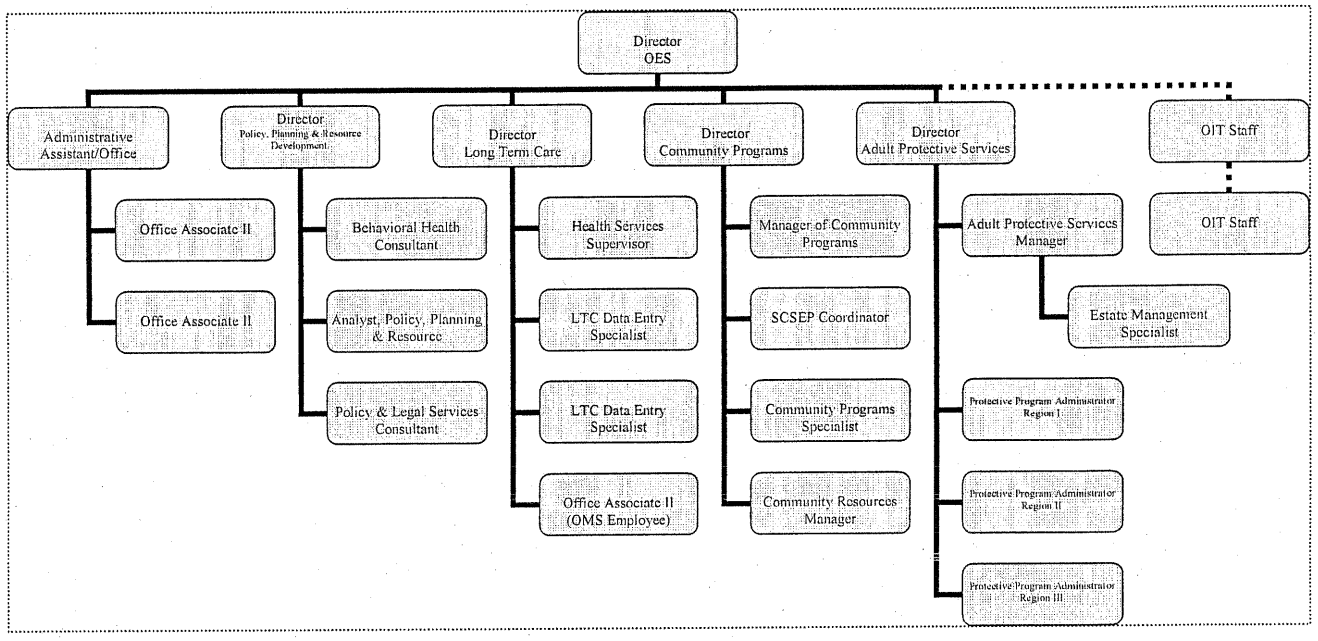
Comments were given at each public hearing by AAA staff persons. Public Health has a "Rural Health Plan" and it was suggested that there may be opportunities to collaborate and create greater efficiencies if both plans move in the same direction on certain issues. There were questions as to whether Maine government could do more to increase the reimbursement to adult day services. A request was also made for assistance in helping AAAs secure additional funding for the Meals on Wheels program, whether that be marketing March for Meals fundraising initiatives, or other ideas.

Comments were also submitted by e-mail from the Direct Care Alliance, Alzheimer's Association of Maine, and the Joint Advisory Committee on Select Services for Older Adults (JAC). The Direct Care Alliance requested that additional attention be given to the paid direct care and personal assistance workforce, and the workforce gap that limits services to older, homebound adults. The Alzheimer's Association of Maine spoke favorably of the plan's attention to training and supporting family caregivers and a commitment to offer Best Friends training. The Association's comments were critical of waitlists for home-based care and homemaker services, questioning how older adults can remain in their homes if these services are not readily available, particularly if eligibility requirements are established for Private Non-Medical Institutions. Comments were also made about use of the Long-term care Needs Assessment when state-funded programs have not yet been factored into the projection model. The JAC comments highlighted a lack of attention given to geriatric mental health, and suggested the OES explore developing a locus of care for the mental health needs of Maine's older adults.

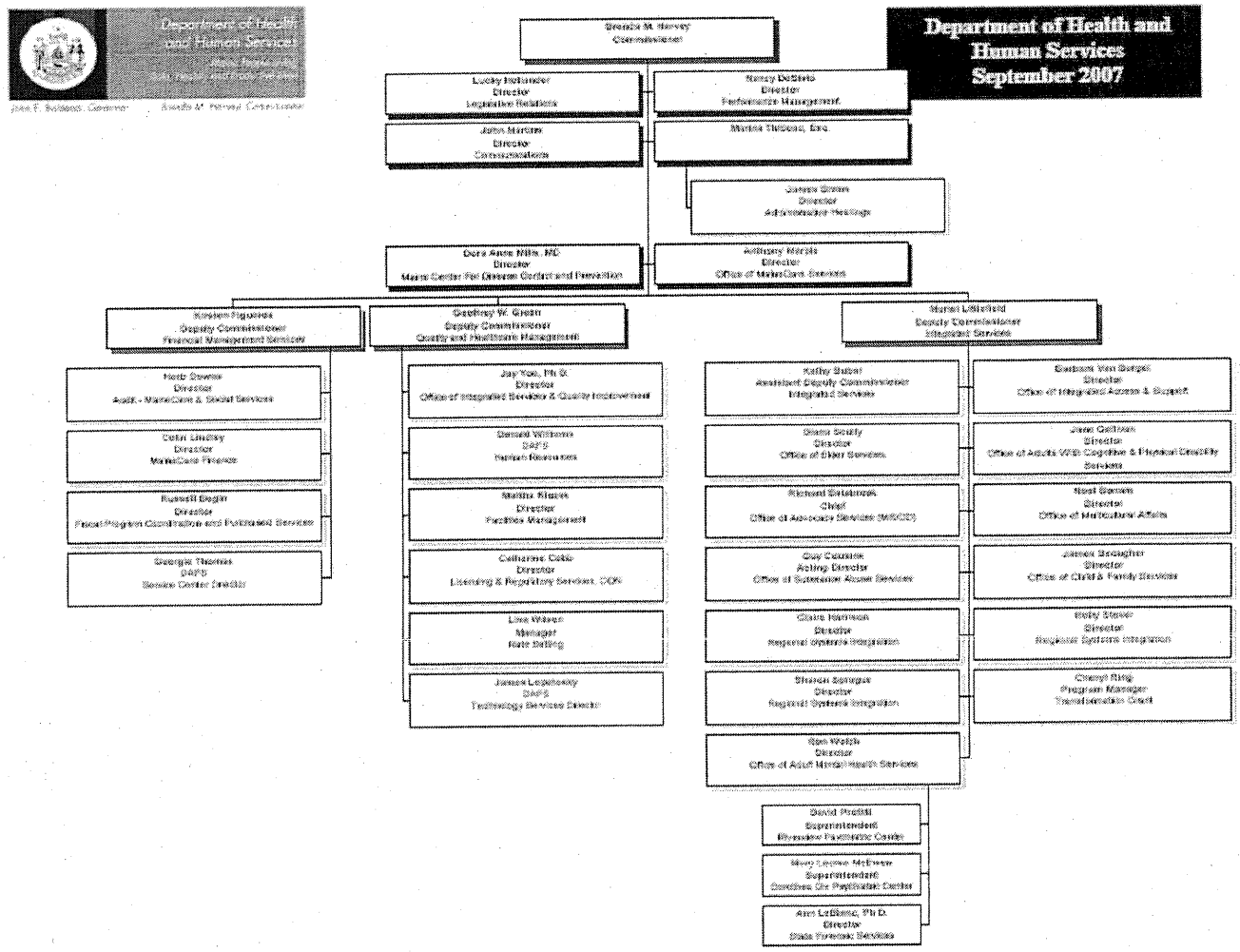
Public comments, to the extent possible and feasible, were addressed in the final version of Maine's State Plan on Aging.

APPENDIX B – OES ORGANIZATIONAL CHART

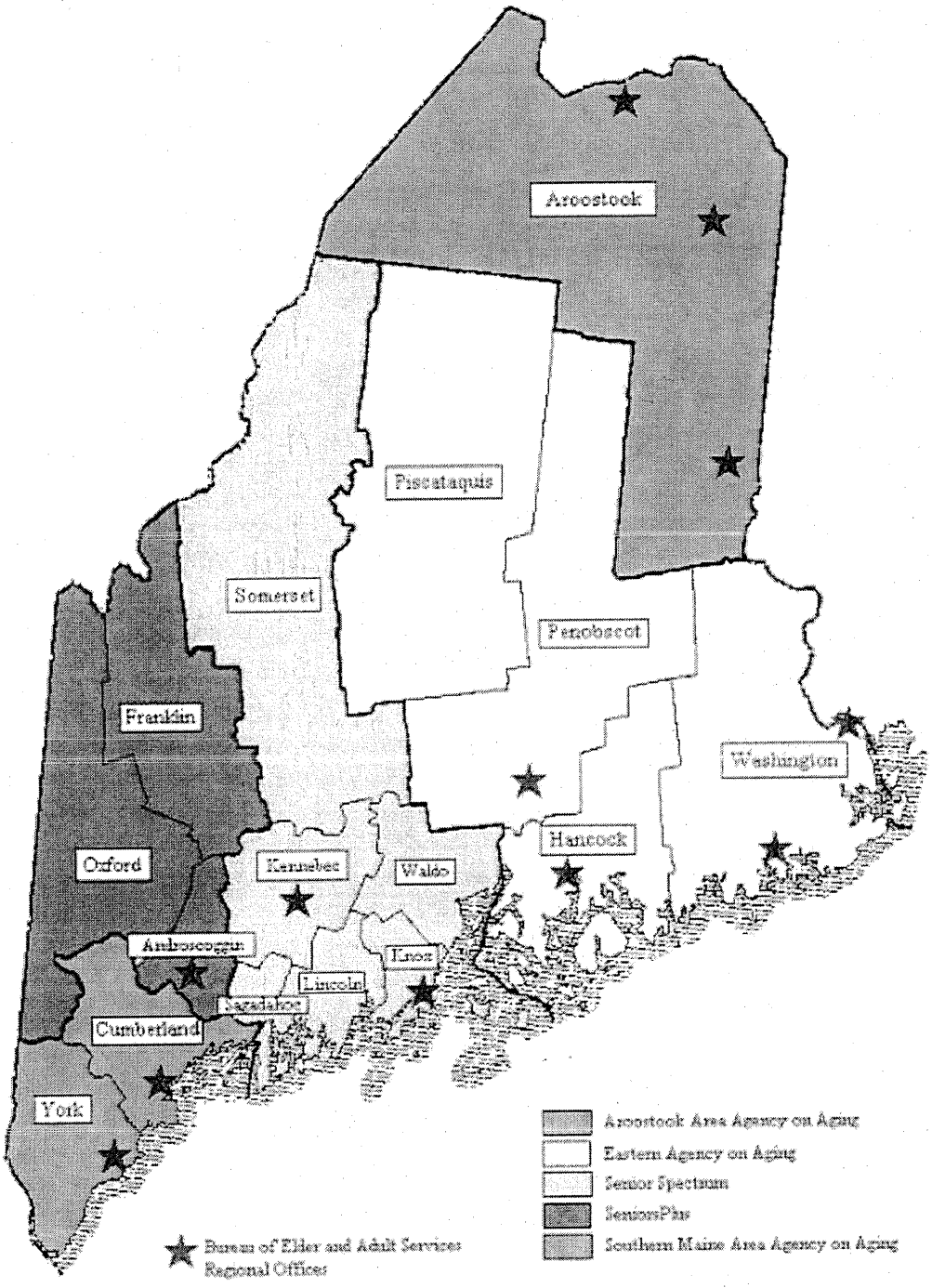
OFFICE OF ELDER SERVICES
MAINE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES



APPENDIX C – DHHS ORGANIZATIONAL CHART



APPENDIX D – AAA SERVICE AREAS



APPENDIX E - IFF

Maine Intrastate Funding Formula

The Maine Office of Elder Services intrastate funding formula (IFF) meets all of the requirements stipulated in Sections 305(a) (2) (C) (i), 305(a) (2) (c) (ii) and 305(d) of the Older Americans Act. The factors and weights in the formula are based upon the 2000 Census, Special Tabulation on Aging.

The IFF is the result of a twelve month process that began in November 2004, which involved extensive consultation between the Maine Office of Elder Services and the area agencies on aging (AAAs), Maine Office of Elder Services Advisory Committee, state legislators and other interested individuals. A member of the Maine Association of AAA Directors represented the AAAs and worked closely with its membership in the development of recommendations and comments to the Maine Office of Elder Services. The Maine Association of AAA Directors and AAAs recommended specific factors and urged to the Maine Office of Elder Services to make every effort to minimize financial hardship to any AAA as a result of a new formula.

In addition, The Maine Office of Elder Services convened meetings with interested state legislators; consulted with the AAAs, advisory groups; and posted the draft allocation model and formula on the Maine Office of Elder Services web site for review and comment by the general public. The Maine Office of Elder Services held a public hearing on November 21, 2005.

In developing the formula, the Maine Office of Elder Services' goal was to create a model to optimize the allocation of state and federal funding to the area agencies while minimizing any adverse impact due to dramatic shifts in the demographic data impacting on the formula factors. As part of the process the Maine Office of Elder Services reviewed: the comments and recommendations of the area agencies and the public; federal and state statues and regulations regarding allocations of funds; available data and literature to understand the impact of various subsets of the elderly population on the resources of the area agencies. Based on the process above, an IFF model was developed which consists of a formula and a distribution methodology.

Definitions and symbols used in the Intrastate Funding Formula used for allocating Title III Part B, C, and E funds:

Symbol	Definition
B$	Total dollars available under Title III B for distribution to AAAs
C$	Total dollars available under Title III C for distribution to AAAs
E$	Total dollars available under Title III E for distribution to AAAs
60+	Total number of people 60 and over in Maine

75+	Total number of people 75 and over in Maine
EN60	Total number of people 60 and over who are in the greatest economic need in Maine
SN60	Number of people 60 and over who are in the greatest social need in Maine
M60	Number of minority people 60 and over in Maine
R60	Total number of people 60 and over who live in rural area
RGW60	Total number of people 60 and over who live in rural area multiplied by total area in square miles and multiplied by 5% weight
A:60+	Number of people 60 and over in the AAA's PSA
A:75+	Number of people 75 and over in the AAA's PSA
A:EN60	Number of people 60 and over who are in the greatest economic need in the AAA's PSA
A:SN60	Number of people 60 and over who are in the greatest social need in the AAA's PSA
A:M60	Number of minority people 60 and over in the AAA's PSA
A:R60	Number of people 60 and over who live in rural area in the AAA's PSA
A:RGW60	Number of people 60 and over who live in rural area in the AAA's PSA, multiplied by AAA's percentage of total area in square miles, and multiplied by 5% weight
#AAAs	Number of designated AAAs in Maine
*	Multiplied by

An area agency on aging's Title III allocation will be equal to:

$$\frac{(.10*B\$)}{\#AAAs} + \left[\left(\frac{A{:}60+ + A{:}75+ + A{:}M60+ + A{:}SN60 + A{:}EN60 + A{:}R60 + A{:}RGW60}{60+ + 75+ + M60+ + SN60 + EN60 + R60 + RGW60} \right) * (.90*B\$) \right]$$

PLUS

$$\frac{(.10*C\$)}{\#AAAs} + \left[\left(\frac{A{:}60+ + A{:}75+ + A{:}M60+ + A{:}SN60 + A{:}EN60 + A{:}R60 + A{:}RGW60}{60+ + 75+ + M60+ + SN60 + EN60 + R60 + RGW60} \right) * (.90*C\$) \right]$$

PLUS

$$\frac{(.10*E\$)}{\#AAAs} + \left[\left(\frac{A{:}60+ + A{:}75+ + A{:}M60+ + A{:}SN60 + A{:}EN60 + A{:}R60 + A{:}RGW60}{60+ + 75+ + M60+ + SN60 + EN60 + R60 + RGW60} \right) * (.90*E\$) \right]$$

The intrastate funding formula allocates Older Americans Act Title III B, C, and E funds to area agencies on aging. The percent distribution as of January 2007 is as follows:

Titles III B, III C, and III E	
Aroostook Area Agency on Aging	8.78%
Eastern Agency on Aging	21.16%
Senior Spectrum	27.02%
SeniorsPlus	15.77%
Southern Maine Agency on Aging	27.27%

Minimum Required Expenditures from Title III B Funds

The Older Americans Act requires the Bureau of Elder and Adult Services to specify in the State Plan the minimum amount it requires the area agencies on aging to spend from their Title III B Supportive funds on three priority categories of services. For the effective period of this plan, the Office of Elder Services will require each area agency on aging to spend a minimum of 50% of their Title III B funds on access services (such as transportation, outreach, information and referral), 5% on in-home services, and 10% on legal services.

