

Services for Elders and Other Adults Who Need Long-Term Home- and Community-Based Care

A Report to 124th Maine Legislature by the
Maine Department of Health and Human Services about
Four Related Pieces of Legislation (LDs 400, 1059, 1078 and 1364)

January 20, 2010

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Executive Summary

The following are recommended actions developed by two groups convened to address the provisions of the following four bills enacted and/or held over by the 124th Maine Legislature.

LD 400	An Act to Implement the Recommendations of the Blue Ribbon Commission to Study Long-term Home-based and Community-based Care. See Appendix 1 .
LD 1078	An Act to Strengthen Sustainable Long-term Supportive Services for Maine Citizens. See Appendix 2 .
LD 1059	Resolve to Enhance Health Care for Direct Care Workers. See Appendix 3 .
LD 1364	An Act to Stimulate the Economy by Expanding Opportunities for Personal Assistance Workers. See Appendix 4 .

The Department of Health and Human Services (DHHS) convened approximately 30 interested parties to learn about and analyze Maine's system of home- and community-based services. From these interested parties, a smaller 18-member Lean Core Team was formed to develop detailed objectives and propose a Lean Implementation Plan. The Lean Core Group met 9 times, in half day or all day meetings from August through December 2009. Work groups have begun to meet to address the Implementation Plan. See [Appendix 5](#).

DHHS also convened a Direct Care Worker Task Force to address worker-related issues identified in the four bills. See [Appendix 6](#). The Task Force included more than a dozen participants who met in five half-day meetings beginning in October 2009. This report includes some highlights from the Task Force. A more detailed report entitled "Report of Direct Care Worker Task Force" is available at <http://www.maine.gov/dhhs/reports/lfc-services-adults.shtml>.

Maine's economy and state budget challenges have an impact on the State's ability to implement all of the recommended improvements in home and community-based services resulting from the Lean process and the substantial efforts of the Direct Care Worker Task Force within the timelines specified in the legislation. Changes can and will be made now within the constraints of the budget. The financial environment encourages policymakers and lawmakers to think boldly about how best to address Mainer's needs for long-term care services. With the demographic elder wave, preferences of people who need or receive long-term services and supports, and the huge costs of long-term care, there is an urgent need to figure out how best to sustain these services not only today, but well into the future.

Recommendations

1. Balance the mix of services in Maine's system of long-term services and supports.

- a. Establish a global budget for long-term services and supports as a management tool for the allocation of resources.
- b. Establish the ratio (percent) of financial resources that Maine should commit to home- and community-based services and to institutional services. This should be consistent with federal health care reform proposals to increase the Federal Medical Assistance Percentage (FMAP) when a greater percent of long-term care expenditures are for home- and community-based services.
- c. Establish a long-term goal of 50% of total long-term care expenditures allocated to home- and community-based services.
- d. Fund home- and community-based services at a level that eliminates waiting lists.

- 2. Streamline Maine's system of home- and community-based services.**
 - a. Combine multiple existing programs into fewer programs to promote equity, facilitate portability among program choices and living arrangements and optimize service use by the person in need of services.
 - b. Create greater equity across long-term home-based programs in terms of financial eligibility requirements, types and amounts of services available, rates of reimbursement, and wages paid to direct care workers.
 - c. Design MaineCare-funded waiver and state plan programs and state-funded programs to include both agency-provided and self-directed services.
 - d. Identify opportunities for inclusion of independent support services (i.e. homemaker/IADL activities) as a MaineCare-funded service.
- 3. Develop a simple and unified self-directed model across programs with budget authority.**
 - a. Create a single model of self-direction based on best practices to be incorporated into all home- and community-based services.
 - b. Develop a single skills training curriculum for people participating in self-direction.
 - c. Include and consistently define surrogacy in all self-directed programs.
 - d. Develop "budget authority" within the self-directed options to allow greater flexibility for consumers in directing services to meet their needs.
 - e. Recognize and maximize elements of self-direction even for people who choose to have an agency deliver services.
- 4. Create and maximize flexibility in the planning and delivery of services.**
 - a. Allow greater flexibility in the implementation of service plans.
- 5. Maximize the ability of people to make informed choices.**
 - a. Create standard terms and definitions for services and programs.
 - b. Develop a public education campaign to inform people about home- and community-based services.
 - c. Develop clear, concise and easily understood guide and other resource materials for people seeking or receiving services.
 - d. Improve the awareness of options among all providers and during the discharge planning process (hospitals, physicians, etc.)
- 6. Design a quality management strategy across funding streams and population groups.**
 - a. Establish care coordination standards to maximize quality outcomes for people who receive services.
 - b. Develop/review protocols for scheduling and coordinating home visits by providers and care management agencies including at-risk criteria.
 - c. Establish maximum care coordination caseload ratios.
 - d. Continue to review/define conflicts of interest and potential for harm in at least the following areas: eligibility determinations, assessment, care plan authorization, service plan implementation, care coordination and service provision.
 - e. Enhance standards and training for all those who work in the long-term care system.
- 7. Optimize the independence of persons receiving services.**
 - a. Identify alternative funding opportunities.

- b. Identify gaps and needs for assistive technology.
- c. Identify resources for the Aging and Disability Resource Centers (ADRCs).

8. Improve the financial and functional eligibility determination processes.

- a. Educate assessors and eligibility workers about new program options.
- b. Develop information materials that will be shared at the time of assessment.
- c. Continue implementing process improvements in order to provide effective, efficient access to a new streamlined system.

9. Develop a clear, equitable, rational framework for direct care workers in terms of compensation, classification of job titles, and training and advancement.

- a. Achieve equitable wage levels across programs.
- b. Establish a statewide job classification system of direct care worker job titles, focusing on personal care jobs within the DHHS home- and community-based service programs.
- c. Develop a logical sequence of employment tiers, showing employment and training links among long-term care and acute care jobs—in both facilities and home-based services.
- d. In addition to DHHS, involve the Department of Education, the Board of Nursing, and the Department of Labor in the implementation of these actions.
- e. Ensure participation of direct care workers in the federal grant recently awarded to the Governor's Office of Health Policy and Finance to provide subsidies to help uninsured low income direct care workers, part-time workers, and seasonal workers pay for health insurance.

10. Assure consistency in rate-setting approaches and cost components across programs.

- a. Use common methods for inflation or other adjustments in rates.
- b. Include consistent cost components in rates (e.g. wages, benefits, training, travel, supervision, and administrative costs.)

1. Four Bills

Overview. Four key bills before the 124th Maine Legislature relate to home- and community-based services for adults with long-term care needs. The bills listed below have required the Maine Department of Health and Human Services (DHHS) to complete many inter-related tasks since June 2009 and to report back to the Legislature in early 2010.

LD 400	An Act to Implement the Recommendations of the Blue Ribbon Commission to Study Long-term Home-based and Community-based Care See Appendix 1 .
LD 1078	An Act to Strengthen Sustainable Long-term Supportive Services for Maine Citizens See Appendix 2 .
LD 1059	Resolve to Enhance Health Care for Direct Care Workers See Appendix 3 .
LD 1364	An Act to Stimulate the Economy by Expanding Opportunities for Personal Assistance Workers See Appendix 4 .

The 124th Legislature enacted LD 400 as PL 2009, Chapter 420 and LD 1078 as PL 2009, Chapter 279 and carried over LDs 1059 and 1364 with an expectation of reports by DHHS.

LD 400 (Chapter 420). This law directs DHHS to report to the Legislature's Appropriations and Financial Affairs Committee and Health and Human Services Committee about:

- ⇒ A comprehensive long-term care budget.
- ⇒ Progress on increased funding and access to home- and community-based services.

LD 400 also requires DHHS to report to the Health and Human Services Committee about:

- ⇒ Wait lists and strategies to eliminate them.
- ⇒ Funding sources for assistive technologies.
- ⇒ Comprehensive and systematic approach to training, reimbursement and benefits for direct care workers in home- and community-based care, residential care facilities and nursing facilities.
- ⇒ Work done on expenditures and operations of the Aging and Disability Resource Centers and efforts to improve the discharge planning process and provision of information to consumers and their families.

LD 1078 (Chapter 279). This law instructs DHHS to:

- ⇒ Convene a work group to meet at least three times, using a "disciplined improvement analysis and implementation" process to develop recommendations;
- ⇒ Report recommendations of the work group to the Health and Human Services Committee; and
- ⇒ Develop a plan for consolidated home-and community-based services to be implemented by 7/1/10.

The law requires the work group to develop recommendations relating to intake and eligibility determination, consumer assessment, development of plans of care, the definition of qualified providers, and the means to standardize rates and wages within the system. The law also requires the work group to review personal care services to determine the extent to which:

- ⇒ Consumers know about and have access to a full range of personal care service options;
- ⇒ Access to personal care services is expeditious;
- ⇒ Personal care services are delivered efficiently and in a manner that promotes maximum consumer choice;
- ⇒ Personal care services are transparent and easily understood by consumers and their families;
- ⇒ Personal care services are portable from one provider to another;
- ⇒ Personal care services are flexible to meet the needs of the consumer; and
- ⇒ Provider rates and worker wages are standardized to promote overall efficiency and ensure a sufficient number and quality of direct-care workers.

LDs 1059 and 1364. Two bills introduced during the First Regular Session of the 124th Maine Legislature were held over until a future session of the 124th. With regard to LD 1059, DHHS promised the Insurance and Financial Services Committee that it would research and report on Montana's model of providing health care for direct care workers and its applicability to Maine. With regard to LD 1364, which proposes standard administrative rates and wages at \$12/hour, DHHS promised the Health and Human Services Committee that it would review and report on wages and rates for direct care workers as part of its work on LD 1078.

2. Completing the Tasks Required by the Legislature

Lean Process. On August 11, 2009, approximately 30 interested persons gathered to learn about “Lean”, the improvement process to be used to analyze Maine's system of home and community-based services pursuant to Public Law 2009, Chapter 279 (LD 1078). The process involves three primary steps—mapping the “current state” of whatever area is under scrutiny, mapping the “desired future state”, and developing and carrying out an implementation plan to move from the current state to the future state. Lean is a process of continuous improvement, so the work is ongoing. During implementation, identified improvements are fleshed out, further refined, and carried out.

Because another Lean process was already underway to expedite the financial and level-of-care eligibility determination processes for people seeking home- and community-based services, this subsequent Lean process picked up on the steps in the process after a person seeking services has been determined financially and functionally eligible.

Lean Roles. As the “Lean Sponsor”, Muriel Littlefield, DHHS Deputy Commissioner for Integrated Services, had oversight of the process for LD 1078. As “Lean Manager”, Diana Scully, Director of the DHHS Office of Elder Services, had day-to-day responsibility for this process and was supported by Cheryl Ring of the DHHS Commissioner's Office. DHHS Lean Staff Walter Lowell, PhD, and Lita Klavins served as the “Lean Facilitators”, guiding participants through the process. Julie Fralich, Elise Scala and other staff from the Muskie School, University of Southern Maine, gathered and provided information from other states and the Federal Government relating to the issues discussed during the Lean process.

The Lean Core Team. In September 2009, DHHS convened an 18-member Lean Core Team to examine and identify improvements in the process a person experiences to receive home- and community-based services. See Appendix 5. To inform the work of the Core Team, DHHS convened a half-day Consumer Focus Group. Next, the Core Team held 4 full-day and 3 half-day meetings to identify the current state, desired future state, and process improvements. The

Team reported its findings to Lean Sponsor Muriel Littlefield on December 1, 2009 and has organized into implementation groups to tackle a number of implementation tasks. Implementation groups have already met a number of times to begin their work. Please see <http://www.maine.gov/dhhs/reports/ltc-services-adults.shtml> for more information about the Lean process.

The Direct Care Worker Task Force. In October 2009, DHHS convened a 17-member Direct Care Worker Task Force, which held five half-day meetings to address inter-connected issues raised in the 4 bills. See [Appendix 6](#). The Muskie School's Elise Scala provided extensive support to the Task Force, sharing comprehensive information about job and training requirements for various types of direct care workers, wages paid to direct care workers, and rates paid to various types of providers who hire the workers. The Task Force also brought in other resource people. During one meeting, they met with DHHS rate-setting staff to discuss current rate-setting methodologies and rate structures. In another meeting, the Task Force met with Trish Riley, the Governor's Director of Health Policy and Finance, to discuss the federal grant received to provide a subsidy for health care benefits for direct care workers and part-time workers in Maine. The Task Force also connected with people in Montana to learn more about how they provide health care coverage to direct care workers. Please see <http://www.maine.gov/dhhs/reports/ltc-services-adults.shtml> for more information about the Worker Group.

The Lean Implementation Plan. The Lean Core Team developed an Implementation Plan with 15 specific objectives. The Team identified responsible persons and due dates for each of the objectives. *The deadlines are intended to assure that new rules will be proposed by mid-March with the target implementation date of July 1, 2010, as specified by LD 1078.* See [Appendix 7](#).

Discharge Planning. PL 2009, Chapter 420 (LD 400) requires DHHS to report on efforts to improve the discharge planning process and provision of information to consumers and their families. The Lean Core Team discussed the importance of making sure hospitals, physicians and families are aware of the range of service options during the discharge planning process. DHHS addressed issues relating to discharge planning through a separate stakeholder group first organized during the 123rd Legislature pursuant to LD 335 (2007 Resolves, Chapter 61) and now continued by the 124th Legislature pursuant to LD 1245 (2009 Resolves, Chapter 122). This other group will submit a separate report to the 124th Legislature about these critical issues.

Other Legislative Requirements. DHHS has been working on a number of additional tasks identified in PL, Chapter 420:

- ⇒ Development of a comprehensive budget presentation for long-term care services and supports that is complementary to the State's vision for a consumer-centered approach to long-term care. See [Appendix 8](#).
- ⇒ Review of progress on funding and access to home- and community-based services, including the status of wait lists and strategies to eliminate them. See [Appendix 9](#).
- ⇒ Identification of possible funding sources for assistive technologies and Aging and Disability Resource Centers. The Lean Core Group has an Implementation Team that is working on using existing funding sources to access assistive technology. Last summer DHHS applied for and received federal grants to provide funding for the Aging and Disability Resource Centers. See also the DHHS response to Recommendation 5 in the next section.

3. Recommendations Flowing from the Lean Process

Many Areas of Consensus. There was a high degree of consensus about key aspects of home- and community-based services among the many members of the Lean Core Team who devoted days of hard and thoughtful work and good will to the process of responding to the four pieces of legislation. For example, team members agreed that:

- ⇒ There should be better balance in Maine's system of long-term services and supports between institutional services and home- and community-based services.
- ⇒ There should be more equity across long-term care programs in terms of financial eligibility requirements, types and amounts of services available, rates of reimbursement, and wages paid to direct care workers.
- ⇒ There should be fewer programs that may be achieved by combining multiple programs into comprehensive programs.
- ⇒ There should be much greater flexibility for people in directing their services in terms of the types and schedule of services they receive and tasks to be completed.
- ⇒ A single self-directed model based on best practices should replace the current different self-directed programs and should be incorporated into all home and community-based programs. The improved model should include the use of "surrogates" to assist those unable to direct their own care with provision to protect the health and safety of the person receiving the services. Self-direction for all personal care should be integrated into overall care even if a person chooses services delivered by an agency.
- ⇒ There should be "budget authority" for people receiving home and community-based services. This means that within parameters defined by the State, people should be allowed to decide how to spend funds authorized to address their personal care needs in order to remain at home, again with built-in protections to assure their health and safety.
- ⇒ People should receive full and easily understood information about options in order to make informed choice throughout the process of applying for and receiving long-term services and supports. People should have information before they even apply for services. A key component should be options counseling by Maine's Aging and Disability Resource Centers. Clear, concise, and easily understood printed materials should be combined with ready and easy access to services.
- ⇒ Care coordinators should function as navigators, available both while people are receiving services at home and if they are moved in and out of hospitals and/or long-term care facilities.
- ⇒ Funding resources should facilitate greater use of technology, including low tech adaptations as well as developing high tech services and tools to maximize and support independence.
- ⇒ It is important to marshal private resources to support persons who need long-term services and supports, because public resources are insufficient. These include natural community and faith-based connections, as well as peer networks.
- ⇒ The assessment process, which includes a focus on the strengths of a person, should be expanded to look at what services or tools the person needs to live as independently as possible.