Title III Part D Funding Formula

The Older Americans Act requires the Office of Elder Services to establish a formula for allocating Title III Part D funds, used for health promotional activities, to the area agencies on aging that takes into consideration those with greatest economic need and those in Medically Underserved Areas (MUAs). The target population includes the un-institutionalized population living in MUAs who are (a) 65 years of age and older and disabled and (b) those 65 years of age and older with incomes below poverty.

Title III D
Aroostook Area Agency on Aging 11%
Eastern Agency on Aging 53%
Senior Spectrum 23%
SeniorsPlus 12%
Southern Maine Agency on Aging 1%

The major difference between the current approved and the past IFF is the utilization of additional weights and factors. The factors and weights in this IFF more accurately reflect the demographic changes of the aging population in the state since the early 1990's. 2000 Census data shows that the state experienced a high level of growth in the 75+ age cohort. The increasing "75+" age cohort and "Rural" status of its service population are recognized in this IFF. In addition, this formula takes into greater consideration the population segments that place the greatest demands on the area agencies on aging's funding resources.

This IFF allows for an equitable allocation of Older Americans Act funds that considers: current demographic data and changes; continued preference to serve those of greatest economic and social needs; reflect the population segments served; and the needs and concerns of the AAAs.

APPENDIX F – LIST OF ASSURANCES

Listing of State Plan Assurances and Required Activities
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

ASSURANCES

Sec. 305(a)-(c), ORGANIZATION

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan.

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(i) The State agency shall provide an assurance that the State agency will set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

Sec. 306 AREA PLANS

(a)(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

Sec. 307 STATE PLANS

(a)(3)(B)(i) The State agency shall, with respect to services for older individuals residing in rural areas, provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000.

(a)(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(a)(7)(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(a)(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(a)(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(a)(11) The plan shall provide that with respect to legal assistance—

(A) the plan contains assurances that area agencies on aging will

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services;

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(a)(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(a)(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(a)(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(a)(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(a)(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(a)(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(a)(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(a)(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(a)(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(a)(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308 PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705 ADDITIONAL STATE PLAN REQUIREMENTS

(1) The State plan shall provide an assurance that Maine, in carrying out any chapter of this subtitle for which Maine receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) The State Plan shall provide an assurance that Maine will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) The State plan shall provide an assurance that Maine, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) The State plan shall provide an assurance that Maine will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) The State plan shall provide an assurance that Maine will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant

State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) Maine will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Diana Sully

July 31, 2008

Signature and Title of Authorized Official

Date

APPENDIX I

Survey of Maine People Receiving Home-Based Services, Presentation by Brenda Gallant, Maine Long-Term Care Ombudsman, October 20, 2008

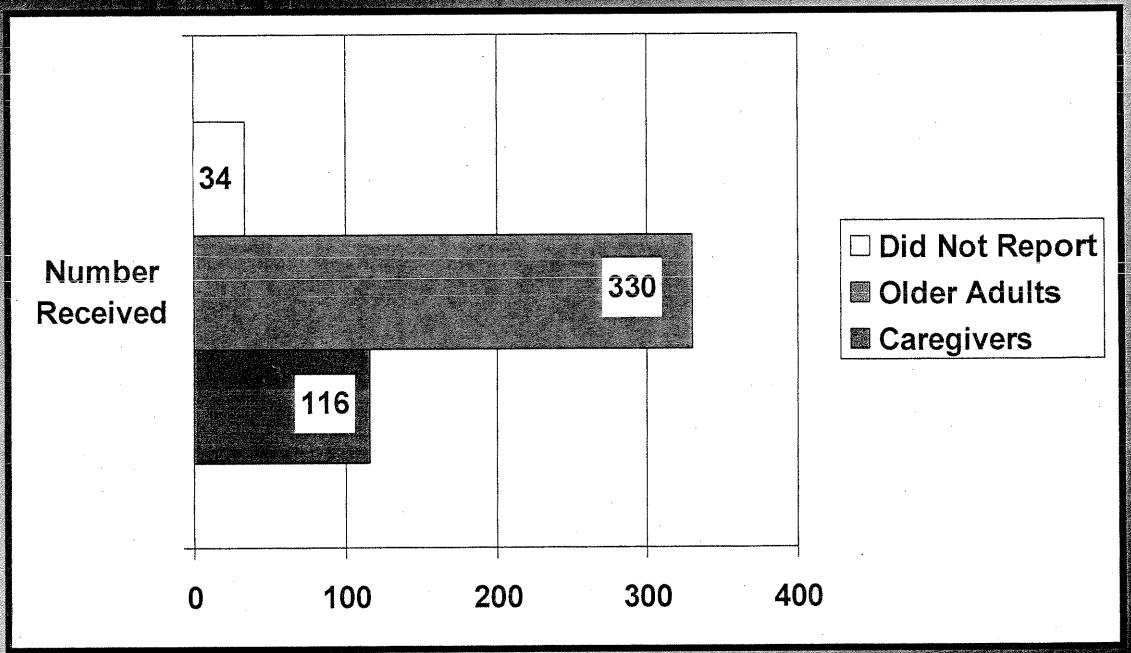
Survey of Maine People Receiving Home-Based Services

Distributed in August 2008 to approximately 1300 consumers and caregivers across Maine with assistance from many agencies

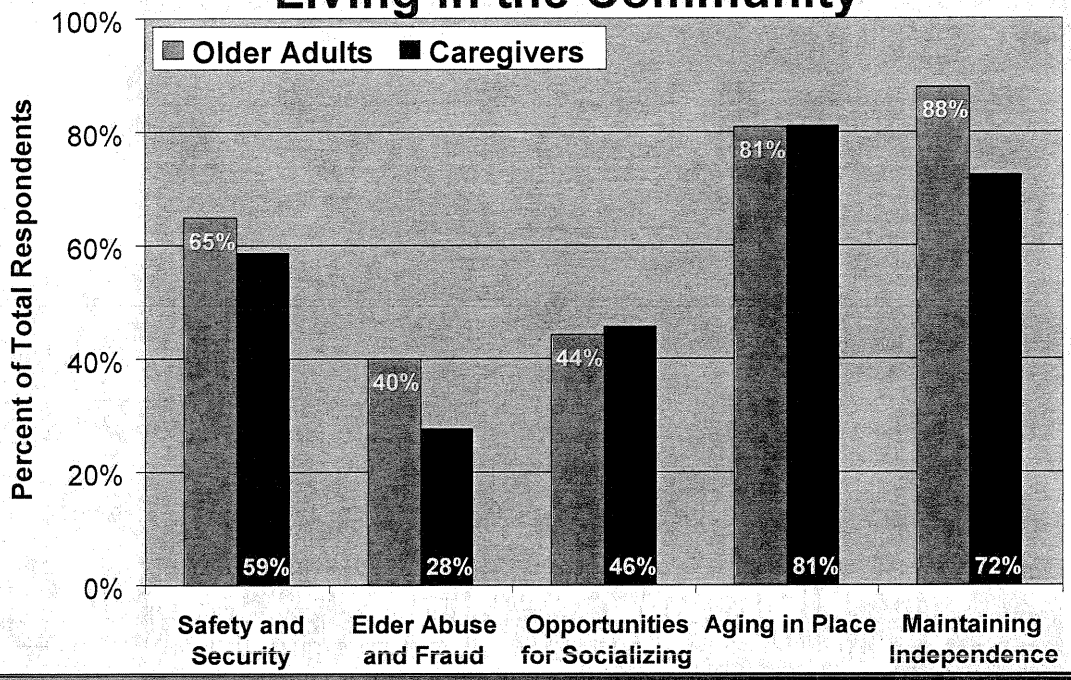
"The Home Health Care program helps keep me home with my husband and not have to go to a nursing care home. Thank you!"

Blaine House Conference on Aging

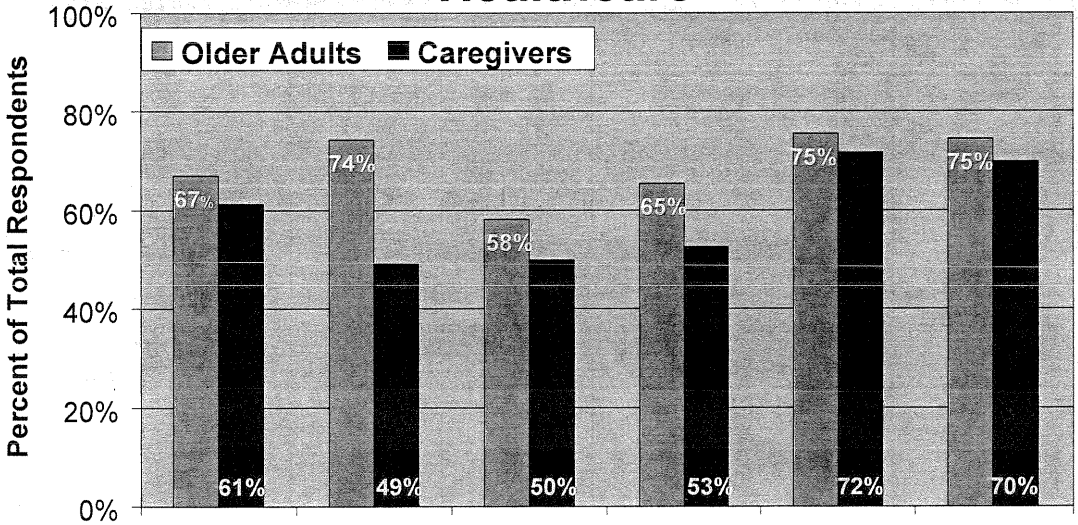
Mail Survey: N=480



Identified Concerns:
Living in the Community



Identified Concerns:
Healthcare

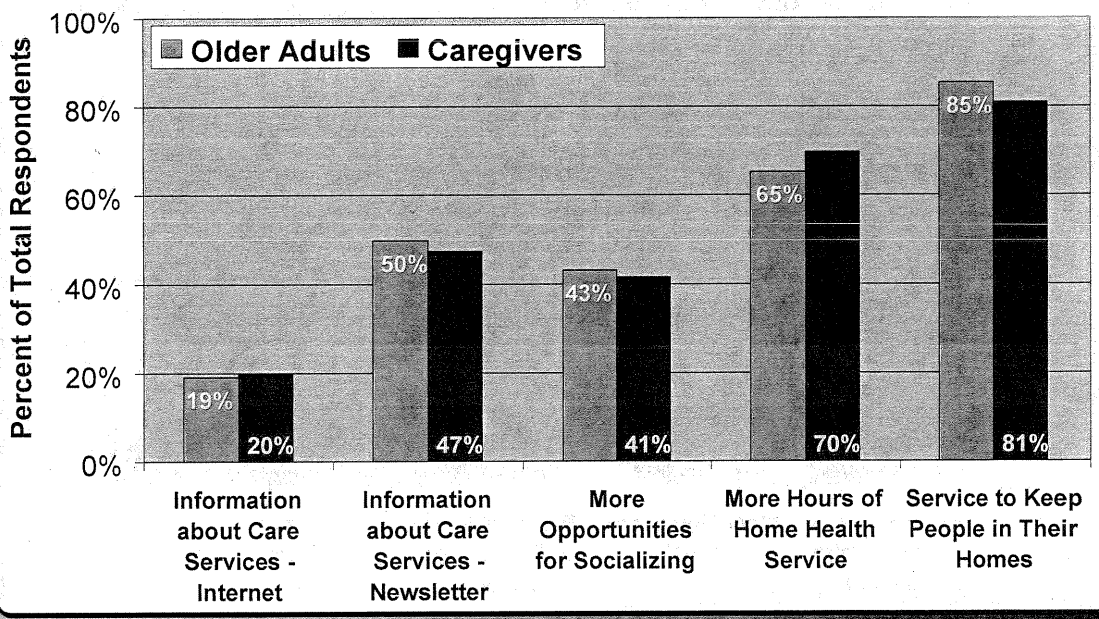


Identified Concerns: Some Other Items Identified

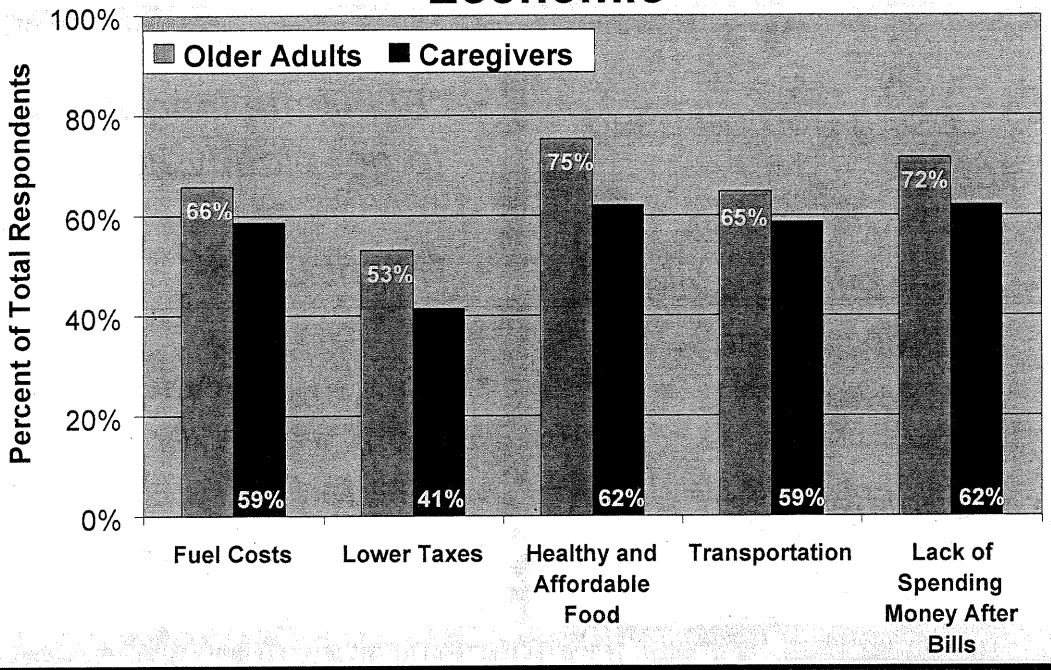
- *"Losing home-based care"*
- *"Maintaining a clean and organized household"*
- *"Qualified Staff"*
- *"Eliminate long waiting to get elderly help"*
- *"Night Care"*
- *"Getting people to work wherever needed"*