- ⇒ With regard to direct care workers, there should be fewer categories of workers; training modules that allow career choices and options; and consistency in basic skills required to provide care and in worker wages, benefits and training requirements.
- ⇒ Rate structures for home- and community-based services across all the programs should include the same components (e.g. wages, benefits, training, travel, supervision.)

Recommendations, Discussion and Response. A discussion of recommendations and the response by DHHS follows. The original 15 objectives from the Lean Implementation Plan shown in Appendix Z have been reordered and, in some instances, combined for ease of reading. The objective number from the Implementation Plan is indicated in parentheses after each recommendation stated in **bold** below.

1. Balance the mix of services in Maine's system of long-term services and supports.
(Objective 4)

- a. Establish a global budget for long-term services and supports as a management tool for the allocation of resources.
- b. Establish the ratio (percent) of financial resources that Maine should commit to home-and community-based services and to institutional services. This should be consistent with federal health care reform proposals to increase the Federal Medical Assistance Percentage (FMAP) when a greater percent of long-term care expenditures are for home-and community-based services.
- c. Establish a long-term goal of 50% of long-term care expenditures allocated to home-and community-based services.
- d. Fund home- and community-based services at a level that eliminates waiting lists.

Discussion. One of the Lean Implementation Groups met a few times to discuss the issue of balancing the mix of institutional and home- and community-based resources in Maine's system of long-term services and supports. The group examined a number of articles¹, reports² and power point presentations from other states (e.g. Ohio, Vermont, Oregon, Washington, New Jersey and Colorado) on the rationale and usefulness of creating a unified long-term care budget, also referred to as a global budget. They also held a conference call with the Director of the Area Agencies on Aging in Ohio, a state with recent experience in the adoption of a unified LTC budget approach.

The group discussed some of the key reasons for establishing a global budget. A report from AARP provided the following rationale for a global budget:

Consolidation (of LTC services) and global budgeting facilitate consumer choice and access to a variety of LTC service options by allowing program administrators to move LTC dollars among institutional and community-based programs. Global budgeting gives responsibility for the budgets of all LTC programs to a single administrative unit. It allows financing to follow clients through the system as their needs and preferences change over time. (Fox-Grage, p. 5)

¹ Wendy Fox-Grage, Barbara Coleman, and Dann Milne, Pulling Together: Administration and Budget Consolidation of State Long-Term Care Services, AARP Public Policy Institute, 2006. www.aarp.org/ppi

² Leslie Hendrickson and Susan Reinhard, State Policy in Practice -- Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices, Rutgers Center for State Health Policy, <http://www.hcbs.org/moreInfo.php/doc/998>

³ Building a Cost-effective, Consumer-friendly Long-term Services and Support System: Final Report of the Unified Long-Term Care Budget Workgroup http://aging.ohio.gov/resources/publications/ULTCB_final_report.pdf

The group recommends the establishment of a global budget for long-term services and supports as a tool for managing and balancing the allocation of resources in Maine.

The group also discussed developments at the national level that will have a bearing on the mix of home- and community-based versus institutional services provided in Maine. Provisions included in the Senate version of the Health Care Reform bill create a number of incentives for states to increase the proportion of long-term care expenditures spent on home- and community-based services. Under this proposal, states will receive increases in Federal Medical Assistance Percent (FMAP) if they meet certain targeted spending percentages by 2015 (e.g. 25% and 50% of long-term care spending). States also will have to meet other structural requirements related to a single entry point system, conflict-free care management, and core standardized assessment instruments.

The recommendations described above position Maine to be eligible to receive enhanced federal funding if the Senate version of the health care reform bill passes. Even without passage of such provisions, the group supports creation of a global budget as one of a number of tools to balance the long-term care system.

It was also noted that there are great differences across states in how nursing facility eligibility is defined, how home- and community-based services waivers under Medicaid are administered, and the type and mix of home care services that are funded under a Medicaid program. It will be important for the State of Maine to follow and comment on proposals at the national level with respect to the definition of home versus institutional services and the impact such definitions will have on Maine. The group discussed the importance of clarifying the definition of institutional versus in-home services and supports. The group considers residential care services to be in the category of "institutional" versus "in-home" services.

The group reviewed information about waiting lists for home-based services. They reached consensus "that waiting lists and recent decisions to suspend assessments to determine eligibility of need demonstrate an ongoing lack of available resources for individuals who require home and community based services."

DHHS Response. If the Legislature agrees with the global budget recommendation, DHHS will be able to recommend a structure for the budget.

DHHS agrees with the actions to move toward a more balanced system of publicly funded long-term care services and agrees that it is important to define "institutional versus in-home" services. DHHS also agrees that many residential care facilities are institutional in nature. As part of its federal State Profile Tool Grant, DHHS project staff are reviewing criteria and developing a tool for conducting an inventory of residential care facilities in Maine. The issue is more complex than identifying size of facility or number of beds/apartments. Other important factors include: access to privacy; single or private rooms; whether access to housing is contingent upon need for services etc. Some residential care facilities are institutional in nature, while others are not. In establishing a ratio of financial resources committed to home- and community-based services as compared to institutional services, it will be important to categorize residential care facilities appropriately.

DHHS agrees that the State should take full advantage of increases in FMAP rates, if enacted as part of health care reform, and will make every effort to do so. DHHS is pleased to see the Federal Government's interest in providing incentives for states to work toward a more balanced long-term care system, because federal policies add to the challenge of accomplishing this. For example, under the federal Medicaid Program, nursing home care is a mandatory service that

every state must provide, and all cost centers (including room and board) are matched by federal dollars. However, home-based services and residential care are optional services that states may provide, and only service-related cost centers may be matched by federal dollars. Also, under Medicaid, penalties must be assessed for individuals who transfer assets in order to avoid paying for nursing home care out of their own pockets. These penalties do not apply to the vast array of community services, which include residential care and home-based services. DHHS will examine how such financial eligibility policies affect the balance of long-term care services in Maine by creating incentives or disincentives to seek one type of care over another based on interest in preserving a family's personal resources rather than on the long-term care needs of the person.

Given the current economy and lagging state revenues, DHHS will not be able to accomplish the elimination of waiting lists for state-funded home-based services at present. However, DHHS would like to note that the Office of Elder Services has pursued several federal and private grants aggressively and successfully. These include grants for Aging and Disability Resource Centers to provide access and options counseling for long-term services and supports, the Community Living Program to help divert people from long-term care facilities and avoid "spending down" to MaineCare, several evidence-based healthy aging programs to help people remain healthier longer, support for family members who care for loved ones with dementia, and more.

2. Streamline Maine's system of home- and community-based services. (Objective 1)

- a. Combine multiple existing programs into fewer programs to promote equity, facilitate portability among program choices and living arrangements, and optimize service use by the person in need of services.
- b. Create greater equity across long-term home-based programs in terms of financial eligibility requirements, types and amounts of services available, rates of reimbursement, and wages paid to direct care workers.
- c. Design MaineCare-funded waiver and state plan programs and state-funded programs to include both agency-provided and self-directed services.
- d. Identify opportunities for inclusion of independent support services (i.e. homemaker/IADL activities) as a MaineCare-funded service.

Discussion. Maine's system of long-term care services has evolved over many years. In more recent years, the option to self-direct services has been added to a number of programs. Maine has one waiver for adults with physical disabilities, which is exclusively for people who choose to self-direct their personal care services. Maine has another waiver for older adults and adults with disabilities that offers a self-directed option with the use of surrogacy, called the Family Provider Service Option. This waiver includes a greater range of services—personal care, nursing services, transportation, home modifications, and others.

People also may choose to self-direct services under two programs funded by the MaineCare State Plan and under three state-funded programs. One of the State Plan programs and one of the state-funded programs include a range of services; the others include personal care and/or homemaker services.

The Core Lean Team recommends that DHHS redesign these programs as follows:

- ⇒ The two MaineCare waivers should be redesigned and combined to include both agency and self-directed options and both should allow the use of surrogacy under the self-directed option.

- ⇒ The two MaineCare State Plan programs should also be combined and redesigned to include the full range of home-based services and should include both agency and self-directed options.
- ⇒ The two state-funded home based care programs—one for elders and others with disabilities and one for self-directed services—should be redesigned and combined to include both agency and self-directed options.

In addition, the Core Lean Team recommends that certain homemaker activities should be included as covered services under MaineCare rather than through only the state-funded Independent Support Services program.

DHHS Response: DHHS commits to implementing actions during 2010 that do not require additional resources and are allowable under federal Medicaid law and regulations.

3. Develop a simple and unified self-directed model across programs with budget authority.

(Objective 2)

- a. Create a single model of self-direction based on best practices to be incorporated into all home- and community-based services.
- b. Develop a single skills training curriculum for people participating in self-direction.
- c. Include and consistently define surrogacy in all self-directed programs.
- d. Develop “budget authority” within the self-directed options to allow greater flexibility for consumers in directing services to meet their needs.
- e. Recognize and maximize elements of self-direction even for people who choose to have an agency deliver services.

Discussion. As noted above, Maine’s system of long-term services and supports includes the option to self-direct services within a number of its programs. A number of core features of these self-directed models vary across programs. Elements that vary include: the entity responsible for financial management of services, the ability to use a surrogate to self-direct services, the services that are available, the curricula for skills training, and the reimbursement structure.

None of the current models includes “budget authority”. Budget authority means that a person may be provided with an individual budget that includes some or all of the funding that has been authorized for his or her home- and community-based services. Within this budget, the person may purchase individually selected goods and services. With the assistance of counselors and a financial management services entity, the person assumes responsibility for managing his/her individual budget. Within the boundaries of the authorized budget, s/he may specify the services to be provided, schedule the services to meet his/her needs, and establish the qualifications of workers or agencies to provide services.⁴

There was a high degree of consensus among the members of the Lean Core Group that there should be a single model of self-directed care with greater consistency in the design and administration across the system of Maine’s system of long-term services and supports.

DHHS Response: DHHS commits to implementing these actions during 2010.

4. Create and maximize flexibility in the planning and delivery of services. (Objectives 5, 6, 11)

- a. Allow greater flexibility in the implementation of service plans.

⁴ Excerpt from *Developing and Implementing Self-Direction Programs and Policies; A Handbook*.

Discussion. The Core Lean Team identified a number of ways the system could be made more flexible in the development of care plans and the implementation of the services authorized in the care plans. Providers proposed a number of changes that would improve the responsiveness and efficiency of the system. The details of increasing this flexibility will be further refined during the implementation of new rules.

DHHS Response. DHHS agrees with these actions.

5. Maximize ability of people to make informed choices. (Objectives 3, 7)

- a. Create standard terms and definitions for services and programs.
- b. Develop public education campaign to inform people about home- and community-based services.
- c. Develop a clear, concise and easily understood guide and other resource materials for people seeking or receiving services.
- d. Improve awareness of options among all providers and during the discharge planning process (e.g. hospitals, physicians, etc)

Discussion. The ability of consumers to make informed choices starts with the availability of the right information at the right time. Many expressed the need for a public education campaign that would inform the general public of the long-term services and supports that are available and where to get further information about those options. The complexity of the services, eligibility requirements and funding sources further compromises the ability of people to make informed choices.

Particular concern was expressed over the need to inform key providers (e.g. hospital discharge planners, physicians, LTC facilities) of the expanding role of the ADRCs to provide options counseling, the role of the Good Health Systems assessors, and the home- and community-based programs that are available.

DHHS Response. During the summer of 2009, the Office of Elder Services applied for three federal grants from the Administration on Aging relating to home and community based services. Many of the activities outlined in these grants will facilitate the implementation of actions to improve informed choice.

Two of the grants will provide funds to support options counseling and other outreach activities:

- ⇒ An Aging and Disability Resource Center Grant that provides funding to all five of Maine's area agencies on aging to provide options counseling regarding home- and community-based services, thereby increasing access to these services for elders and people with disabilities. LD 400 required DHHS "as resources permit...[to] work with the 5 area agencies on aging to identify and seek federal or other appropriate funding sources to provide services on a statewide basis through the Aging and Disability Resource Centers." Securing these federal grant dollars is a tangible demonstration of carrying out this task.
- ⇒ A Community Living Program Grant that provides funding to four of Maine's area agencies on aging (one chose not to participate) to individuals who are not eligible for Medicaid but who need long-term services and supports. This grant also opens up the opportunity for funding from the Veterans Administration to provide home and community-based services for veterans. This grant also increases the capacity of the area agencies on aging to provide options counseling for elders and people with disabilities who are at risk of "spending down" to MaineCare and who are at risk of admission to a nursing facility or a residential care facility.

The third grant will support the development of self-directed services for people with dementia through the use of family members and other surrogates.

6. Design a quality management strategy across funding streams and population groups.

(Objectives 8, 14)

- a. Establish care coordination standards to maximize quality outcomes for people who receive services.
- b. Develop/review protocols for scheduling and coordinating home visits by providers and care management agencies including at-risk criteria.
- c. Establish maximum care coordination caseload ratios.
- d. Continue to review/define conflicts of interest and potential for harm in at least the following areas: eligibility determinations, assessment, care plan authorization, service plan implementation, care coordination and service provision.
- e. Enhance standards and training for all those who work in the long-term care system.

Discussion. The importance of assuring the quality of the home care system was a consistent theme throughout Lean discussions. Case managers play a critical role in assuring quality. The Core Lean Team identified a number of areas where improvements could be made in care management functions. This included the development of care management standards that would more clearly define roles and responsibilities, functions, caseloads, and training. There was concern about the size of current caseloads—more than 100 individuals per case manager for Elder Independence of Maine and close to 70 individuals per Independent Living Specialist for Alpha One.

The Core Lean Team acknowledged that multiple checks and balances are built into the system for monitoring quality. While case managers play a key quality oversight role, provider agencies and their direct care workers have the most direct day-to-day contact with people receiving services and are a first line of quality assurance. Protocols for more efficiently scheduling home visits and identifying people at greater risk and in greater need of home visits were recommended.

A critical area where consensus was not reached relates to the provision of care management by service providers. Two of the Lean Implementation Groups noted that proposed provisions in the Senate version of the health care reform bill include a number of requirements that a state must meet in order to receive enhanced Federal Medical Assistance Percentage (FMAP) for home and community based services. In addition to meeting certain target percentages of spending on home- and community-based services, a state must submit an application and include:

- ⇒ A single entry point system (through an agency, organization, coordinated network or portal).
- ⇒ Conflict-free care management.
- ⇒ Core standardized assessment instruments.
- ⇒ Data collection (service data, quality data, outcomes measures).

DHHS Response. DHHS will implement these actions, consistent with the quality and conflict-free requirements included in health care reform legislation, whether or not the legislation is enacted, and within the availability of public resources.

7. Optimize independence of persons receiving services. (Objective 9)

- a. Enhance options for assistive technology across programs.
- b. Identify alternative funding opportunities.
- c. Identify gaps and needs for assistive technology.

Discussion. The Core Lean Team recognizes the benefit of providing assistive technology as a covered service under home and community-based programs. Advances in technology have created many products that increase a person's independence, allowing him/her to remain at home. As a starting point, the Lean Implementation Plan proposes introducing assistive technology as a covered service under the state-funded program and incorporating its use under the budget authority component of the new consumer-directed programs.

DHHS Response: DHHS is committed to increasing the use of assistive technology to help address the personal care needs of individuals who need long-term services and supports within available resources.

8. Improve the financial and level of care eligibility determination processes.

- a. Educate assessors and eligibility workers about new program options.
- b. Develop information materials that will be shared at the time of assessment.
- c. Continue implementing process improvements in order to provide effective, efficient access to new streamlined system.

Discussion. The Core Lean Team recognized that its scope of work did not include determination of financial and functional eligibility addressed in a previous and ongoing Lean process. However, the Team recommends that people responsible for the financial and functional processes be included in any training activities or development of informational brochures, since they often are the first to have contact with the person seeking services.