Helpful Items & Services Identified

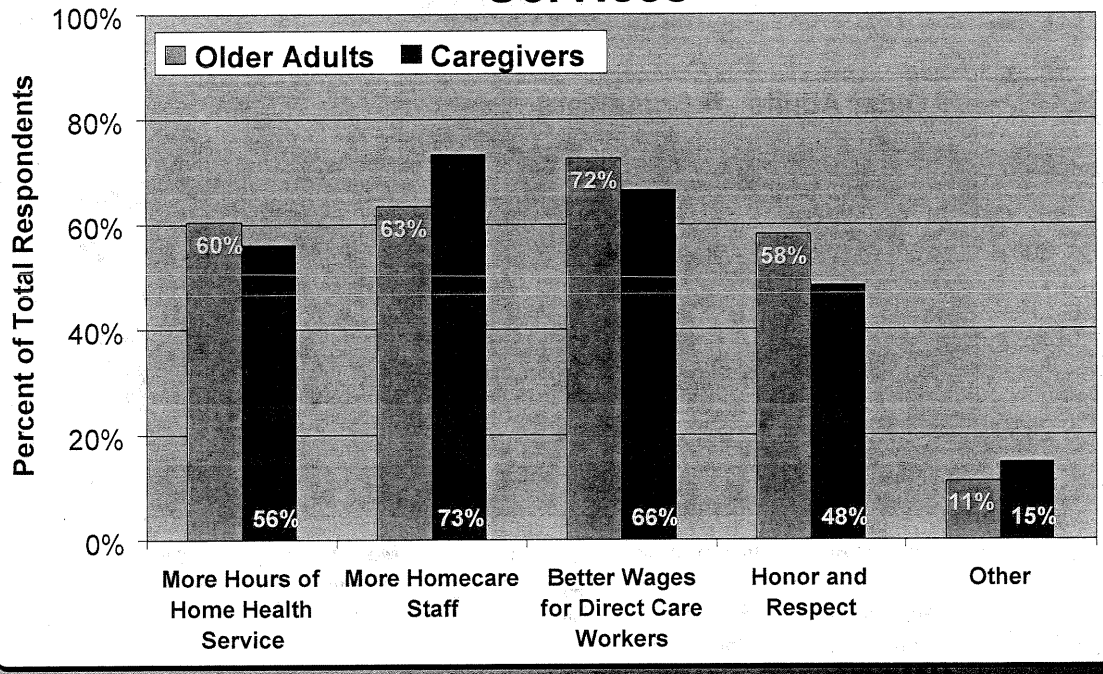
Services



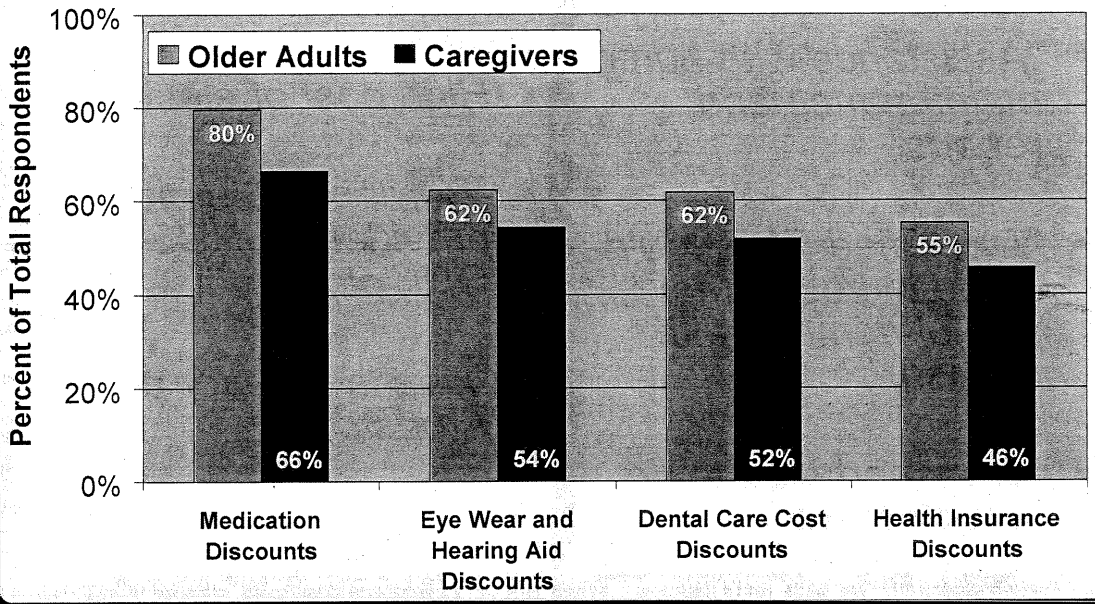
Identified Concerns:
Economic



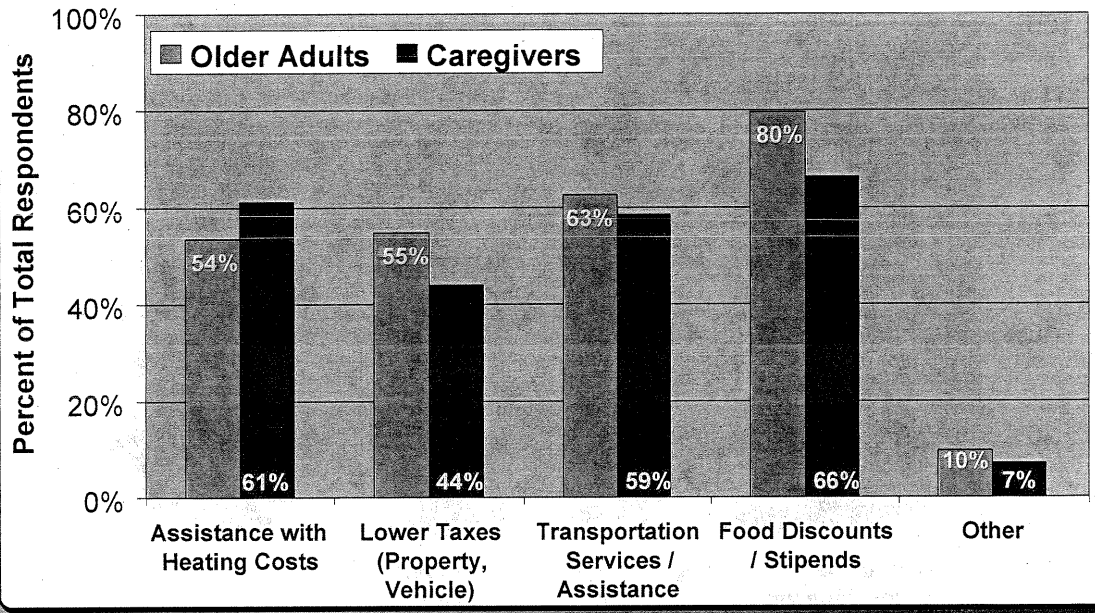
Identified Concerns:
Services



Helpful Items & Services Identified
Health Care



Helpful Items & Services Identified
Cost of Living

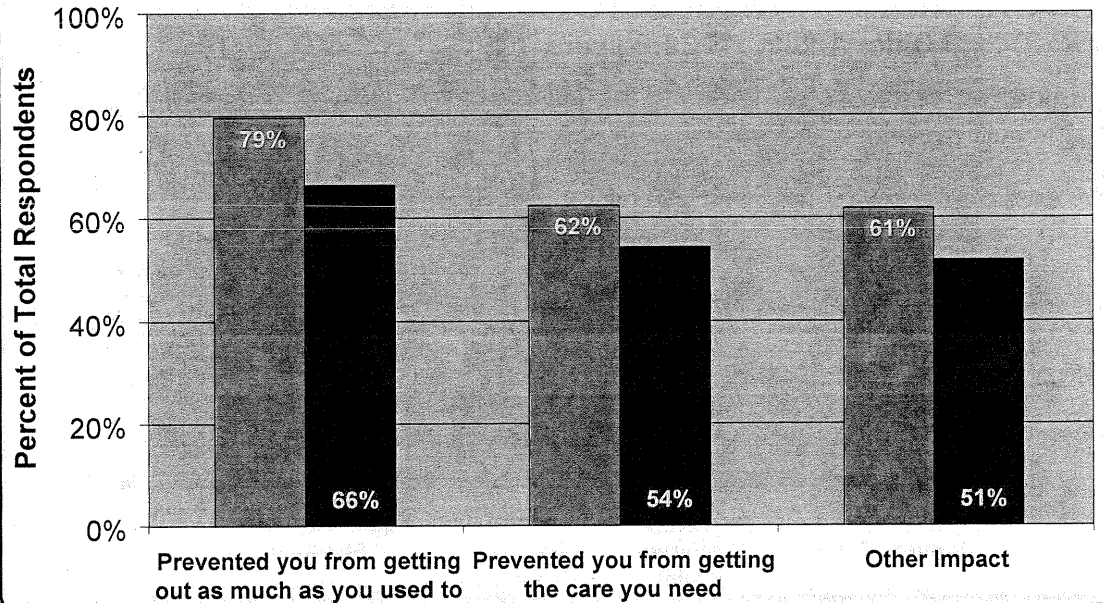


Helpful Items & Services Identified
Some Others Identified

- *"Assistance with home maintenance and repairs"*
- *"A certified RN should come to house (as part of home health service)"*
- *"Transportation to do volunteer work"*

- *High cost of electricity*
- *"Burden on service providers (CHCS, OHI, etc.)"*
- *"Health care for all in Aroostook"*

Impact of Increased Costs for Food, Gas & Heating Oil

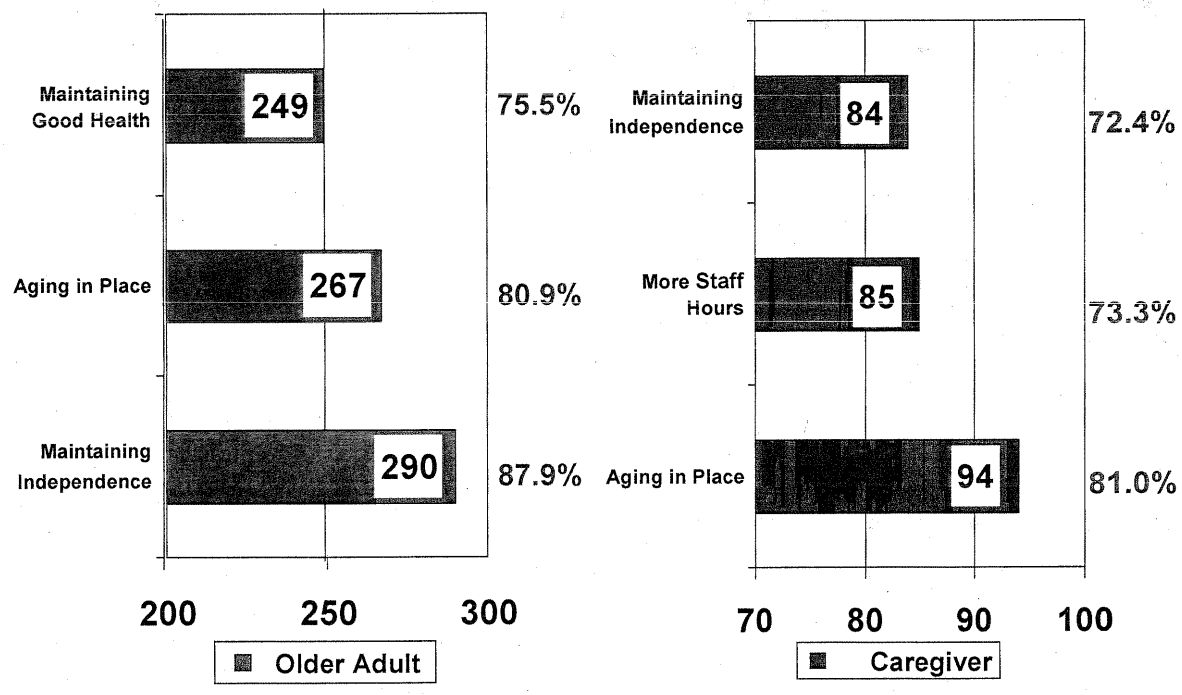


Impact of Increased Costs for Food, Gas & Heating Oil

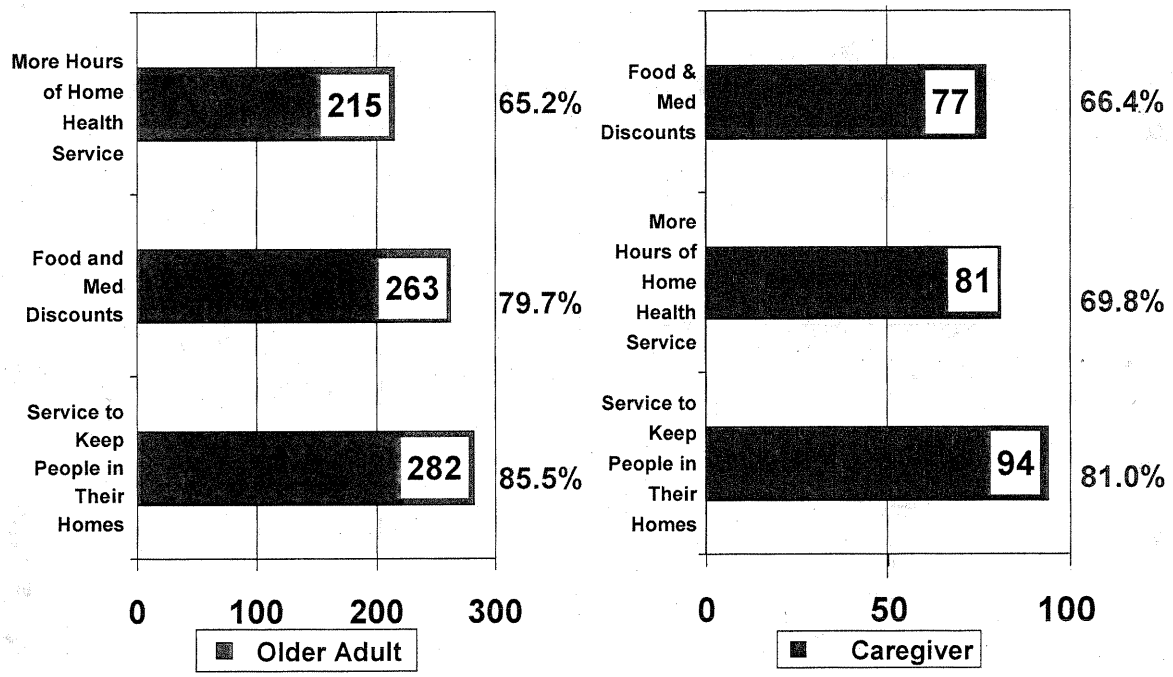
Some Other Issues Identified

- *"Heating costs may impact on ability to stay home"*
- *"Doctors up in Aroostook never stay long-term"*
- *"My stress level has increased exponentially which has a negative effect on my health"*
- *"Would go [out] more if things less expensive"*
- *"Can't buy medicine I need b/c not covered by insurance"*
- *"Don't eat as well as I should, can't get out when I want to"*

Top Three Concerns



Top Three Wishes



Some Other Comments About: Long-Term Home Based Care

- *"Very long waits for assistance even though qualifications are met"*
- *"I really like it because I have someone who cares"*
- *"Consider each individual's needs"*
- *"I am so grateful for what is provided"*
- *"I believe people live a better quality of life at home and live longer at home with assistance"*
- *"Money towards training is necessary"*
- *"I wouldn't be in my apartment if it wasn't for LTC"*
- *"I'm scared, need money, when will this end?"*
- *"Not enough workers in this area. Pay and travel not enough"*
- *"Elderly desperately need more care and assistance in every statement mentioned on this survey!"*

Blue Ribbon Commission to Study the Future of Home-Based and Community-Based Care

Brenda Gallant
Maine Long-Term Care Ombudsman

October 20, 2008

The Consumer Perspective

Maine families and their loved ones who need long-term care services are like us. That is to say, they want the same things that we would want if someone in our family needed care or if we needed long-term care services. I know from many years experience of working with consumers and their family members throughout the state as well as from experiences within my own family, what Maine's long-term care system would look like if it reflected the needs and wishes of consumers. it is designed to serve.

Our elderly and disabled citizens want a long-term care services system that offers:

- Choice
- Information about available services
- Access to needed services
- Services that support Independence
  (whenever possible consumers want to remain in their homes)
- Quality services
- Direct Care workers who are well trained, well supervised and reliable
- Dignity and Privacy in their care
- Their wishes respected
- Assistance when problems with care arise

Blaine House Survey

1,300 caregivers and consumers were surveyed across the state:
87.9% of consumers and 72.7% of caregivers listed maintaining independence as a primary concern. In addition, respondents indicated that they were very concerned about having services to remain in the community.

We are all aware that Maine established itself as a national leader in the development of home and community-based care services. (home-based care, adult day services, homemaker etc) These services are cost effective and they also provide the quality that Maine consumers want. While we have this good foundation in place, it is being threatened by reductions in funding.

It is of great concern that between 2000 and 2006 there was a 36% reduction in the legislative allocation for Home-Based Care funding ($16.3 million to $10.4 million). The legislative allocation in fy 2008 was $10.7 million.

At the same time, there was a 38% increase in funding for nursing facilities. The legislative allocation for nursing facility care was $256.3 million to $354.8 million. The legislative allocation for FY 2009 was $369.4 million. It is important that we invest in all service areas.