DHHS Response: DHHS commits to taking these actions recommended by the Core Lean Team. Some members of the Core Team questioned whether the earlier Lean process that focused on eligibility has resulted in any changes. The answer is yes. For example:

- ⇒ An electronic process for sharing assessment information that replaces the current manual process is being piloted in the DHHS district office in Augusta.
- ⇒ Communications regarding classification assessment outcomes between the Office of Elder Services and Good Health Systems has been automated.
- ⇒ Communications protocols have been established between the Office of Elder Services, Good Health Systems, Office of Integrated Access and Support, and MaineCare to improve coordination of service delivery.
- ⇒ Training has been provided to DHHS long-term care workers in order to expedite financial eligibility determination in complex cases.
- ⇒ Improvements implemented so far have enabled DHHS to serve more consumers without increasing administrative costs.

Other changes recommended as a result of the previous Lean process have not been implemented yet because of lack of resources (e.g. modifications in the ACES information system) or because they must coincide with implementation of the new Maine Integrated Health Management System (MIHMS).

9. Develop a clear, equitable, rational framework for direct care workers in terms of compensation, classification of job titles, and training and advancement.

- a. Achieve equitable wage levels across programs.
- b. Establish a statewide job classification system of direct care worker job titles, focusing on personal care jobs within the DHHS home- and community-based service programs.
- c. Develop a logical sequence of employment tiers, showing employment and training links among long-term care and acute care jobs—in both facilities and home-based services.
- d. In addition to DHHS, involve the Department of Education, the Board of Nursing, and the Department of Labor in the implementation of these actions.
- e. Ensure participation of direct care workers in the federal grant recently awarded to the Governor's Office of Health Policy and Finance to provide subsidies to help uninsured low income direct care workers, part-time workers, and seasonal workers pay for health insurance.

Discussion. An estimated 22,000 people in Maine are currently employed in jobs providing personal care, aide, and support services to elders and people with disabilities living in their homes and communities, and in residential and nursing care facilities. With growth of the direct care/support workforce projected to reach 30,000 in the next 10 years, Maine will need to identify and implement systemic approaches to fully utilize its current workforce, and to recruit, train and retain new people if it expects to have the number and quality of direct care workers needed. Please see the separate report by the Direct Care Worker Task Force.

The Direct Care Worker Task Force was convened by DHHS to review LDs 400, 1078, and 1364 to recommend changes to direct care worker employment policies and training programs, and to gather information about a health insurance demonstration project for LD 1059. Worker and provider members agreed that deliberate and systematic changes are necessary to resolve the issues of too many different job titles, varied qualification and training requirements, financial barriers to training and health benefits, training credentials that are not recognized or transferable across programs, and inconsistent and inequitable wages and benefits. The Task Force reviewed DHHS personal care services, program rules, workforce titles, training and wages, and health insurance proposals.

DHHS Response. DHHS generally supports these actions within the constraints of funding, statutes and regulations. There is insufficient information regarding the proposed multi-departmental mechanism for DHHS to take a position on that particular item.

With regard to LD 1059, the Legislature's Insurance and Financial Services Committee was interested in the Montana's use of Medicaid to cover the costs of health insurance for some direct care workers. However, funding is not currently available to increase rates paid to providers with direct care workers because of the economy. Fortunately, as a result of the leadership and efforts of the Governor's Office of Health Policy and Finance, the grant from the Health Resources and Services Administration provides a starting point opportunity for helping at least some direct care workers pay for health care benefits through subsidies.

10. Assure consistency in rate-setting approaches and cost components across programs.

- a. Use common methods for inflation or other adjustments in rates.
- b. Include consistent cost components in rates (e.g. wages, benefits, training, travel, supervision, and administrative costs.)

Discussion. During one of its meetings, the Direct Care Worker Task Force met with DHHS rate-setting staff to discuss current rate-setting methodologies and rate structures. The Task Force learned that the method of setting and managing reimbursement rates for direct care workers varies across programs. The variations include:

- ⇒ The rate-setting structure itself—the method/formula used to set provider payment/service reimbursement rates (e.g. prospective versus cost reimbursed; case mix adjusted versus flat rate/ base rates and procedure code rates, agency rate versus worker wage rate).
- ⇒ The cost components included in the rate- categories and amounts (e.g. wages, benefits, training, travel, supervision, administrative costs, and other discretionary costs).
- ⇒ The frequency and method for reviewing rates and options for providers to request a review (inflation, COLA adjustments, provider input).
- ⇒ Requirements for providers to submit financial reports, like cost reports, that can be used to monitor costs, adequacy of rates, financial status of providers, and possibly workforce information (staffing levels, turnover, retention, etc).

The Maine Legislature's role in reviewing, setting/changing rates, structure and related rules is a default system that responds to targeted initiatives directed by a variety of groups or individuals. Over time, the targeting of select programs, the timing, types and amount of the changes requested and approved, and the variations in the budget environment allows for widening variations across programs.

DHHS Response. DHHS generally agrees with these recommendations and will work toward implementation within the constraints of funding. While it does not seem to be the right time here in Maine to add to our rate-setting resources, these functions are important to the development of DHHS and its capacity to respond to and take the lead on issues such as these.

4. Some Closing Thoughts by DHHS

July 1 Implementation. Public Law 2009, Chapter 279 (LD 1078) requires DHHS to implement coordinated in-home and community support services for elders and adults with disabilities by July 1, 2010. DHHS has already begun the policy work required to make changes recommended through the Lean process. For MaineCare-funded programs, the federal Centers for Medicare and Medicaid Services (CMS) will need to approve at least some of the changes. It will be simpler to make changes in the state-funded programs. DHHS anticipates that some of the work can be completed by July 1, 2010, but certainly not everything will be in place by then. Any steps taken by DHHS to implement Lean recommendations and the provisions of Chapter 279 must take into account the broader plan of DHHS to pursue managed care for MaineCare-covered services, including long-term care.

Lack of Clarity. Certain provisions of Chapter 279 are not clear. The new law specifies that "The program must have a unified system for intake and eligibility determination for all consumers, regardless of diagnosis, type of disability or demographic factors, including age, using the multi-disciplinary teams pursuant to section 7323, consumer assessment and the development of plans of care that take into consideration the consumer's living arrangement, informal supports and services provided by other public or private funding sources to ensure non-duplication of services for consumers."

DHHS does not understand what is meant by a "unified system of intake and eligibility determination." As described below, DHHS already has a contract with a single statewide entity to perform functional assessments for people applying for long-term care services.

It also is not clear to DHHS what is intended by the reference to Section 7323. Enacted in 1981 as part of the original Home-Based Care Act, this section requires DHHS to designate several multi-disciplinary teams throughout the State to assist with evaluations of adults with long-term care needs. The teams are required to:

- ⇒ Include at least one social services or health care professional and, whenever possible, the person and his/her family member or other representative.
- ⇒ Develop a plan of services for the adult with providers of services;
- ⇒ Arrange for needed services;
- ⇒ Re-evaluate the person periodically to determine his continuing need for services; and
- ⇒ Consult when possible with the person's attending physician, if any.

Since the mid-1990s, DHHS has implemented a two-step assessment and care management process for each person who seeks home- and community-based services. DHHS has implemented Section 7323 through this process. Nurse assessors in every part of the state meet with the person, his/her designated family member and/or other party. Working with providers and consulting with physicians are key components of care management. Avoiding duplication is a key aspect of both steps.

Current System. For the time being—at least until managed care is ready to go—DHHS plans to improve but continue using its current system, as follows:

- ⇒ The assessment process is completed through a contract with a statewide independent assessing agency (Goold Health Systems), which acts as an agent of the State. Based on the functional/medical needs of each person, the assessing agency informs the person about the service options available and authorizes a plan of care including the type and level of services for which s/he is eligible. A nurse assessor travels to wherever the person resides (e.g. at home, in the hospital, or at a long-term care facility) to perform the assessment, which takes an hour and a half to two hours to complete. [Note: This process applies to all applicants for long-term care services, including facility-based care and home- and community-based services. Approximately 18,000 face-to-face assessments are performed each year.]
- ⇒ For individuals determined eligible for home and community-based services, the independent assessing agency refers each person to one of two contracted agencies operating on a statewide basis for help with care management:
 - Elder Independence of Maine (EIM) helps approximately 4,000 elders and adults in need of long-term care get linked to and receive a broad range of home and community-based services. EIM recruits a network of providers and assures their quality on behalf of DHHS. The providers include 43 personal care agencies, 19 adult day providers, 55 facility-based respite care providers, 19 home health agencies (nursing, therapies, home health aides); 26 providers of emergency response services, and others (independent RNs, home modifications, and medical-related transportation). EIM also helps link persons to the services they need and choose, bills MaineCare on behalf of providers in the network, and performs administrative functions on behalf of DHHS.
 - Alpha One helps more than 600 adults with disabilities to self-direct the personal care services they receive. Alpha One provides skills training to help people hire and manage their personal care attendants and provides support to help people live independently.