As you consider and evaluate Maine's home and community-based care system, I believe that the central question that must be asked is: Is a lack of adequate funding for home and community-based services forcing consumers who could otherwise be served in the community to leave their homes only to be served in a much more expensive setting? In other words we have a good foundation for community services that just need adequate funding. Commissioner Harvey said recently that we will have to do more with less. These services allow us to do that.

Wait List:

Please don't forget that we have 721 consumers waiting for home based care services. 88 of these consumers meet nursing facility eligibility and another 166 are one step below nursing facility level eligibility. In addition we have a wait list of 762 for homemaker services. In the month of September, 9 consumers were discharged from homemaker services due to admission to nursing facilities. It is noteworthy that these consumers were maintained in the community with homemaker services.

Family Caregiving:

Maine families along with direct care workers are the backbone of the home care system. To a large extent they are a silent group devoted to providing care for their loved ones who need services to remain in their homes. It is important to point out that when we assess for services, we only supplement what families already provide. This means there is a dollar value for the care and assistance families provide.

The Family Caregiver Alliance's National Center On Caregiving in conjunction with the Department of Epidemiology and Population Health , Albert Einstein College of Medicine (2006) published data regarding care giving for every state. Maine's data is as follows:

136,959 Maine families provided care for family members, friends;
This equaled 147,000,000 hours of care over a period of a year;

The value of this care was 1 billion, 455 million;

17% of these caregivers had provided over 40 hours/week of care;

½ of these caregivers were providing care to older adult family members; and,

12% reported taking time off from work to provide care.

LD 519, Introduced by Rep. Jim Campbell:

Sometimes a little help goes a long way. The intent of this legislation was to provide support to family caregivers. Commissioner Harvey suggested that $200,000 in HBC funds be used for a demonstration project to accomplish this goal. The Maine Association of Area Agencies on Aging, the AAA Directors and LTCOP met to plan the project. The funds for this project would be utilized to help caregivers. Funds would be distributed equally to the 5 AAAs.
Family caregivers would be asked, what is a barrier to your care giving?
A maximum of $1,000/ family would be utilized to address the problem identified by the care giver.

EXAMPLES OF HOW DEMONSTRATION PROJECT FUNDS WERE USED TO HELP FAMILY CAREGIVERS:

When a house burned, funds were used to replace medical equipment and supplies lost in the fire.

$1,000 was used to purchase a used chair lift that typically costs more than $3,000. This enabled a daughter to take her mother into her home. The bedroom and bath were on the second floor so the chair lift made all the difference.

Part of a driveway was tarred. This was very important because the consumer could not get across the gravel driveway in his wheelchair. The company who did the tarring also donated some of the tar.($1,000).

Dad in his 90's with Alzheimer's couldn't get in and out of the tub. Funds were used to put in a shower stall. Family members also donated funds for this renovation.

A daughter who moved to Maine to take care of her parent lost her health insurance. She developed medical issues which might have interfered with he ability to provide care. Funds were used to get doctor's care and medication. As a result, she is doing well and is able to continue to provide care.

Assisted Living

You have all seen the Inn at City Hall. There are 6 other projects like that one in the state that provide excellent and cost effective care. These projects brought $24,000,000 in private capital to our state and caused the renovation and good use of buildings that would probably have been left unused.

We are working with DHHS Staff to identify a funding mechanism for these projects. I hope you will recommend the support for these quality, cost-effective projects.

###

APPENDIX J

National Developments in Medicaid Managed Long-Term Care,
Presentation by Paul Saucier,
University of Southern Maine, Muskie School of Public Policy,
October 20, 2008

National Developments in Medicaid Managed Long-Term Care

Paul Saucier, Muskie School of Public Service

Presented to the Blue Ribbon
Commission To Study Long-term Home-based and
Community-based Care

Maine Legislature, Augusta
October 20, 2008

UNIVERSITY OF
SOUTHERN MAINE

Muskie School of Public Service

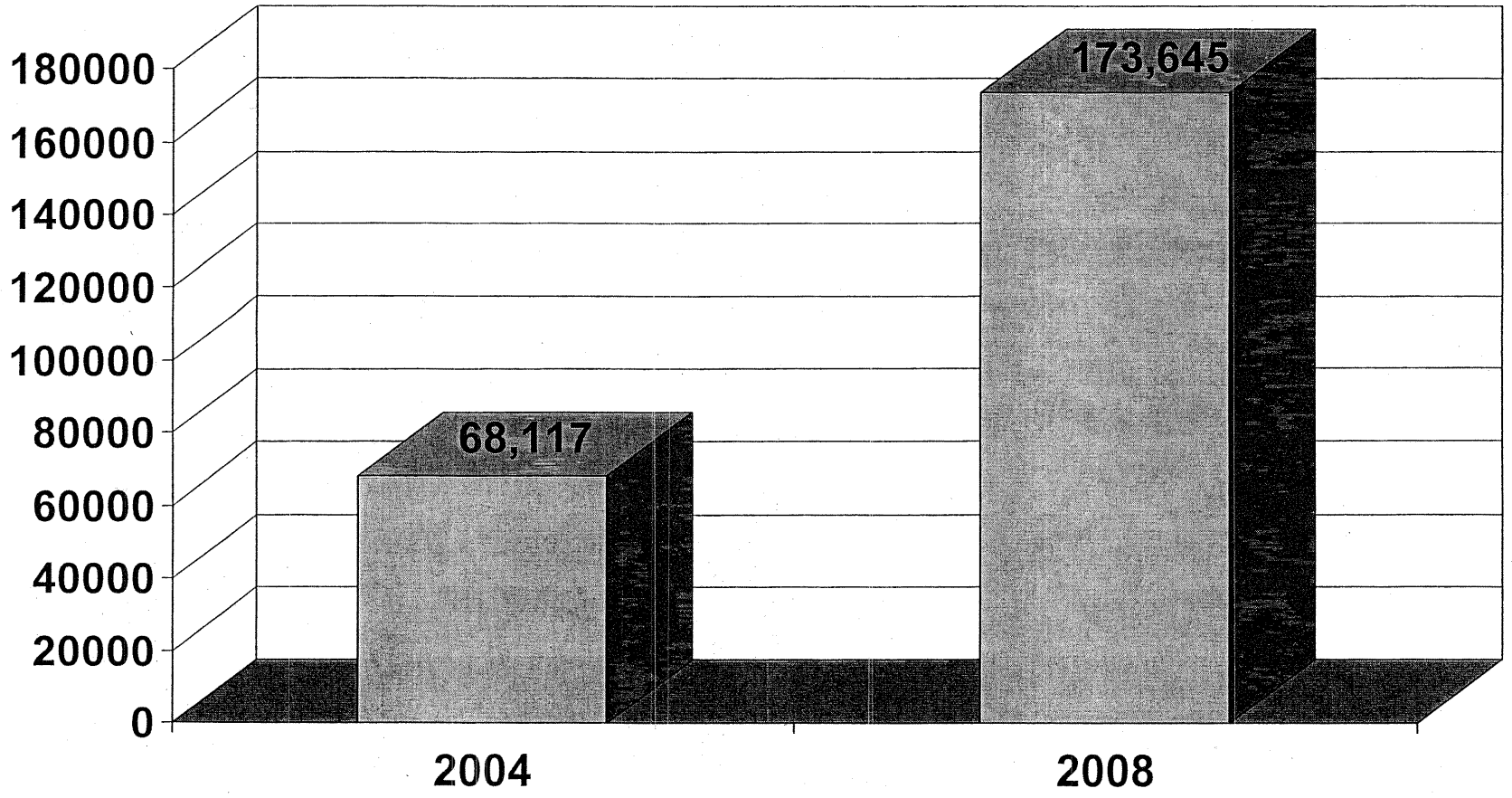
What is Medicaid managed long term care?

- Broad term describing:
  - various population groups (older persons; adults with physical, developmental disabilities)
  - range of LTC need
  - Range of contractors
    - Community-based organizations
    - HMOs (for profit and non-profit)
    - Counties
- Contractor is responsible for some LTC on a risk basis

Wide variation in level of contractor risk

Contractor at risk for:	**Examples:**
Long term and related services only (not primary or acute)	Wisconsin Family Care
Most Medicaid Services (primary, acute, LTS)	Texas Star+Plus Florida Diversion
Medicaid and Medicare services (primary, acute, LTS)	Massachusetts Senior Care Options New Mexico Coordinated Long Term Services Wisconsin Family Care Partnership

Recent national enrollment growth



UNIVERSITY OF SOUTHERN MAINE

Muskie School of Public Service

Enrollment remains small relative to traditional LTC

- In 2004, enrollment was 2.3% of total Medicaid LTC consumers
- Enrollment and growth have been concentrated in 7 states: MN, TX, NY, AZ. WI. FL. MA
- 70% of enrollment is in top four states
- NM began enrollment in August– 38,000 expected
- At least 6 states are working on new initiatives

States seek greater value through MMLTC

- Quality
  - Greater access to home and community services (flexibility and incentive)
  - Better coordination of services over time and place (accountability)
  - Greater attention to evidence-based practices (effectiveness)
  - Adoption of performance measures, pay for performance approaches (oversight, incentives)
- Cost
  - Greater budget predictability (capitation)
  - Substitution of services where appropriate (flexibility and incentive)
  - Aligned incentives for consumer, contractor, state (e.g., greater HCBS)

MMLTC appears to be effective at rebalancing

- Arizona Long Term Care System: *from 1998 to 2002, the percentage of members being served in their own homes or in alternative residential settings increased from 41.1 percent to 63.3 percent.*

- Texas Star+Plus: *substantial reductions in hospital and emergency room use relative to the control group. Increases in day activity and personal assistance services.*

- Minnesota Senior Health Options: *homemaker services, home-delivered meals, and outpatient rehabilitation all increased relative to control groups.*

- Wisconsin Family Care: *Waiting lists for long-term care services in Family Care counties were eliminated, while waiting lists in comparison counties continued to increase. Personal care services increased and hospital length of stay decreased.*

Conditions may drive more MMLTC going forward

- By 2010, dual eligible Medicare Special Needs Plans (SNPs) must have agreements in place with state Medicaid programs
- State revenue forecasts look gloomy, and these models offer budget predictability.
- Models have now been brought to scale in a handful of states.

Are there viable contractors in Maine?

- Currently, 4 companies offer Medicare MC
  - Martin's Point (Generations)
  - United (Evercare)
  - Aetna
  - Arcadia (Northeast Community Plan)
- Combined, they have 5300 members in 10 counties: Androscoggin, Cumberland, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Sagadahoc, York
- Arcadian and United offer dual eligible SNPs
- Other possible partners?

Other viability factors

- State agency capacity and experience: shift from utilization review of a service to defining and monitoring system outcomes
- Policy: shift from service-by-service rules to contract specifications
- Politics: stakeholders are often wary of managed care approaches

Summary

- MMLTC models are helping states rebalance
- MMLTC approaches are tailored to local conditions, but employ common strategies (care coordination over time and place; capitation)
- Rate of enrollment growth has been rapid in recent years, but is still very small nationally
- New Medicare requirements in 2010 provide incentives for SNPs to work with states

Contact Information

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207-780-5176

Managed Long-Term Services Programs in Four States

	Massachusetts Senior Care Options (SCO)	New Mexico Coordinated Long Term Services (CoLTS)	Texas STAR+ PLUS	Wisconsin Family Care	Wisconsin Family Care Partnership
Inception Date and Evolution	2004	2008	1998 Harris County (Houston); 2007 expansion to 4 additional areas	1995 partial capitation; 2000 all LTS capitated; 2008 statewide expansion begun	1996 started in 5 counties, significant expansion underway
Eligibility					
Older persons	Yes	Yes	Yes	Yes	Yes
Younger adults with disability	No	Yes	Yes	Yes	Yes
Level of LTS need	Any or no LTS needs	Any or no LTS needs	Any or no LTS needs	Limited to persons with an LTS need of any kind	Limited to persons certified at NH level of care
Medicaid Enrollment	Voluntary	Mandatory	Mandatory	Mandatory	Voluntary
Services in Medicaid Capitation	All services, no exceptions.	All except behavioral health, which is carved out to separate entity.	All except Rx; NF liability limited to 120 days	All LTS and related (therapies, home health, equipment). Primary, acute, Rx remain FFS.	All services, no exceptions.
Approach to Medicare	Included in model design. Contractors must maintain SNP status and include Medicare for dually eligible members.	Included in model design. CoLTS contractors must maintain a Medicare product (SNP preferred) for dually eligible members.	Coordination required by State contract; SNP status may be pursued by contractors but is not required.	Coordination required by State contract.	Included in model design. Contractors must maintain SNP status and include Medicare for dually eligible members.
Area Covered	8 counties around the state.	Planned for statewide; 7 counties currently starting up.	5 major metro areas around the state.	24 counties, with remainder of state expected by 2011	11 counties, expansion plans for 6 more. Expect more expansion in future.
Enrollment LTS Members/All Members	4500/10,000	Enrollment began Aug, '08. (Target population estimated at 38,000.)	23,000/153,000	15,700/15,700	2,994/2,994
Federal Authorities	§1915(a) for Medicaid (no waivers); Special Needs Plan authority for Medicare	§1915(b) and (c) waivers for Medicaid; Special Needs Plan authority for Medicare	§1915(b) and (c) waivers for Medicaid; Special Needs Plan authority for Medicare as needed.	§1915(b) and (c) waivers for Medicaid	§1915(a) authority and §1915 (c) waiver for Medicaid; Special Needs Plan authority for Medicare

Prepared September, 2008 for the 24th National Home and Community Based Services Conference, Boston. FMI contact Paul Saucier at the University of Southern Maine Muskie School (pauls@usm.maine.edu) or Brian Burwell at Thomson Reuters (brian.burwell@thomsonreuters.com).

APPENDIX K

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

Evidence-Based Healthy Aging Programs

Blue Ribbon Commission on Home and Community-Based Care

September 22, 2008
Linda Samia, PhD, RN
University of Southern Maine

1

Overview of Presentation

1. Background and significance of evidence-based health promotion and prevention
2. Key components and outcomes of five evidence-based healthy aging programs
3. Current service and opportunity in Maine

2

Evidence-Based Health Promotion Programs

Evidence base – scientifically tested components of a body of knowledge

- Evidence about the health issue that supports:
  - **"*Something* should be done."**
- Evidence about a tested intervention or model that supports:
  - **"*This* should be done."**
- Evidence about the design, context and attractiveness of the program that supports:
  - **"*How* this should be done."**

3

Evidence-Based Healthy Aging

National Initiative

- Administration on Aging: Choices for Independence (2003 & 2006)
- National Council on Aging/Atlantic Philanthropies: Sustainable Systems Grant (2008)

  - Goals:
    - Build prevention into community-living
    - Create sustainable systems

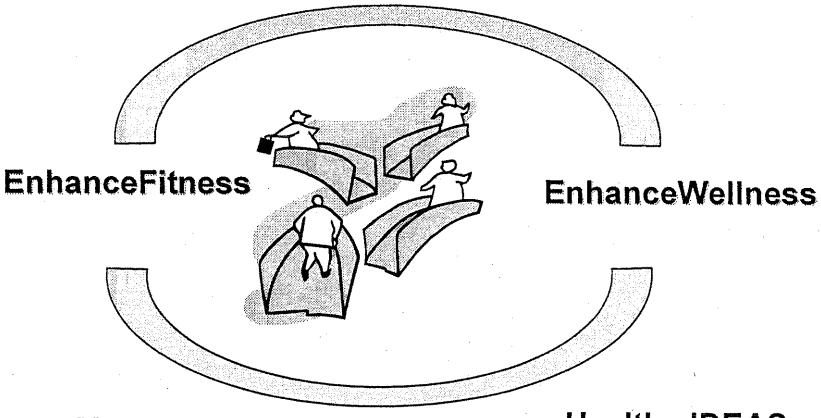
4

Maine

Evidence-Based Health Promotion Programs

Living Well

(Chronic Disease Self Management Program)



A Matter of Balance

Healthy IDEAS

5

Healthy Choices for ME

Goals

- Develop sustainable statewide infrastructure
- Facilitate public/private partnerships
- Expand access to rural and underserved areas
- Develop network of volunteers

Strategic Partners

- Maine's Office of Elder Services
- Maine Center for Disease Control and Prevention
- Five Agencies on Aging
- MaineHealth's Partnership for Healthy Aging
- Elder Independence of Maine
- Office of MaineCare Services
- Maine Primary Care Association
- Senior Community Service Employment Program (SCSEP)
- Foundations and Health plans

6

The Challenge and Opportunity

- 80% of older adults: 1 chronic disease; 50% as least 2
- 95% of healthcare spending for older adults attributed to chronic conditions
- Growing evidence base: changes in lifestyle at any age can improve health & function
- People want to change unhealthy habits but need support
- The medical care sector alone can not improve the health of older adults with chronic conditions.

Mensah: www.nga.org/Files/ppt/0412academyMensah.ppt#18
State of Aging and Health in America 2007: www.cdc.gov/aging

7

Prevention Works for Older Adults

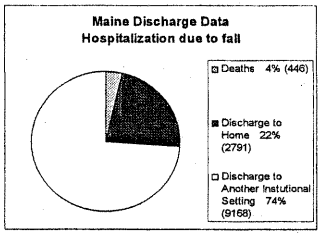
- Longer life
- Reduced disability
  - Later onset (compression of morbidity)
  - Fewer years of disability prior to death
  - Fewer falls
- Improved mental health
  - Positive effect on depressive symptoms
  - Possible delays in loss of cognitive function
- Lower health care costs

A New Vision of Aging: Helping Older Adults Make Healthier Choices. (2006). Center for Advancement of Health. http://www.healthyagingprograms.org/resources/NewVisionAging_HealthierChoices.pdf

8

Falls in Maine: Population 65+

- Each year one of every three adults age 65 or older falls
- Falls are the leading cause of unintentional injury death
- 2000 to 2004: 12,406 fall injury hospital discharges*



- 2004: 7,395 emergency department visits: treated and released for an injury due to an unintentional fall

*Unknown where the fall took place for 66% of the fall injury hospitalizations
Report prepared by the Maine Injury Prevention Program, Maine Center for Disease Control and Prevention, 9/28/2006

9

Depression and Aging

Depression is:

- not a normal part of aging
- a treatable illness
- a common, chronic condition that reduces physical, mental and social functioning ⟶ disability

Depression in Maine:

- The rate of depressive symptoms among persons receiving long-term care in Maine is twice the national average[1]
- 40% of the aged 60 and older population in residential care or home care have a diagnosis of depression[2]

[1] QI data from the national CMS website for the first quarter for 2005 – reported by Joint Advisory Committee
[2] MDS,MDS-RCA, and MeCare data: SFY 2006

10

Evidence-Base Program Philosophy

A Participant-Centered Approach

- Personal choice and responsibility for change
- Active participation
- Emphasis on behavior
- Self-efficacy /Self-management
- Cognitive restructuring- thinking about things in a different way

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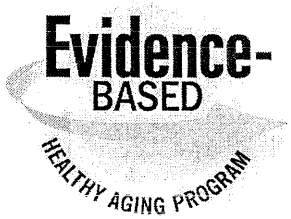
Turnkey Programs

- Licensed programs
- Instructor training
  - Train-the-trainer model
  - Instructor manual
  - Training materials
- Marketing materials
- Participant manuals
- Quality monitoring and evaluation
  - Instructor satisfaction
  - Participant satisfaction
  - Participant outcomes
  - Fidelity checklists
- Technical Assistance
  - Peer support



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Healthy IDEAS
Identifying Depression, Empowering Activities for Seniors

- Evidence-based community depression program designed to:
  - Detect and reduce the severity of depressive symptoms
  - Improve the linkage between community aging service providers and health care professionals
  - Prevent recurrence of depression
- Target population: frail, community dwelling high-risk older adults (60+), often overlooked and under-treated
  - EIM – HCB Elder Waiver population
- Embedded in LTC care manager role

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Healthy IDEAS Core Elements and Outcomes

Incorporates 4 components into the ongoing service delivery of care management

- Screening and assessment
- Education about depression and self-care
- Referral and linkage to health and mental health professionals
- Behavioral activation

Outcomes from National Translation Project

- Increased knowledge of how to get help for depression
- Reduction in depression severity and pain
- Increased knowledge of how to reduce symptoms through increasing activities
- Self report of increased level of physical and social activity

•Quijano, L.M., Stanley, M.A., Petersen, N.J., Casado, B.L., Steinberg, E.H., Cully, J.A., Wilson, N.L. Healthy IDEAS: •A depression intervention delivered by community-based case managers serving older adults. (2007). • *Journal of Applied Gerontology* 26:139-156.

14

Maine's Program at Elder Independence of Maine

- **Healthy IDEAS statewide:**
  - 196 HCB consumers screened between Nov. 2007 and July 2008.
    - 43% (n=84): Positive 2-question screen
    - 56% (n = 47): GDS* score of 6 or more (mean score = 9.3 on scale of 0 – 15)
      - » 57% (27/47): Behavioral Activation
      - » 57% (27/47): Referred to healthcare provider
  - *15 item Geriatric Depression Scale

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Living Well – Chronic Disease Self-Management Program

- Six session workshop designed to improve:
  - self-efficacy
  - self-management of chronic conditions and symptoms
- Target population: Community dwelling adults and caregivers
  - 60+ population and caregivers: current initiative
  - Adults with different chronic conditions participate in same group
  - Ability to problem solve
- Lay leader volunteers: train-the-trainer model

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Self-Management Tool Box

- Physical activity
- Using mind to manage symptoms
  - relaxation, distraction, self-talk, visualization
- Better breathing
- Understanding emotions
- Managing pain
- Healthy eating
- Communication
- Working with health professionals
- Managing medications
- Problem solving

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Living Well - Chronic Disease Self-Management Program

Health Outcomes at 6 Months

- Improved self-rated health
- Decreased disability, pain, shortness of breath
- Improved functioning
- Increased energy / decreased fatigue

Utilization Outcomes at 1 year

- Fewer visits to physician and emergency departments (0.689 visits)
- Fewer days in the hospital (0.111 fewer days)
- Fewer hospitalizations (0.012 fewer hospitalizations)
- Cost savings per participant projected between: $390 and $750

Lorig, KR, Ritter, PL, & Gonzalez, VM. (2003). Hispanic chronic disease self-management: a randomized community-based outcome trial. *Nursing Research, 52,* 361-369.

Lorig KR, Sobel DS, Stewart AL, Brown Jr BW, Ritter PL, González VM, Laurent DD, Holman HR. Evidence suggesting that a chronic disease self-management program can improve health status while reducing utilization and costs: A randomized trial. Medical Care, 37(1):5-14, 1999.

Lorig KR, Ritter P, Stewart AL, Sobel DS, Brown BW, Bandura A, González VM, Laurent DD, Holman HR. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. Medical Care, 39(11),1217-1223, 2001.

Sobel, DS, Lorig, KR, & Hobbs, M. (2002). Chronic Disease Self-Management Program: From development to dissemination. *The Permanente Journal, 6,* 15 – 22.

18

Living Well Reach and Adoption in Maine

Program Implementation: February 2007

18 Living Well Sites (13 counties)

- Agencies on Aging
- Regional Hospitals
- Healthy Maine Partnerships
- Physician Practices
- Retirement Communities

Trainers and Leaders

- 2 T-Trainers
- 12 Master Trainers
- 95 Leaders

- **Participants**
  - 325 participants (2/07 – 7/08)

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A Matter of Balance Program

Eight session class designed to:

- reduce the fear of falling
- increase the activity levels of older adults who have concerns about falls

Target population:

- Community dwelling older adults, 60+
- Ability to problem solve

Participants learn to:

- View falls and fear of falling as controllable
- Set realistic goals for increasing activity
- Change their environment to reduce fall risk factors
- Promote exercise to increase strength and balance

Tennsdedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L. & Jette, A. (1998). A randomized, controlled trail of a group intervention to reduce fear of falling and associated activity restriction in older adults. *Journal of Gerontology, Psychological Sciences*, 54B (6), P384-P392.

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A Matter of Balance/Volunteer Lay Leader Model (MOB/VLL) Outcomes in Maine

Participants = 335

- Significant Improvement in:
  - Falls self-efficacy (6 weeks & 6 months***, 12 months**)
  - Falls control (6 weeks**, 6 & 12 months*)
  - Falls management (6 weeks***, 6 & 12 months***)
  - Decline in monthly falls (6 & 12 months***)
  - Increased exercise level (6 weeks** & 6 months*)

- ***p<.05 **p<.01 ***p<.001**

Healy, T. C., Peng, C., Haynes, P., McMahon, E., Botler, J. & Gross, L. (2008). The Feasibility and Effectiveness of Translating A Matter of Balance into a Volunteer Lay Leader Model. Journal of Applied Gerontology, 27 (1), 34-51.

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MOB/VLL Reach and Adoption in Maine

22 MOB/VLL Master Trainer Sites (13 Counties)

- Agencies on Aging
- Regional Hospitals
- Healthy Maine Partnerships
- YMCAs
- Community Centers
- Retirement Communities

Trainers

- 4 Lead Trainers
- 60 Master Trainers

Participants

- 1400 participants (since 2003)

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ENHANCE WELLNESS

- Designed for older adults with chronic conditions at risk for hospitalization. Creates a team with:
  - Participant
  - Registered Nurse
  - Social Worker
  - Primary Care Physician
  - Health Mentor
- Seeks to improve health and functioning and reduce unnecessary medical care with:
  - A health screening and action plan
  - Ongoing personal encouragement and feedback
  - Problem solving, health education and regular monitoring
  - Support and links to community services

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ENHANCE WELLNESS

Randomized Control Trial Results

Participants

- Hospital days decreased by 72%
- Number of seniors hospitalized decreased by 38%
- Meds used for sleep and depression decreased by 36%
- Higher levels of physical activity
- Better functioning in daily living activities

Health mentors

- Physical function scores increased
- 28% mentors increased exercise
- 22% mentors increased social activity
- 50% increased self-management techniques

Leveille SG, et al. (1998). Preventing disability and managing chronic illness in frail older adults: A randomized trial of a community-based partnership with primary care. *Journal of American Geriatrics Society*, 46:1-9. URL: www.americangeriatrics.org

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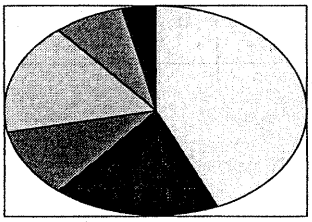
ENHANCE WELLNESS

Health Action Plan Issues:



On average, 84% of participants achieve and maintain their health action plan goals.

(PFHA 2007)

2 Maine Sites

25

ENHANCE FITNESS

EnhanceFitness (5 sites in Maine)

- a low-cost, highly adaptable exercise program offering levels that are challenging enough for active older adults and levels that are safe enough for the unfit or near frail.
- 3 times per week for 60 minutes
- 60+ population

- Exercise components *(Core Elements)*
  - cardiovascular endurance
  - strength training
  - balance and posture
  - Stretching
- Outcomes:
  - Improved physical and social functioning
  - Reduced incidence of pain, fatigue, and depression

•Wallace JI, et al. (1998). "Implementation and effectiveness of a community-based health promotion program for older adults." *Journal of Gerontology: Medical Sciences*, 53a(4): M301-M306. URL: www.americangeriatrics.org

Ackermann RT, et al. (2003). "Community exercise program use and changes in healthcare costs for older adults." *American Journal of Preventative Medicine*, 25(3): 232-7.

Belza B, et al. (2006). "The effects of a community-based exercise program on function and health in older adults: the EnhanceFitness Program." *Journal of Applied Gerontology*, 25(4):291-306.

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Future Opportunity

- Improve statewide access to most vulnerable
- Secure public/private funds for sustainability
- Expand: to older adults with capacity to problem solve
  - Residential Care
  - Assisted Living
  - Independent Housing with Services
- Explore other evidence-based in-home programs
  - Targeting caregivers
  - Training workforce

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Living Well – Chronic Disease Self-Management

Augusta
Maine Primary Care Association
(207) 621-0677 ext 222

SpectrumGenerations
1-800-282-0764

Bangor
Eastern Area Agency on Aging
(207) 941-2865

Bar Harbor
Healthy Acadia
(207) 288-5331

Belfast
Waldo County Healthcare
(207) 930-6745

Boothbay Harbor
St. Andrews Village
(207) 633-0920

Brunswick
Parkview Adventist Medical Center
(207) 373-2162

Damariscotta
SpectrumGenerations
Coastal Community Center
(207) 563-1363

Houlton
Houlton Regional Hospital
(207) 532-9471

Presque Isle
Aroostook Agency on Aging
1-800-439-1789

The Aroostook Medical Center
207-768-4160

Sanford
Goodall Hospital
(207) 490-7703

Scarborough
Southern Maine Agency on Aging
1-800-427-7411
(207) 396-6527

Vinalhaven
Islands Community Medical Center
(207) 863-4341

Waterville/Augusta
MaineGeneral Health
(207) 621-3742

Waterville/Skowhegan
Inland Hospital
(207 861-3292

Skowhegan
Somerset Heart Health
(207) 474-7473

Western Maine
The Memorial Hospital – N. Conway
(603) 356-5461 ext 417

Matter of Balance Volunteer Lay Leader Model

Augusta
MaineGeneral Medical Center
(207) 624-3814

SpectrumGenerations
1-800-282-0764

Bangor
Eastern Agency on Aging
1-800-432-7812

Belfast
Healthy Living Project/Waldo County General Hospital
(207) 930-2650

Boothbay Harbor
St. Andrews Village
(207) 633-0920

Brunswick
People Plus
(207) 729-0757

Damariscotta
Coastal Community Center
(207) 563-1363

Dover-Foxcroft
Piscataquis Regional YMCA
(207) 564-7111

Fort Kent
St. John Valley Partnership
(207) 834-4187

Gardiner
Healthy Communities Capital Area
(207) 582-8011

Lewiston
St. Marguerite d'Youville Pavilion
(207) 777-4200

Machias
Senior Companion Program
1-800-287-1542

Norway
Healthy Oxford Hills
(207) 743-5933 ext. 776

Pittsfield
Sebasticook Valley Hospital
(207) 487-3890 ext. 113

Portland
Maine Medical Center
(207) 774-2381

Orono
Senior Companion Program
(207) 629-9272, ext. 206

Presque Isle
Aroostook Area Agency on Aging
1-800-439-1789

Sanford
Sanford-Springvale YMCA
(207) 324-4942

Goodall Hospital
(207) 490-7437

Sangerville
Friends of Community Fitness
(207) 876-4813

Scarborough
Southern Maine Agency on Aging
1-800-427-7411

South Paris
Market Square Health Care Center
(207) 743-7086

EnhanceFitness

Belfast
Waldo County YMCA
(207) 338-4598

Lewiston
St. Mary's Regional Medical Center
(207) 755-3722

Portland
USM Lifeline
(207) 780-4641

Sangerville
Friends of Community Fitness
(207) 876-4813

Skowhegan
Somerset Sports and Fitness
(207) 474-2224

EnhanceWellness

Boothbay Harbor
St. Andrews Village
(207) 633-0920

Portland
Partnership for Healthy Aging
(207-775-1095

Healthy Choices FOR ME!

Maine's Office of Elder Services (OES) was awarded a three year competitive grant from the Administration on Aging (AoA) in October 2006 to build upon current efforts to advance evidence-based prevention and wellness programs in Maine. In collaboration with MaineHealth's Partnership for Healthy Aging, the area agencies on aging, and other community partners, the OES will implement and disseminate evidence-based programs statewide during the next three years. Each program empowers older people to take more control of their own health through life style and behavioral changes. Priority will be given to expand program access to rural areas and selected underserved areas.

Program Descriptions

The ***Chronic Disease Self-Management Program***, *or* ***Living Well***, is a workshop given two and a half hours, once a week, for six weeks. People with different chronic health problems attend together. Program participants demonstrate significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations.

A Matter of Balance/Volunteer Lay Leader **(MOB/VLL)*** program, specifically designed to reduce fear of falling, stop the fear of falling cycle, and improve activity levels among community-dwelling older adults. Participants have found significant improvement regarding their level of falls management; falls control; level of exercise; and social limitations with regard to concern about falling.

** MOB/VLL has received national awards from the American Society on Aging and National Association of Area Agencies on Aging for innovation and quality in aging programs.*

EnhanceWellness is an effective, participant driven, health promotion and management program that helps older adults with chronic conditions achieve their personal health goals through health action plans, and has demonstrated significant results in the utilization of health care services.