There is also a state-funded Independent Support Services Program (formerly known as the Homemaker Program) to which the assessing agency refers eligible individuals. Provided

through a contract with Catholic Charities Maine, these services help approximately 1,800 people.

New MaineCare Rule. Under a proposed MaineCare rule that will take effect during the Spring of 2010, care management services will be called "care coordination". DHHS has developed these proposed rules in order to have "unbundled" rates (e.g. rates for services and rates for administrative tasks) and to assure that people seeking and receiving services have choice. Qualified agencies approved by DHHS will provide care coordination in order to:

- ⇒ Assure that each person:
 - Is offered choices in service delivery based on his/her needs, preferences, and goals;
 - Is assisted with locating service providers; and
 - Receives appropriate, effective and efficient services, which allow him/her to retain or achieve the maximum amount of independence possible and desired;
- ⇒ Oversee the appropriateness of the plan of care by regularly obtaining feedback from the person receiving care and monitoring the person's health status.

Solid Building Blocks. DHHS believes that there are solid building blocks for Maine's system of home- and community-based services. These include the independent assessment and care coordination to help each person receive the level and types services s/he needs to remain at home.

Some have proposed the consolidation of these functions with service provision. While this idea may seem to be conceptually appealing as a way to target more public dollars on services and increased wages for direct care workers, DHHS does not support this. DHHS certainly hopes that there will be more public dollars for services and wages some day in the not-too-distant future, but it has not seen evidence that such consolidation would save money. To the contrary, if assessment and/or care management are consolidated within agencies that provide services, DHHS will need more resources to perform increased oversight in order to assure quality and manage the conflicts of interest inherent in such a system.

With contract incentives encouraging timely assessments and reliance on technology for information transfer, the current system of assessment and care coordination is quite efficient and cost-effective. For a small state like Maine, such a centralized system makes economic sense. Maine's current system assures that decisions are made uniformly and fairly throughout the State and that all services are prior authorized by an independent entity. With the implementation of improvements identified through the Lean process, the system will be even better.

DHHS is currently examining models of managed care that could be used for MaineCare services. Thus, DHHS believes that any systemic changes to be made in Maine's long-term care system must occur in the context of this broader picture. The assessment and care coordination building blocks already in place for home- and community-based services are quite consistent with a managed care system. Meanwhile, for equity and cost-containment reasons, DHHS believes it would be irresponsible to eliminate these crucial resource management functions or hand them over to providers that have an inherent conflict of interest regarding the type and amount of services they provide.

Appendix 1

Public Law 2009, Chapter 420

**LD 400. An Act to Implement the Recommendations
of the Blue Ribbon Commission to Study
Long-term Home-based and Community-based Care**

Sponsored by Senator Margaret Craven

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

Whereas, citizens of the State who are elderly or who are adults with physical disabilities are in need of services, as evidenced by the waiting lists in November 2008 containing 870 persons for homemaker services and 375 persons for home-based care services; and

Whereas, the Federal Government has discontinued funding for the Aging and Disability Resource Centers that have been providing information to the elderly and adults with disabilities and their families; and

Whereas, the agencies and programs that provide the needed services lack the resources to serve the persons waiting for services and require immediate appropriations of funding to meet those needs; 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 enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA§7301, sub-§2, as enacted by PL 1981, c. 511, §1, is amended to read:

2. Policy. The Legislature declares that it is the policy of this State, with regard to in-home and community support services:

- A. To increase the availability of in-home and community support services long-term care services that are consumer-driven, optimize individual choice and autonomy and maximize physical health, mental health, functional well-being and independence for adults with long-term care needs through high-quality services and supports in settings that reflect the needs and choices of consumers and that are delivered in the most flexible, innovative and cost-effective manner;
- B. That the priority recipients of in-home and community support services, pursuant to this subtitle, ~~shall must be the elderly and disabled adults with long-term care needs who are at the greatest risk of being, or who already have been, placed inappropriately in an institutional setting without needed in-home and community support services; and~~
- C. That a variety of agencies, facilities and individuals ~~shall must~~ be encouraged to provide in-home and community support services and to increase the percentages of adults with long-term care needs receiving in-home and community support services;

- D. To promote and encourage public and private partnerships among a variety of agencies, facilities and individuals;
- E. To support the roles of family caregivers and a qualified workforce in the effort to streamline and facilitate access to high-quality services in the least restrictive and most integrated settings; and
- F. To establish the most efficient, innovative and cost-effective system for delivering a broad array of long-term care services.

Sec. 2. 22 MRSA §7302, sub-§5, as enacted by PL 1981, c. 511, §1, 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 that~~ lessen the effects of disabilities; and other appropriate and necessary social services.

Sec. 3. Planning for comprehensive presentation of long-term care budget for services and supports for adults with long-term care needs. The Department of Health and Human Services shall undertake a process to provide a comprehensive presentation of a budget for long-term care services and supports for adults with long-term care needs that is complementary to the State's vision for a consumer-centered approach to long-term care. By January 1, 2010, the Commissioner of Health and Human Services shall submit a report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs and health and human services matters.

Sec. 4. Report. The Department of Health and Human Services shall report by January 1, 2010 to the joint standing committee of the Legislature having jurisdiction over health and human services matters on:

1. Waiting lists for services for home-based and community-based care and homemaker services for adults with long-term care needs and strategies to eliminate waiting lists;
2. Funding sources for assistive technologies to help accomplish the State's vision of long-term services and supports for adults with long-term care needs;
3. A comprehensive and systematic approach to training, reimbursement and benefits for direct care workers in home-based and community-based care, residential facilities and nursing facilities; and
4. Work done regarding the expenditures and the operations of the Aging and Disability Resource Centers and efforts to improve the discharge planning process and the provision of information to consumers and their families.

Sec. 5. Increase number of people served. The Department of Health and Human Services shall undertake efforts to increase the number of people served and funds spent in home-based and community support services for people with long-term care needs. The department shall report annually through 2015 on its progress regarding increased funding and access to in-home and community support services by February 1st beginning in 2010 to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs and health and

human services matters.

Sec. 6. Aging and Disability Resource Centers. As resources permit, the Department of Health and Human Services shall work with the 5 area agencies on aging to identify and seek federal or other appropriate funding sources to provide services on a statewide basis through the Aging and Disability Resource Centers.

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

Effective June 17, 2009

Appendix 2

Public Law 2009, Chapter 279

**LD 1078: An Act To Strengthen Sustainable
Long-term Supportive Services for Maine Citizens**

Sponsored by Representative Matthew Peterson

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §50 is enacted to read:

§ 50. Planning for long-term care services

By January 15, 2012 and every 4 years thereafter the department, after input from interested parties, shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the current allocation of resources for long-term care and the goals for allocation of those resources during the next 4 years. The report must be based on current and projected demographic data, current and projected consumer needs and recent or anticipated changes in methods of delivery of long-term care services and must include any action taken by the department to further these goals and any recommendations for action by the Legislature.

Sec. 2. 22 MRSA §7301, as enacted by PL 1981, c. 511, §1, is amended to read:

§ 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;
- E. The majority of adults with long-term care needs have indicated a preference to remain in their own homes and in community settings rather than having their needs met in institutional settings;
- F. For many adults with long-term care needs and their families, the process to identify and secure appropriate services may be confusing and difficult to navigate; and
- G. A sustainable system of long-term care to meet the needs of citizens must emphasize in-home and community support services that capitalize upon personal and family responsibility.