EnhanceFitness is a low-cost exercise program, taught by certified fitness instructors, for seniors with a wide range of physical abilities The classes include strength training with wrist and ankle weights, as well as aerobics, stretching, and balancing exercises. Studies have shown a marked improvement in participants' physical and social functioning, as well as a decline in areas such as pain, fatigue, and depression.

Healthy IDEAS is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. Participants have shown significantly decreased depression symptoms and pain associated with depression.

Contact Linda Samia, Office of Elder Services, for information on becoming a partner site: 287-9209 or tamara.herrick@maine.gov. Current program locations are listed on next page.

The funding for this program was provided in part by grant #90AM312001 from the Administration on Aging to the Maine Department of Health and Human Services, Office of Elder Services.

Healthy Choices for ME Programs

EnhanceWellness

EnhanceWellness is designed for independent living older adults 60+ with chronic health conditions. The program supports participants in making the changes they want to improve their health.

The program includes:

- the EnhanceWellness Team: participant, registered nurse, social worker, health mentor, primary care physician
- a health screening and action plan
- ongoing personal encouragement and feedback
- problem solving, health education and regular monitoring
- support and links to other community services

Participants enroll in the EnhanceWellness for 6 months.

There is no charge for the program.

Please call Partnership for Healthy Aging at 775-1095 for more information.

A Matter of Balance

Many older adults experience concerns about falling and restrict their activities. **A Matter of Balance** is an award-winning program designed to manage falls and increase activity levels for people age 60 and older.

During the class, participants learn to:

- view falls as controllable
- set goals for increasing activity
- make changes to reduce fall risks at home
- exercise to increase strength and balance

The class consists of eight 2 hour sessions held once or twice a week.

Fee varies by host site.

Please see *Healthy Choices for ME* Program List for class locations and contact information

EnhanceFitness

EnhanceFitness is a low-cost, supervised exercise class for older adults age 50+. It is designed to be safe and effective for seniors with a wide range of physical abilities and can transition to a self-maintained home program.

The program includes:

- strength training
- aerobics
- stretching
- balance exercises

Classes are held for 1 hour three times a week.

Fee varies by host site.

Please see *Healthy Choices for ME* Program List for class locations and contact information.

Living Well

Living Well is designed to help older adults with chronic conditions learn better ways of coping and managing their health. Adults with a chronic condition, or caregivers of persons with chronic conditions, may attend.

During the class, participants learn to:

- set goals that are do-able
- work with others
- find support and solutions to problems
- make daily tasks easier
- relax and manage stress
- work in partnership with their health care team

The class consists of six 2.5 hour sessions held once a week.

Fee varies by host site.

Please see *Healthy Choices for ME* Program List for class locations and contact information.

Healthy Choices for ME information can also be found at www.maine.gov/dhhs/beas/choices and www.211maine.org

APPENDIX L

**Chart of direct-care worker MaineCare policy section,
hourly rate, supervision and training,
Presentation by Mollie Baldwin, Home Care for Maine, September 22, 2008**

Service Provided	*Policy Section*	*Hourly Rate*	*Supervision*	*Training*
ersonal Support Specialist (PSS)	96,MaineCare Benefits Manual	$14.98	**PDN** face to face visit every 6 months	50 hour OES approved Personal Support Specialist cost born by agency or worker
hildren/Adult Homecare Services)			& phone contact every three months	Specialist training program within 180 dayys of hire
ders & Adults w Disabilities	Section 19, MaineCare Benefits Manual		**MW/ADW** Face to face visit every 3 months	8 hours orientation before entering consumer's home for direct care
	OES Policy Section 63		**HBC** every 6 months	No annotatations on CNA registry and criminal background check
ertified Nursing Assistant (CNA)	Section 19 and 96 MaineCare Benefits Manual	$17.20	Supervised by a Registered Nurse	Minimum of 150 hours state approved CNA curriculum.
hildren/Adult Homecare Services)			every 14 days. One face to face visit	Employee must be on Maine CNA Registry and in
			monthly.	good standing with no annotations upon hire.
irect Support Specialist (DSP)	21, 24, 29 MaineCare Benefits Manual	$26.92, $23.63, $21.59		35 hour classroom Direct Support Specialist curriculum
dults MR Services)				40 hr. Certified medication course, Mandated 16 hrs CPR/FA 6.5 hrs within 365 days of hire
abilitative Specialist (HS1)	24 MaineCare Benefits Manual	$27.21	Agency specific	Agency specific only
hildren's MR/Autism Services)				
aily Living Support Specialist (DLSS)	17 MaineCare Benefits Manual	$32.08		35 hour Mental Health Support Specialist
dult Mental Health Services)				training program, 40 hr. Certified 16 hour Medication (CRMA) course, and 6.5 hours CPR course within 365 days of hire
				If all trainings completed within specified timeframe, Muslie will issue MHRT-1 certification.

APPENDIX M

Home and Community-Based Services, Initiatives in Other States and New Ideas, Presentation by Lisa Alecxih, The Lewin Group, October 20, 2008

The LEWIN GROUP

Home and Community-Based Services Initiatives in Other States & New Ideas

Maine Blue Ribbon Commission

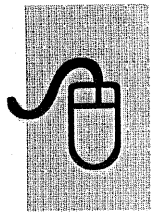
Lisa Alecxih, *Vice President*

lisa.alecxih@lewin.com

703-269-5542

October 20, 2008

Overview



- Background/Context
- What do successful states do?
- How do we know what works?

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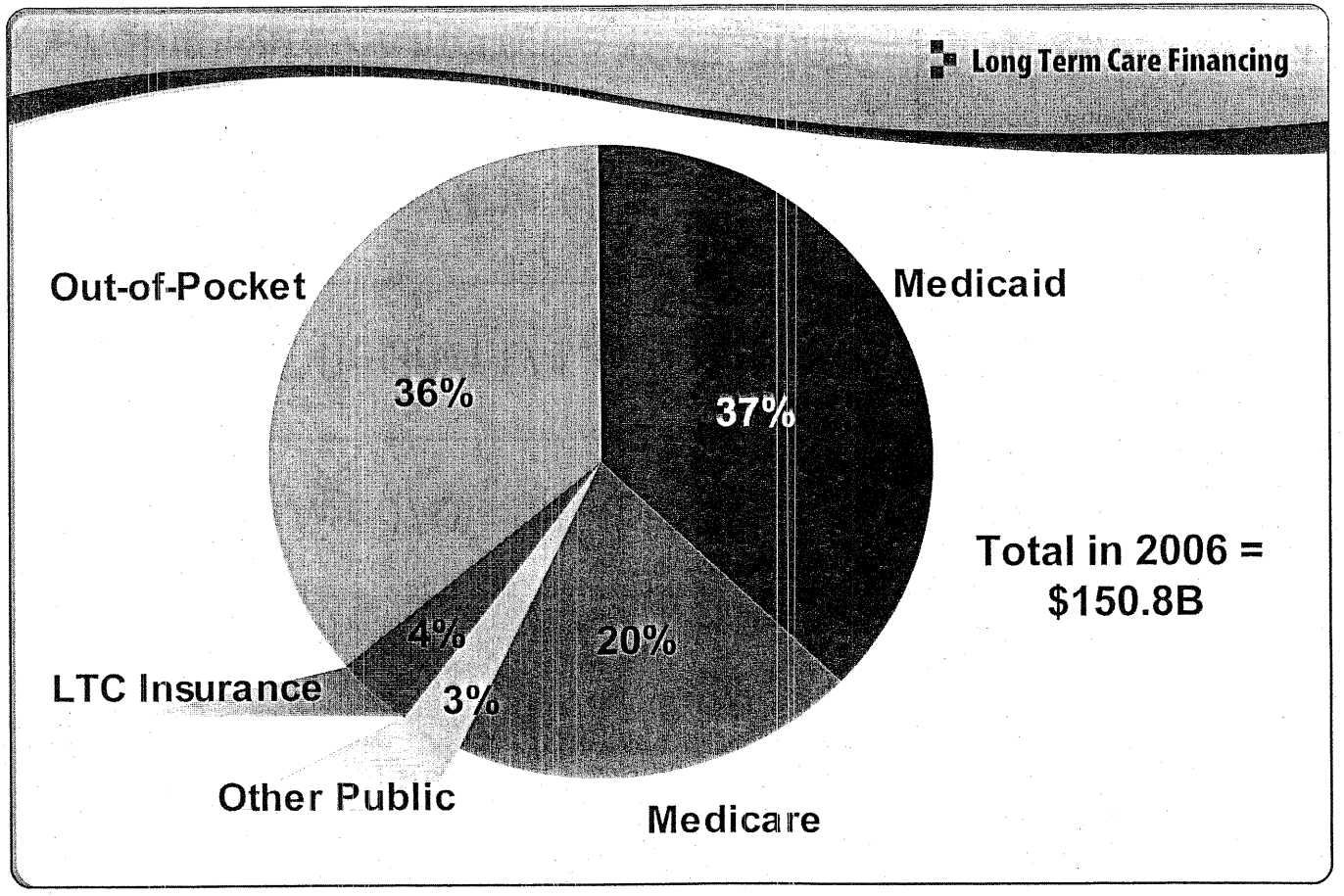
LTC Sources of Financing Among Seniors



Source: The Lewin Group based on the Long Term Care Financing Model.

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Maine Relative to the U.S.

	Maine	U.S.
2007 % Medicaid Aged/Disabled HCBS	25.5%	26.3%
2007 Medicaid NF Resident/1,000 Age 65+	22.3	24.2
A/D Medicaid Spending/Age 65+	$1,652	$1,682
A/D Spending Rate of Increase 1995-2007	1.2%	4.2%

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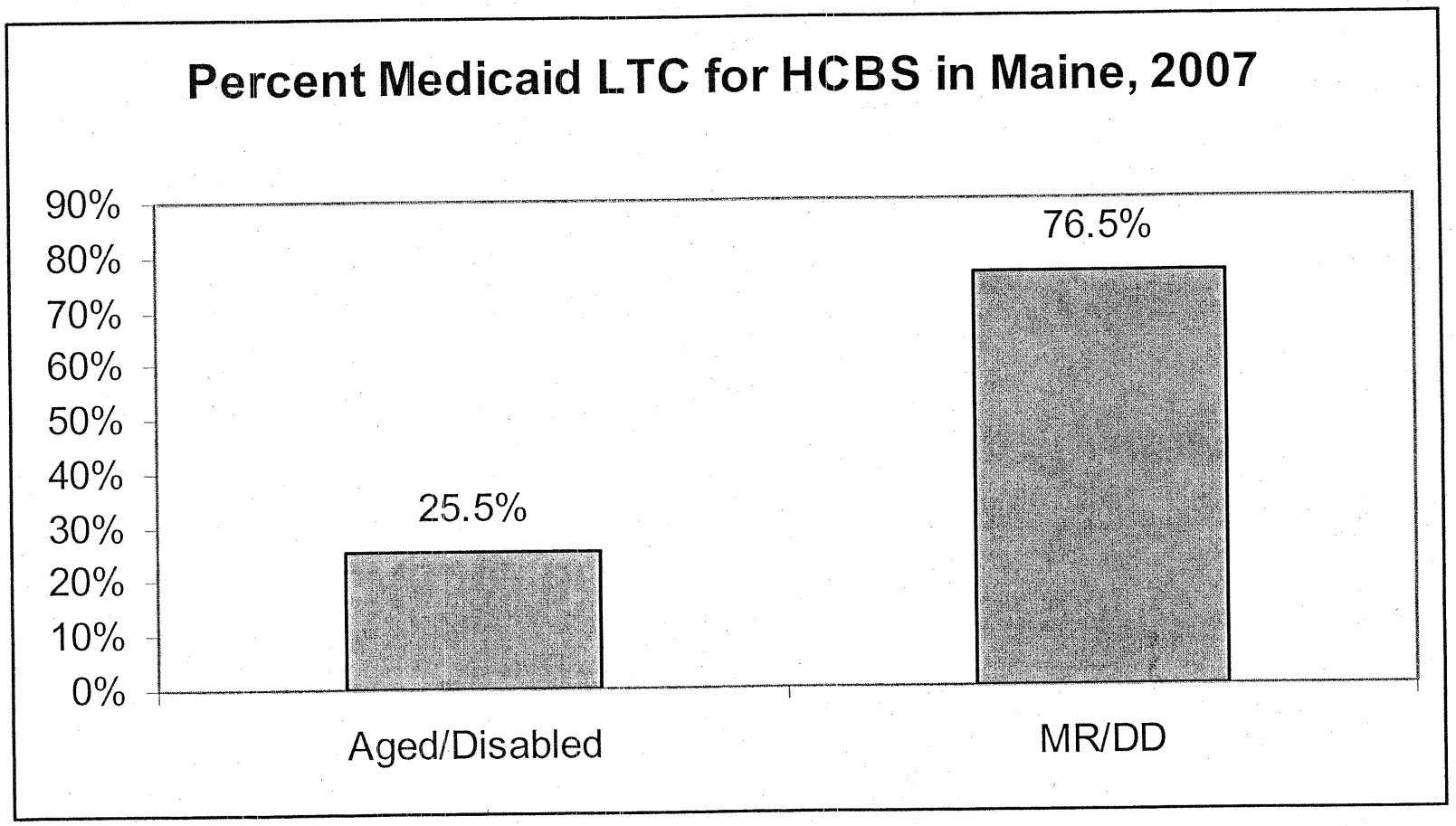
Aged/Disabled Compared to MR/DD



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What do successful states use? Financing Strategies

- Global Budgets
- Nursing Home Bed Buy Backs
- Expansion of Home and Community-based Alternatives
- Capitated Managed Long Term Care
- Long Term Care Insurance Partnership Program
- Targeted State Funds

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Global Budgets/Single Appropriation

- Oregon since 1980s
- Washington since 1995
- Several states adopted since 2006
  - Vermont's 1115
  - Rhode Island, New Jersey and Ohio all with legislation and early implementation
  - South Carolina exploring under their CMS grants

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Nursing Home Bed Buy Backs

- Minnesota
  - Voluntary planned closure and bed layaway programs with rate increases for participating facilities
- Pennsylvania
  - Similar to MN
  - Cost savings amoratized
  - Financial experts work with each facility individually
- Illinois Conversion Work Group
  - Exploring possibilities and funding

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Targeted State Funds

- High risk of nursing home entry and likely to spend down to Medicaid
  - Moved beyond level of care determination
  - Minnesota targets spenddown within 6 months
  - AoA grants refining criteria and methods using Title III funds and state funds
- Evidence-based programs
  - Falls prevention

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What do successful states use? System Strategies

- **Knowledge for Informed Choices**
  - Easily accessible and understandable
  - Options counseling
- **Interventions in Critical Pathways to Institutionalization**
  - Outreach to hospital discharge planners, physicians...
  - Pre-admission screening for institutions
- **Accelerated Eligibility Determination**
  - Fast track
  - Presumptive eligibility
- **Consumer Direction**
- **Transitions out of Nursing Facilities**

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Aging and Disability Resource Centers

- ADRCs can serve as the hub for activities
- List of Statewide ADRCs growing
  - 8 with physical statewide coverage
    - Alaska, Kentucky, Louisiana, New Hampshire, Rhode Island, West Virginia, Guam, and Northern Mariana Islands
  - 5 with legislation or administrative commitment to go statewide
    - Wisconsin, Florida, Michigan, Illinois and Indiana
- 30% of US population lives in ADRC service area

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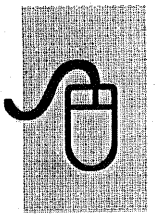
How Do We Know What Works?



- Identify successful states
- Need to establish measures of success
- Need consistent data across all states

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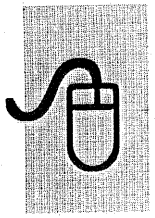
How Do We Know What Works? Three Measures of Progress



- Proportion of Medicaid HCBS spending of the total Medicaid long term care spending
  - Subset of states with 30%+ in 2005 (11 states)
  - National average 23.6%
- Change in institutional placements
  - Decline in per 65+ Medicaid NF use of 25%+ from 1995-2005
  - National average -15.2%
- Change in per capita rate of Medicaid long term care spending
  - Less than or equal to 5.2% annual increase from 1995-2005
  - National average 5.2% annually

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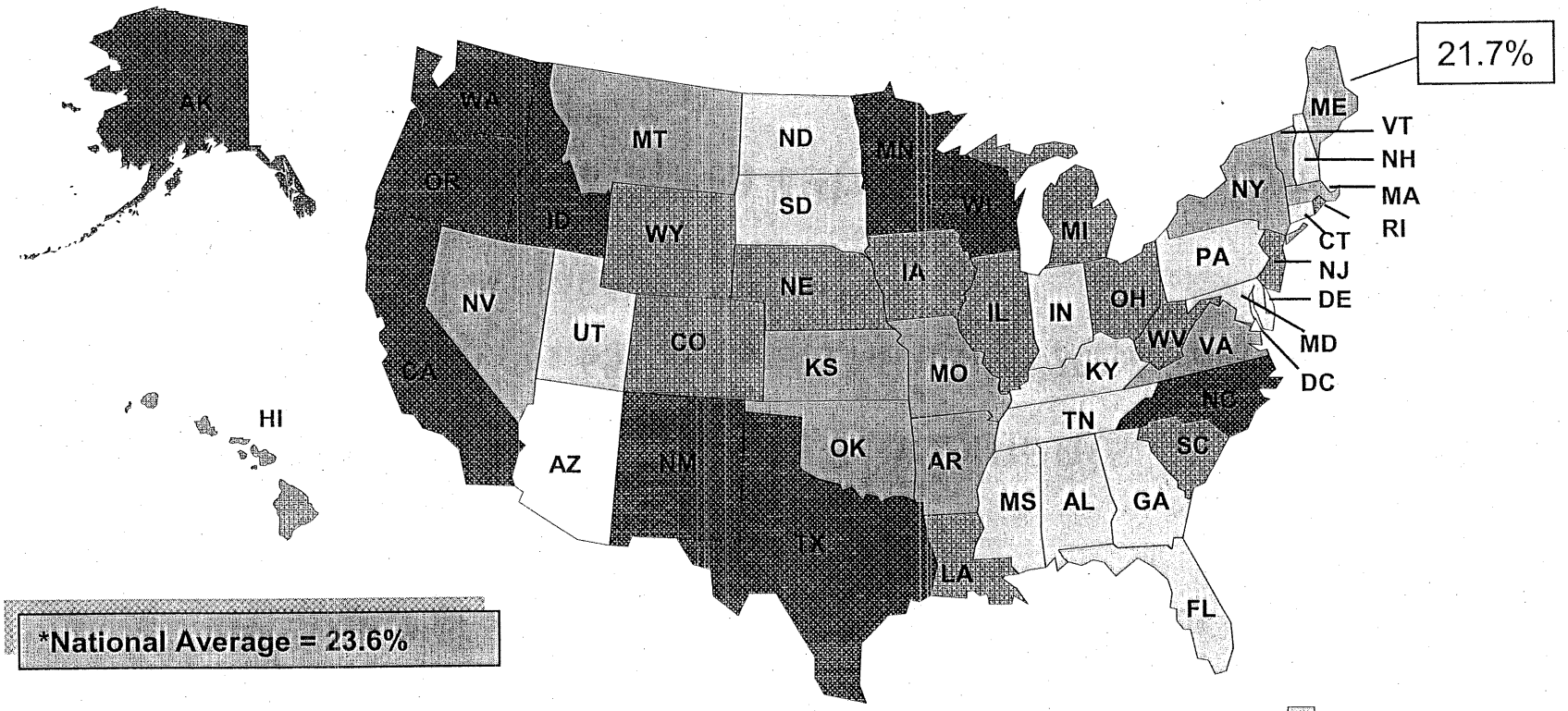
Percent HCBS of Medicaid LTC Among Aged/Disabled, 2005



*National Average = 23.6%

HCBS 33-54%

Alaska, California, Idaho, Minnesota, New Mexico, North Carolina, Oregon, Texas, Washington, Wisconsin

HCBS 20-32%*

Arkansas, Kansas, Maine, Massachusetts, Missouri, Montana, Nevada, New York, Oklahoma, Vermont, Virginia

HCBS 10-19%

Colorado, Hawaii, Illinois, Iowa, Louisiana, Michigan, Nebraska, New Jersey, Ohio, Rhode Island, South Carolina, West Virginia, Wyoming

HCBS <10%

Alabama, Connecticut, Delaware, DC, Florida, Georgia, Indiana, Kentucky, Maryland, Mississippi, New Hampshire, North Dakota, Pennsylvania, South Dakota, Tennessee, Utah

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Source: 2006 Thomson Healthcare Medicaid LTC Data, Lewin Analysis.

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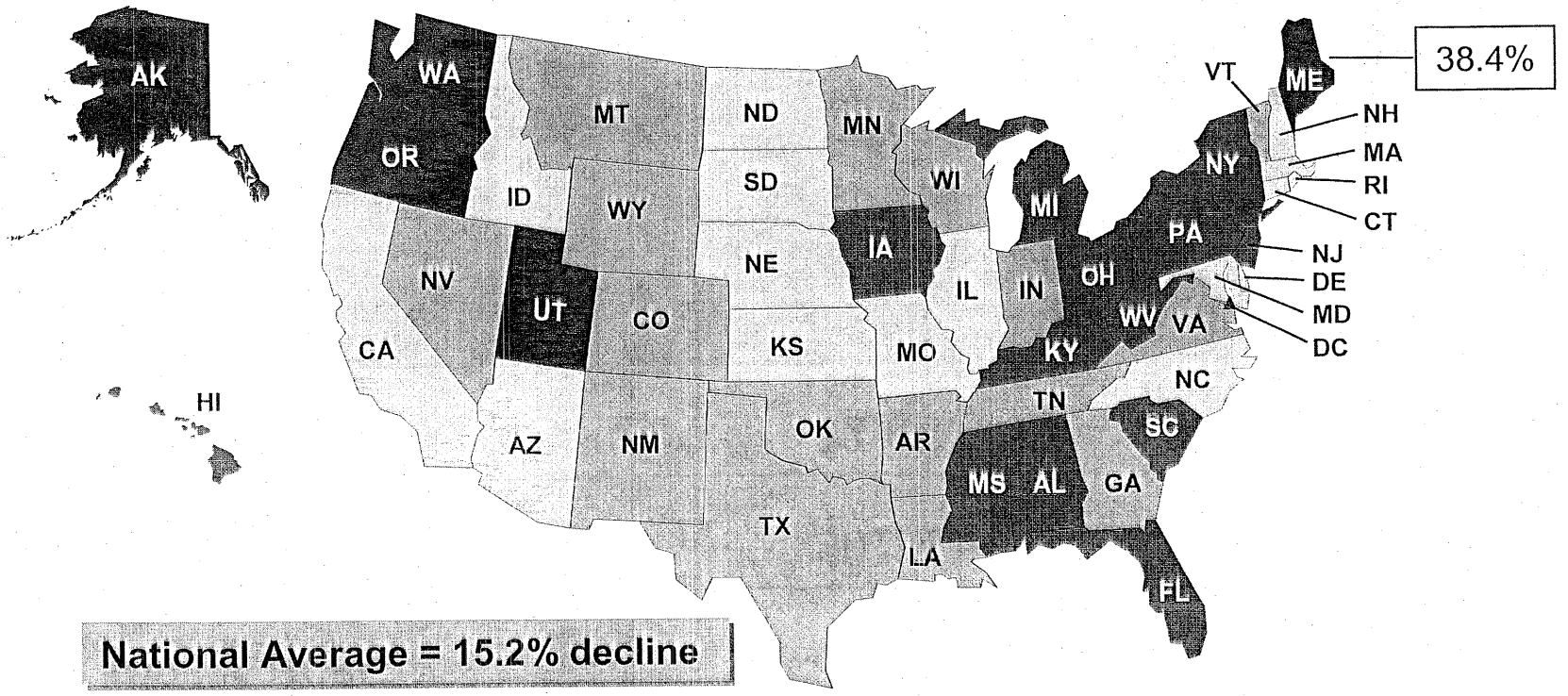
Change in Per Capita Medicaid Nursing Facility Residents, 1995-2005

Source: Mick Cowles (2006) Nursing Home Year Book for residents and Bureau of the Census for population..



National Average = 15.2% decline

30% or More Decline

- Alaska
- Maine
- Oregon
- Washington
- Utah

20% to 30% Decline

- Arkansas
- Colorado
- Georgia
- Indiana
- Louisiana
- Minnesota
- Montana
- Nevada
- New Mexico
- Oklahoma
- Tennessee
- Texas
- Vermont
- Virginia
- Wisconsin
- Wyoming

10% to 20% Decline

- Arizona
- California
- Connecticut
- Delaware
- Idaho
- Illinois
- Kansas
- Maryland
- Massachusetts
- Missouri
- Nebraska
- New Hampshire
- North Carolina
- North Dakota
- Rhode Island
- South Dakota

Less than 10% Decline

- Alabama
- District of Columbia
- Florida
- Hawaii
- Iowa
- Kentucky
- Michigan
- Mississippi
- New Jersey
- New York
- Ohio
- Pennsylvania
- South Carolina
- West Virginia

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States Meeting All 3 Medicaid LTC Measures

	Washington	Minnesota	Wisconsin
1995 % HCBS	18.1%	4.1%	11.5%
2005 % HCBS	50.1%	37.5%	34.3%
% pt difference	32.0%	33.4%	22.8%
1995 NF/1,000 65+	26.7	45.2	42.9
2005 NF/1,000 65+	16.8	31.9	30.6
% difference	-37.0%	-29.3%	-28.8%
Annual change $/65+	5.0%	2.0%	4.6%

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Trend Analysis for Washington

Analysis from 1984 through 2005

- Similar methodology to AARP analysis
- Includes adjustment for national NF use rate decline

Use Rate per 1,000 Age 65+

	HCBS	NF	Total
1984	25.2	31.7	56.9
2005	49.5	16.9	66.3
w/ NF adj.	25.2	27.0	52.2

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Trend Analysis for Washington

- Serving 14% more people than expected
  - +49% in community
  - -88% in nursing facility
- Spending 15% less Medicaid LTC than expected
  - +96% in community
  - -47% in nursing facility
- Adjusting for National NF Use Trend
  - -60% nursing facility users
  - -37% Medicaid $s in nursing facility
  - Spend 4% less overall in Medicaid LTC than expected

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Where is the floor for Medicaid nursing facility use?

Medicaid NF Residents/1,000 age 65+

	Oregon	Washington	Maine	U.S.
1995	16.8	26.7	38.1	30.2
2005	10.8	16.8	23.4	25.7
Percent Change	-34.6%	-37.0%	-38.4%	-15.2%

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States Exceeding 30% Medicaid HCBS Only

	2005 % HCBS	% difference NF/1,000 65+	Annual change $/65+
California	52.3%	-12.7	9.9%
Idaho	37.9%	-18.5	5.6%
New Mexico	51.5%	-22.6%	9.9%
North Carolina	37.9%	-13.4%	6.6%
Vermont	31.5%	-23.0%	5.6%

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What Do Successful States Do Differently?

- Articulate a Government-wide Vision
  - Cross department and sometimes cross-disability
  - Engage all stakeholders in setting the Vision
- Plan to that Vision
  - All policy and funding decisions checked against Vision
  - Determine whether new initiatives/flavor of the month also within the Vision (or whether Vision needs to be modified)
- Execute the Plan
  - Develop a work plan and strategy to fulfill the Vision
- Monitor the Execution with Data
  - Develop measures & reports that indicate progress toward the Vision
- Regularly Reassess the Vision

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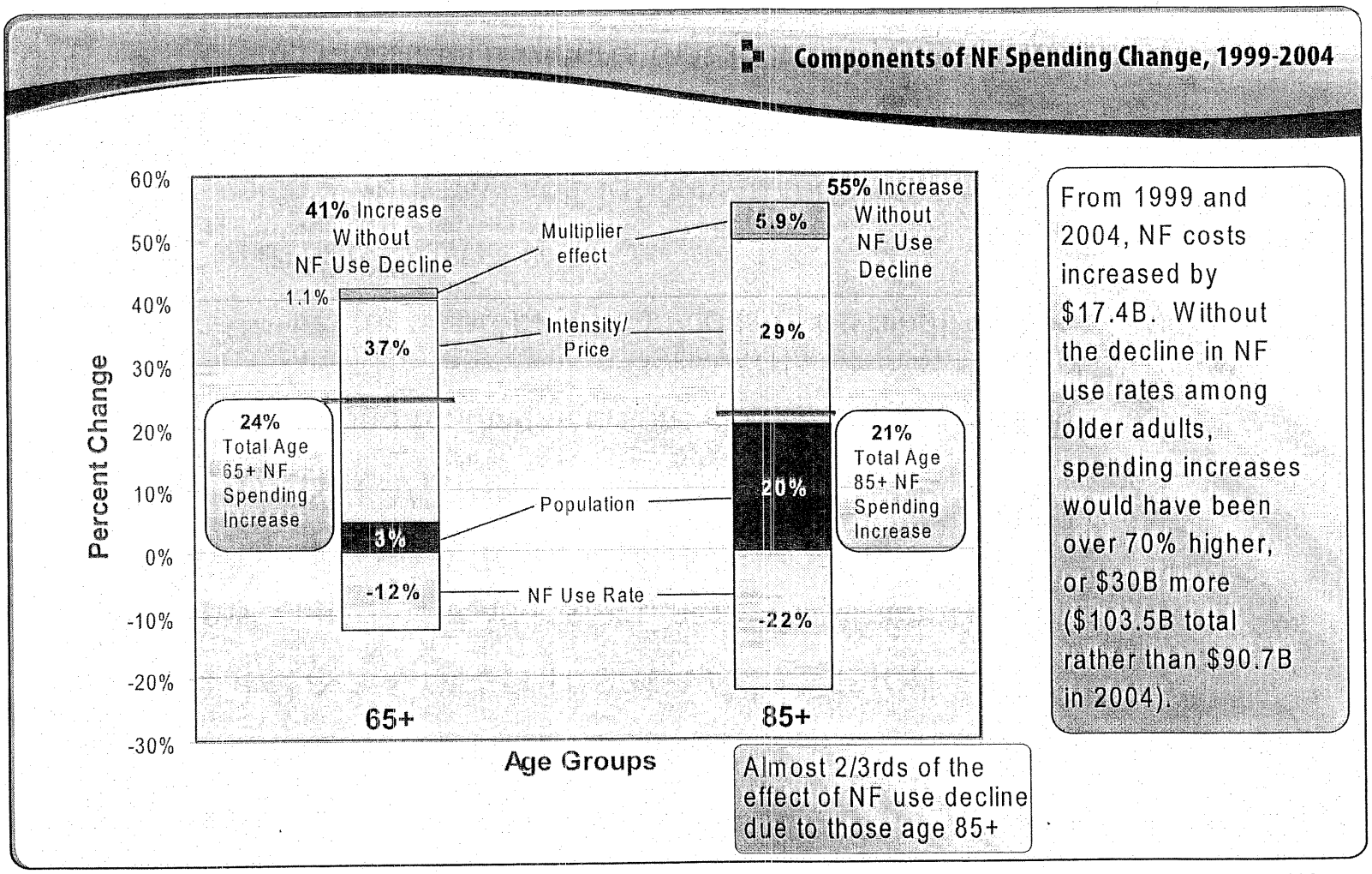
Declines in NF Use Rates More than Offset Population Growth Between 1999 and 2004



Calculations by The Lewin Group based on Hartman et. al. (2007) "U.S. Health Spending By Age, Selected Years Through 2004" *Health Affairs*, doi: 10.1377/hlthaff.27.1.w1, Lisa Alecxih (2006) "Nursing Home Use by "Oldest Old" Sharply Declines", and Bureau of the Census Population Estimates .

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Conclusions

- Maine faces many challenges
  - Growing demand and changing expectations
  - Insufficient numbers of workers and high turnover rates
  - Constraints on reimbursement
  - Financing silos and institutional bias of Medicaid
  - Lack of insurance to spread risk
- Overcoming these challenges will require
  - Wise public policy decisions
  - Smart business choices by providers
  - Greater personal responsibility

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APPENDIX N

Title 22, Maine Revised Statutes, Chapter 1621

MRS Title 22, Chapter 1621: GENERAL PROVISIONS

Table of Contents

Subtitle 5. IN-HOME AND COMMUNITY SUPPORT SERVICES FOR ADULTS WITH LONG-TERM CARE NEEDS .....