2. Policy. The Legislature declares that it is the policy of this State, with regard to in-home and community support services:

- A. To increase the availability of in-home and community support services, long-term care services that are consumer-driven, optimize individual choice and autonomy and maximize physical health, mental health, functional well-being and independence for adults with long-term care needs through high-quality services and supports in settings that reflect the needs and choices of consumers and that are delivered in the most flexible, innovative and cost-effective manner;
- B. That the priority recipients of in-home and community support services, pursuant to this subtitle, ~~shall must be the elderly and disabled adults with long-term care needs~~ who are at the greatest risk of being, or who already have been, placed inappropriately in an institutional setting ~~without needed in-home and community support services; and~~
- C. That a variety of agencies, facilities and individuals ~~shall must~~ be encouraged to provide in-home and community support services and to increase the percentages of adults with long-term care needs receiving in-home and community support services;
- D. To promote and encourage public and private partnerships among a variety of agencies, facilities and individuals;
- E. To support the roles of family caregivers and a qualified workforce in the effort to streamline and facilitate access to high-quality services in the least restrictive and most integrated settings; and
- F. To establish the most efficient and cost-effective system for delivering a broad array of long-term care services.

Sec. 3. 22 MRSA §7302, as amended by PL 2001, c. 596, Pt. B, §10 and affected by §25 and amended by PL 2003, c. 689, Pt. B, §§6 and 7, is further amended to read:

§ 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.

1-A. Activities of daily living. "Activities of daily living" means activities as defined in federal and state rules including those essential to a person's daily living including: eating and drinking; bathing and hygiene; dressing, including putting on and removing prostheses and clothing; toileting, including toilet or bedpan use, ostomy or catheter care, clothing changes and cleaning related to toileting; locomotion or moving between locations within a room or other areas, including with the use of a walker or wheelchair; transfers or moving to and from a bed, chair, couch, wheelchair or standing position; and bed mobility or positioning a person's body while in bed, including turning from side to side.

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

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

3-A. Consumer. "Consumer" means a person eligible for services under this subtitle.

3-B. Consumer assessment. "Consumer assessment" means an evaluation of the functional capacity of an individual to live independently given appropriate supports with activities of daily living and instrumental activities of daily living or through the provision of information about service options that are available to meet the individual's needs.

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, self-directed care services; 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~~ that 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.

6-A. Instrumental activities of daily living. "Instrumental activities of daily living" means the activities as defined in federal and state rules including those essential, nonmedical tasks that enable the consumer to live independently in the community, including light housework, preparing meals, taking medications, shopping for groceries or clothes, using the telephone, managing money and other similar activities.

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~~ self-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~~ Activities of daily living and instrumental activities 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; or, if providing service to a consumer receiving self-directed attendant services under chapter 1622, a person approved by the consumer or the consumer's surrogate as being able to competently assist in the fulfillment of the personal care assistance services outlined in the consumer's plan of care. 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 or institutionally based long-term care services.

9-A. Qualified providers. "Qualified providers" means community-based agencies or a network of agencies with the organizational and administrative capacity to administer and monitor an array of in-home and community support services that will promote choice and portability with an emphasis on coordinating and implementing the services in the consumer's plan of care.

9-B. Self-directed care services. "Self-directed care services" means services procured and directed by the consumer or the consumer's surrogate that allow the consumer to reenter or remain in the community and to maximize independent living opportunities. "Self-directed care services" includes the hiring, firing, training and supervision of personal care assistants to assist with activities of daily living and instrumental activities of daily living.

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

11. Surrogate. "Surrogate" means an unpaid agent of a consumer designated to assist with the management of the tasks associated with in-home and community support services.

Sec. 4. 22 MRSA c. 1622 is enacted to read:

CHAPTER 1622

COORDINATED IN-HOME AND COMMUNITY SUPPORT SERVICES FOR THE ELDERLY AND ADULTS WITH DISABILITIES

§ 7311. Program established

By July 1, 2010, the department shall establish a coordinated program, referred to in this chapter as "the program," of in-home and community support services that are available under state-funded and MaineCare-funded programs for adults with long-term care needs who are eligible for services from qualified providers pursuant to this subtitle. The program must have a unified system for intake and eligibility determination for all consumers, regardless of diagnosis, type of disability or demographic factors, including age, using the multi-disciplinary teams pursuant to section 7323, consumer assessment and the development of plans of care that take into consideration the consumer's living arrangement, informal supports and services provided by other public or private funding sources to ensure non-duplication of services for consumers.

§ 7312. Rules

The department shall adopt rules as necessary for the effective administration of the program pursuant to this chapter, in accordance with the Maine Administrative Procedure Act. In the development of such rules, the department shall consult with consumers, representatives of consumers and providers. Rules adopted pursuant to this section are major substantive rules as defined by Title 5, chapter 375, subchapter 2-A.

Sec. 5. Plan for consolidated services. The Commissioner of Health and Human Services shall convene a work group of persons representing all of the significant parties, including consumers, interested in the issue of efficient and effective long-term care in the State. The purpose of the work group is to analyze the long-term care service system and to make recommendations that will assist the commissioner in designing the system that promotes consumer choice, transparency, portability and flexibility. The work group shall employ a disciplined improvement analysis and implementation approach and methodology in its work. In this process, personal care services will be reviewed to determine the extent to which the following principles are currently being met:

1. Consumers know about and have access to a full range of personal care service options;
2. Access to personal care services is expeditious;
3. Personal care services are delivered efficiently and in a manner that promotes maximum consumer choice;
4. Personal care services are transparent so that the services are easily understood by consumers and their families;
5. Personal care services are portable from one provider to another;
6. Personal care services are flexible to meet the needs of the consumer; and
7. Provider rates and worker wages are standardized to promote overall efficiency and ensure a sufficient number and quality of direct-care workers.

The work group must meet at least 3 times and provide a report to the Joint Standing Committee on Health and Human Services by January 15, 2010. The report must contain the work group's recommendations for improvements in the long-term care system in the State. These recommendations must address intake and eligibility determination, consumer assessment, development of plans of care, the definition of qualified providers and the means to standardize rates and wages within the system.

Sec. 6. State plan amendment or waivers. The Department of Health and Human Services shall submit to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services any amendments or waivers needed to establish any part of a consolidated program, including a program of consumer-directed care described in the Maine Revised Statutes, Title 22, chapter 1622.

Effective September 12, 2009

Note: §7311, newly enacted by Chapter 279, refers to §7323, enacted in 1981 as part of the original Home-Based Care Act. Here is the language from the referenced section:

§7323. Multidisciplinary teams

1. **Team designation.** The commissioner shall designate several multidisciplinary teams throughout the State to assist the department with evaluations of adults with long-term care needs. [1981, c. 511, §1 (NEW).]
2. **Membership.** Each multidisciplinary team must include at least one social services professional or health care professional and, whenever possible, the adult with long-term care needs and a family or designated representative. [1997, c. 734, §3 (AMD).]

- 3. Duties.** For each adult with long-term care needs evaluated by a multidisciplinary team, the team shall assist the department to:
- A. Determine the eligibility of the adult for in-home and community support services; [1981, c. 511, §1 (NEW).]
 - B. Develop a plan of services for the adult, in cooperation with the probable providers of the services, whenever such providers are not members of the team; [1981, c. 511, §1 (NEW).]
 - C. Arrange for the provision of the needed services; [1981, c. 511, §1 (NEW).]
 - D. Reevaluate the adult periodically to determine his continuing need for the services; and [1981, c. 511, §1 (NEW).]
 - E. Consult when possible with the adult's attending physician, if any. [1981, c. 511, §1 (NEW).]

Appendix 3

LD 1059: Resolve, To Enhance Health Care for Direct Care Workers

Sponsored by Senator Nancy Sullivan

Sec. 1 Demonstration project established. Resolved: That the Department of Professional and Financial Regulation, Bureau of Insurance shall set up a demonstration project, named the Direct Care Workforce Health Coverage Working Group, through which long-term care service providers unable to afford high-quality health insurance for their direct care workers may receive higher levels of reimbursement for MaineCare services they provide. The Bureau of Insurance shall assess what the effect of these workers' receiving this benefit has on worker retention; and be it further

Sec. 2 Report. Resolved: That the Department of Professional and Financial Regulation, Bureau of Insurance shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters 4 years after the start of the program with a report and recommendations. The joint standing committee of the Legislature having jurisdiction over insurance matters may submit legislation; and be it further

Sec. 3 Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Provides funds for the Direct Care Workforce Health Coverage Working Group demonstration project.