22 §7301. Legislative intent

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.

22 §7302. Definitions

As used in this subtitle, unless the context otherwise indicates, the following terms have the following meanings.

1. **Adults with long-term care needs.** "Adults with long-term care needs" means adults who have physical or mental limitations which restrict their ability to carry out activities of daily living and impede their ability to live independently, or who are at risk of being, or who already have been, placed inappropriately in an institutional setting.

2. **Agreement.** "Agreement" means a contract, grant or other method of payment.

3. **Commissioner.** "Commissioner" means the Commissioner of Health and Human Services.

4. **Department.** "Department" means the Department of Health and Human Services.

5. **In-home and community support services.** "In-home and community support services" means health and social services and other assistance required to enable adults with long-term care needs to remain in their places of residence. These services include, but are not limited to, medical and diagnostic services; professional nursing; physical, occupational and speech therapy; dietary and nutrition services; home health aide services; personal care assistance services; companion and attendant services; handyman, chore and

homemaker services; respite care; counseling services; transportation; small rent subsidies; various devices which lessen the effects of disabilities; and other appropriate and necessary social services.

6. Institutional settings. "Institutional settings" means residential care facilities, licensed pursuant to chapter 1664; intermediate care and skilled nursing facilities and units and hospitals, licensed pursuant to chapter 405; and state institutions for individuals who are mentally ill or mentally retarded or who have related conditions.

7. Personal care assistance services. "Personal care assistance services" means services which are required by an adult with long-term care needs to achieve greater physical independence, which may be consumer directed and which include, but are not limited to:

A. Routine bodily functions, such as bowel or bladder care;

B. Dressing;

C. Preparation and consumption of food;

D. Moving in and out of bed;

E. Routine bathing;

F. Ambulation; and

G. Any other similar activity of daily living.

8. Personal care assistant. "Personal care assistant" means an individual who has completed a training course of at least 40 hours, which includes, but is not limited to, instruction in basic personal care procedures, such as those listed in subsection 7, first aid and handling of emergencies; or an individual who meets competency requirements, as determined by the department or its designee. Nothing in Title 32, chapter 31, may be interpreted to require that a personal care assistant be licensed under that chapter or supervised by a person licensed under that chapter.

9. Provider. "Provider" means any entity, agency, facility or individual who offers or plans to offer any in-home or community support services.

10. Severe disability. "Severe disability" means a disability which results in persons having severe, chronic physical, sensory or cognitive limitations which restrict their ability to carry out the normal activities of daily living and to live independently.

22 §7303. Programs; rules

1. Programs required. The department shall establish and administer, pursuant to this subtitle, programs of in-home and community support services for adults with long-term care needs, by itself or in cooperation with the Federal Government.

An adult with long-term care needs, who applies for services under any such program, is entitled to receive the services, provided that the department has determined that the adult is eligible and provided that sufficient funds are available pursuant to this subtitle to pay for the services.

2. Rules. The department shall promulgate such rules, including rules that specify the criteria to be used in ranking proposals, as may be necessary for the effective administration of any programs of in-home and community support services pursuant to this subtitle, in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375. In the development of such rules, the department shall consult with consumers, representatives of consumers or providers of in-home and community support services.

22 §7304. Delivery of services

1. Staff; providers. In order to provide in-home and community support services, the department may

use its own staff and its designees and enter into agreements with providers.

2. Agreement. Each agreement shall specify, among other things, the types of in-home and community support services to be provided, the cost of the services, the method of payment and the criteria to be used for evaluating the provisions of services.

3. Proposals. The department shall solicit proposals from providers who would like to provide in-home and community support services, pursuant to this subtitle. Providers shall submit proposals in such form and manner as may be required by the department. The department shall select proposals according to rankings based on the criteria developed pursuant to section 7303, subsection 2.

22 §7305. Funds

1. Federal and private funds. The department may apply for and use any federal or private funds and other support which become available to carry out any program of in-home and community support services.

2. Fee scale. The department shall develop, whenever practicable, sliding fee scales for in-home and community support services provided pursuant to this subtitle.

3. Vouchers. The department may, through the use of vouchers, make payments directly to adults with long-term care needs to enable them to purchase in-home and community support services pursuant to this subtitle.

4. Distribution. The department shall disburse funds, pursuant to this subtitle, in a manner that ensures, to the extent practicable, equitable distribution of services among adults with long-term care needs and among the various regions of the State.

22 §7306. Demonstration projects

The department may initiate demonstration projects to test new ways of providing in-home and community support services, including, but not limited to, projects which test the ability of hospitals, skilled nursing facilities or intermediate care facilities to provide these services.

22 §7307. Relatives as providers

The department may not refuse to pay a relative of an adult with long-term care needs for the provision of in-home and community support services or personal care assistance services if the relative is qualified to provide the service and the payment is not prohibited by federal law or regulation.

22 §7308. Respite Care Fund

The department shall administer the Respite Care Fund for the purpose of providing short-term respite care for persons with Alzheimer's disease and other dementias. This respite care may include short-term in-home care, nursing or residential care facility stays, hospital or adult day care or home modifications. The department also may use the fund to carry out the purposes of the National Family Caregiver Support Program.

22 §7309. In-home providers

A landlord may not charge a tenant additional rent or utilities for a person who provides in-home and community support services to the tenant. A landlord may request a letter from the Department of Health and Human Services to verify a tenant's eligibility for the use of in-home or community support services. This section is repealed January 1, 2009.

APPENDIX O

Legislation Recommended by the Blue Ribbon Commission to Study the Future of Home-based and Community-Based Care
November 5, 2008

Legislation Recommended by the Blue Ribbon Commission
to Study the Future of Home-based and Community-Based Care
November 5, 2008

Sec. 1. 22 MRSA §7301 is repealed.

Sec. 2. 22 MRSA §7301-A and §7301-B are enacted to read:

§7301-A. Purpose

It is declared to be the public policy of the State and the purpose of this subtitle to promote a system-based focus for providing a broad array of long-term care services that is consumer-driven, optimizes individual choice and maximizes the physical health, mental health, functional wellbeing and independence of older adults and adults with physical disabilities through high quality services and supports in settings that reflect the needs and choices of individual consumers and that are delivered in the most flexible, innovative and cost-effective manner.

§7301-B. Findings; Policy

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;

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; and

2. Policy. The Legislature declares that it is the policy of this State to promote a system-based focus for providing a broad array of long-term care services that is consumer-driven and that:

A. Maximizes consumer choice and autonomy throughout the continuum of long-term care services and increases the availability and percentage of adults with long-term care needs receiving quality in-home and community support services;

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

C. Promotes and encourages public and private partnerships throughout a variety of agencies, facilities and individuals to provide in-home and community support services;

D. Supports the role of family caregivers and a qualified workforce to streamline and facilitate access to quality in-home and community support services in the least restrictive and most integrative settings; and

E. Establishes the most efficient, innovative and cost-effective system for delivering a broad array of long-term care services.

Sec. 3. 22 MRSA §7302, sub-§ 5 is amended to read:

5. In-home and community support services. "In-home and community support services" means health and social services and other assistance required to enable adults with long-term care needs to remain in their places of residence. These services include, but are not limited to, medical and diagnostic services; professional nursing; physical, occupational and speech therapy; dietary and nutrition services; home health aide services; personal care assistance services; companion and attendant services; handyman, chore and homemaker services; respite care; hospice care; counseling services; transportation; small rent subsidies; various devices which lessen the effects of disabilities; and other appropriate and necessary social services.

Sec. 4. Planning for unified long-term care budget for services and supports to the elderly and adults with physical disabilities. The Department of Health and Human Services shall undertake a planning process for the adoption of a unified budget for long-term care services and supports for the elderly and adults with physical disabilities that will be complimentary to the State's vision for a consumer-centered approach to long-term care. The Commissioner of Health and Human Services, the Commissioner of Administration and Financial Services and the Office of Fiscal and Program Review shall work together to prepare a revised chart of accounts that will concentrate all long-term care services and supports accounts for the elderly and adults with physical disabilities in the Office of Elder Services, including program and administrative costs in the Office of Elder Services and excluding accounts in the Office of MaineCare Services, and accounts related to mental health, mental retardation and developmental disabilities. By January 1, 2010, the Commissioner of Health and Human Services and the Commissioner of Administrative and Financial Services shall submit a report to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services. The report must contain a plan for a unified budget that may be implemented by July 1, 2010.

Sec. 5. Adoption of long-term care priority; action. The Department of Health and Human Services shall adopt as a priority reduction of the waiting lists through the provision of services for home and community-based care and homemaker services for the elderly and adults with disabilities during fiscal year FY09 and elimination of the waiting lists through the provision of services in their entirety during the state fiscal years FY10 and FY11.

Sec. 6. Assistive technologies. The Department of Health and Human Services shall explore uses of and develop funding sources for assistive technologies to help accomplish the State's vision of long-term services and supports for the elderly and adults with physical disabilities. In doing this work the department shall consult with interested and

knowledgeable individuals and organizations and the Finance Authority of Maine regarding financing options for consumers through the Kim Wallace Adaptive Equipment Loan Program, now also known as mPower. By January 1, 2010, the Department of Health and Human Services shall report to the joint standing committee having jurisdiction over health and human services on the results of their work on assistive technologies.

Sec. 7. Alternative funding sources. The Department of Health and Human Services shall explore alternative non-MaineCare sources of funding for the service packages provided to residents in the seven tax credit-assisted assisted living facilities that currently utilize MaineCare funding, such alternative funding to be used in the event MaineCare funding is no longer available to ensure continuation of the service packages. By January 1, 2010 the department shall report to the joint standing committee having jurisdiction over health and human services on their work on exploring alternative funding sources for the service packages.

Sec. 8. Direct care worker training, compensation and benefits. The Department of Health and Human Services shall work with interested parties to develop a comprehensive and systematic approach to training, reimbursement and benefits for direct care workers in home and community-based care, residential facilities and nursing facilities and by December 1, 2009 shall report back to the joint standing committees having jurisdiction over appropriations and financial services and health and human services.

Sec. 9. Reversal of spending trend. The Department of Health and Human Services shall undertake efforts to reverse the spending trend in long-term care to increase the numbers of people served and dollars spent in home and community-based care as compared to the spending on residential care and nursing facility care and shall report annually on their progress by February 1 beginning in 2010 to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services.

Sec. 10. Improved discharge planning process. The Department of Health and Human Services shall undertake an effort in the assessment process for eligibility for long-term care services under the MaineCare program to improve the discharge planning process as it pertains to hospitals and long-term care facilities, including improving the provision of information to the consumer about facility-based and home and community-based options, improving consumer choice in the discharge process, increasing consumer counseling for those choosing self-directed care and education on the availability of hospice services when they might be appropriate. The department shall report to the joint standing committee having jurisdiction over appropriations and financial services and health and human services on work done with regard to this effort by February 1, 2010 and February 1, 2011.

Sec. 11. Aging and Disability Resource Centers. The Department of Health and Human Services shall work with the 5 Area Agencies on Aging to provide services through Aging and Disability Resource Centers on a statewide basis. The department shall provide funding as appropriated in this section. As a condition of receiving the funding the Area Agencies on Aging shall work with hospitals, nursing facilities and residential care facilities to improve the discharge planning process, including improving the provision of information to the consumer about facility-based and home and community-based options, improving consumer choice in the discharge process, increasing consumer counseling for those

choosing self-directed care and education on the availability of hospice services when they might be appropriate. The department shall report to the joint standing committee having jurisdiction over appropriations and financial services and health and human services on work done with regard to this the expenditures made under this section and the operations of the Aging and Disability Resource Centers by February 1, 2010 and February 1, 2011.

Appropriation

Department of Health and Human Services

Long-term Care Services

Provides funding for Aging and Disability Resource Centers in the 5 Area Agencies on Aging to provide information and referral services for the elderly and adults with physical disabilities and their families.

GENERAL FUND	**FY2009-10**	**FY2010-11**
All Other	$300,000	$300,000
TOTAL	$300,000	$300,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES		
TOTAL – ALL FUNDS	**$300,000**	**$300,000**

Sec. 12. Appropriation

Department of Health and Human Services

Long-term Care Services

Provides funding for the Priority Social Services program for critical needs services such as Meals on Wheels and the medical ride program.

GENERAL FUND	**FY2009-10**	**FY2010-11**
All Other	$500,000	$500,000
TOTAL	$500,000	$500,000

Department of Health and Human Services

Long-term Care Services

Provides funding for the family caregiver initiative that provides assistance to families of the elderly and adults with physical disabilities to enable them to remain in their homes.

GENERAL FUND	**FY2009-10**	**FY2010-11**
All Other	$200,000	$200,000
TOTAL	$200,000	$200,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TOTAL – ALL FUNDS	**$700,000**	**$700,000**

SUMMARY

This bill contains legislation suggested by the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care.

Sections 1, 2 and 3 of this bill relate to recommendation #1 from the Commission. Section 1 repeals the section of existing law governing the legislative intent, findings and policy for home and community-based long-term care services for the elderly and adults with physical disabilities that addresses legislative findings and policy. Section 2 enacts a new statement of purpose, and a new findings and policy section for in-home and community supports and services. Section 3 adds hospice services to the definition of in-home and community support services.

Section 4 directs the Department of Health and Human Services to undertake a planning process for the adoption of a unified budget for long-term care services and supports for the elderly and adults with physical disabilities. It directs the Commissioner of Health and Human Services, the Commissioner of Administration and Financial Services and the Office of Fiscal and Program Review to work together to prepare a revised chart of accounts and to report by January 1, 2010 to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services. The report must contain a plan for a unified budget that may be implemented by July 1, 2010.

Section 5 directs the Department of Health and Human Services to adopt as a priority reduction of the waiting lists for home and community-based care and homemaker services for the elderly and adults with disabilities during fiscal year FY09 and elimination of the waiting lists during the state fiscal years FY10 and FY11.

Section 6 directs the Department of Health and Human Services to work with interested persons and organizations and the Finance Authority of Maine to explore uses of and develop funding sources for assistive technologies and to report by January 1, 2010 to the joint standing committee having jurisdiction over health and human services.

Section 7 directs the Department of Health and Human Services to explore alternative non-MaineCare sources of funding for the service packages provided to residents in the seven tax credit-assisted assisted living facilities that currently utilize MaineCare funding, such alternative funding to be used in the event MaineCare funding is no longer available to ensure continuation of the service packages and to report by January 1, 2010 to the joint standing committee having jurisdiction over health and human services.

Section 8 directs the Department of Health and Human Services to work with interested parties to develop a comprehensive and systematic approach to training, reimbursement and benefits for direct care workers in home and community-based care, residential facilities and nursing facilities and to report by December 1, 2009 to the joint standing committees having jurisdiction over appropriations and financial services and health and human services.

Section 9 directs the Department of Health and Human Services to undertake efforts to

reverse the spending trend in long-term care to increase the numbers of people served and dollars spent in home and community-based care as compared to the spending on residential care and nursing facility care and to report annually by February 1 beginning in 2010 to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services.

Section 10 directs the Department of Health and Human Services to undertake an effort in the assessment process for eligibility for long-term care services to improve the discharge planning process as it pertains to hospitals and residential care facilities, including improving the provision of information to the consumer about facility-based and home and community-based options, improving consumer choice in the discharge process, increasing consumer counseling for those choosing self-directed care and education on the availability of hospice services when they might be appropriate and to report to the joint standing committees having jurisdiction over appropriations and financial services and health and human services by February 1, 2010 and February 1, 2011.

Section 11 directs the Department of Health and Human Services to work with the 5 Area Agencies on Aging to provide services through Aging and Disability Resource Centers on a statewide basis, provides $300,000 per year for this purpose and conditions funding on the funding on the Area Agencies on Aging working with hospitals, nursing facilities and residential care facilities to improve the long-term care discharge planning process. It directs the department to report to the joint standing committee having jurisdiction over appropriations and financial services and health and human services on work done with regard to this initiative by February 1, 2010 and February 1, 2011.

Section 12 provides funding for long-term care services for the elderly and adults with physical disabilities in the amount of $500,000 per year for the Priority Social Services program and $200,000 per year for the family caregiver program.