GENERAL FUND	2009-10	2010-11
All Other	\$0	\$500,000
GENERAL FUND TOTAL	\$0	\$500,000

SUMMARY

This resolve requires the Department of Professional and Financial Regulation, Bureau of Insurance to establish a demonstration project named the Direct Care Workforce Health Coverage Working Group to help long-term care service providers unable to afford high-quality health insurance for their direct care workers to receive higher levels of reimbursement for MaineCare services they provide. The project will last 4 years and cost \$500,000. The bureau shall assess if this benefit affects worker retention. The bureau shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters, which may submit legislation.

Appendix 4

**LD 1364. An Act To Stimulate the Economy by Expanding Opportunities
for Personal Assistance Workers**

Sponsored by Representative Matthew Peterson

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3174-LL is enacted to read:

§ 3174-LL. Reimbursement for personal assistance services in MaineCare

The department shall reimburse providers of personal assistance services and personal assistance workers through standardized administrative and pay rates across all MaineCare programs beginning October 1, 2009.

1. **Definition.** For purposes of this section, unless the context otherwise indicates, "personal assistance services" means assistance with activities of daily living and instrumental activities of daily living.

2. **Standardized administrative rate.** The standardized administrative rate must apply to all providers of personal assistance services.

3. **Standardized wage rate.** The standardized wage rate must apply to all personal assistance workers. The wage rate must be at least \$12 per hour.

4. **Rulemaking.** The department shall adopt rules to implement this section, including specifying what constitutes activities of daily living and instrumental activities of daily living. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 22 MRSA §7310 is enacted to read:

§ 7310. Reimbursement for personal assistance services

The department shall reimburse providers of personal assistance services and personal assistance workers through standardized administrative and pay rates across all programs of in-home and community support services and in institutional settings beginning October 1, 2009.

1. **Definition.** For purposes of this section, unless the context otherwise indicates, "personal assistance services" means assistance with activities of daily living and instrumental activities of daily living.

2. **Standardized administrative rate.** The standardized administrative rate must apply to all providers of personal assistance services.

3. **Standardized wage rate.** The standardized wage rate must apply to all personal assistance workers. The wage rate must be at least \$12 per hour.

4. **Rulemaking.** The department shall adopt rules to implement this section, including specifying what constitutes activities of daily living and instrumental activities of daily living. Rules

adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

SUMMARY

This bill establishes the reimbursement by the Department of Health and Human Services for personal assistance services through standardized rates, beginning October 1, 2009, that apply to all providers and workers in programs, institutional settings, in-home services and community support services.

Appendix 5

Lean Core Team Members and Other Lean Participants

Lean Sponsor

Muriel Littlefield, DHHS Deputy Commissioner for Integrated Services

Core Team Members

Lean Manager

Diana Scully, Office of Elder Services, DHHS

Consumer Team Member

Dr. Susan Linet

Direct Care Worker Members

Cathy Bouchard, Maine PASA, Kennebec Valley Organization

Helen Hanson, MSEA-SEIU, DCA Maine PASA, Kennebec Valley Organization

Advocate Members

Brenda Gallant, Maine Long-term Care Ombudsman Program

Leo Delicata, Esq., Legal Services for the Elderly

Provider Members

Betsy Sawyer-Manter, Seniors Plus

Mollie Baldwin, HomeCare for Maine

Sharon Foerster, Elder Independence of Maine

Jay Hardy, Alpha One

Vicki Purgavie, Home Care & Hospice Alliance of Maine

DHHS Staff Members

Heidi Bechard, Office of Adults with Cognitive & Physical Disability Services

David Goddu, Office of Adults with Cognitive & Physical Disability Services

Doreen McDaniel, Office of Elder Services

Other Members

Kate Bridges, Maine AARP

Lorraine Lachapelle, Goold Health Systems, Inc.

Louise Olsen, Muskie School, University of Southern Maine

State Representative Matt Peterson, Alpha One

Lean Facilitators

Walter Lowell, DHHS

Lita Klavins, DHHS

Lean Information Providers

Cheryl Ring, Commissioner's Office, DHHS

Julie Fralich, Muskie School, University of Southern Maine

Elise Scala, Muskie School, University of Southern Maine

Appendix 6

Worker Group Participants

Mollie Baldwin, Home Care for Maine

Cathy Bouchard, Maine Personal Assistance Services Association (PASA)/ Kennebec
Vallue Organization (KVO)

Nicole Brown, KVO Lead Organizer

Rick Erb, Maine Health Care Association

Joyce Gagnon, Maine PASA/KVO

Elizabeth Gattine, Office of Elder Services, DHHS

Helen Hanson, MSEA-SEIU/Alpha One/Direct Care Alliance/Maine PASA

Don Harden, Catholic Charities Maine

Jay Hardy, Alpha One

Matt Peterson, State Representative/Alpha One

Joanne Rawlings-Sekunda, Bureau of Insurance

Cheryl Ring, Commissioner's Office, DHHS

Ted Rippey, MESA-SEIU/Alpha One

DeeDee Strout, Home Care for Maine/KVO

Elise Scala, Muskie School

Diana Scully, Office of Elder Services, DHHS (Task Force Chairperson)

Dawn Worster, Arcadia Healthcare Maine

Appendix Z

Lean Implementation Plan

Objectives	Actions	Vote	Responsible Person(s)	Due Date
#1 Promote equity & optimize consumer use by streamlining the LTC system into one structure that meets all LTC needs.	Design/create system with consolidated waiver, state plan, & state-funded programs that: 1) Are as similar as possible; 2) Have all options available under each; 3) Are portable, allowing for money/budget to follow person; & regardless of program 4) Emphasize consumer strengths.	14	Diana , Jay, Leo, Brenda, Lorraine, Betsy, Heidi, David	12/15/09
	Change state-funded program to 3 levels, using Level 1 money for assistive technologies & pending people.			
	Develop "open" waiver with home-based care as fall-back, decreasing delays.			
	Create assistive technology benefit for each program.			
	Identify the impact & implications for DHHS programs & budgets/pots of money re: what will have to be done to implement the new model, internal to DHHS management & cost to people & cost to system.			
#2 Develop a simple & uniform self-directed model.	Create one model for all agencies. Eliminate differences between the 2 self-directed options.	9	Diana & above, Sharon, Louise	12/15/09
	Borrow best of current systems.			
	Redesign FPSO model. Do away with need for PCA agency for FPSO.			
	Make FPSO easier.			
	Resolve inequities.			
	Develop 1 skills training curriculum.			
	Define/add/increase surrogacy ability to self-directed option (equity among programs).			
	Consolidate payroll Fiscal Intermediary role with State management.			
	Explore & implement expanded & enhanced training modalities: face-to-face, classroom, DVD, online, OJT, etc. to meet the needs of the consumer, surrogates, & family providers.			
	Ensure competent financial services for the consumer & system.			
	Re-look at consumer driven-use of Fiscal Intermediary.			
Address issues with current contractor.				
Help public partnership with hours involved.				
#3 Create standard terms & titles to across programs to enhance understanding for workers and consumers.	Decide upon & change the word for "consumer".		Diana , Helen Rules Group Worker Group	12/15/09
	Decide upon single, inclusive title for caregivers (too many different titles).			
	Spell out specifics of "qualified provider". What does that mean?			
	Standardize names & definitions for the various living types across all program & funding streams.			
#4 Balance LTC system to develop adequate resources & system planning.	Roll up individual budgets into global system needs for resources.	14	Brenda , Jay, Kate, Leo, Sharon, Betsy	12/31/09
	Identify & address unmet needs beyond basic needs.			
	Assure State-level budget includes both NF & community-based \$.			

Objectives	Actions	Vote	Responsible Person(s)	Due Date
<p>#5 Maximize individualization & flexibility of plan of care to assure appropriate and timely services.</p>	Plan of care—how is it defined & constituted?	11	<p>Doreen, Sharon, Leo, Lorraine, Jay, Brenda, Mollie</p>	3/15/10
	Allow more flexibility for authorizing plan of care.			
	Identify unmet needs in care plans.			
	Link unmet needs to MeCare database for statewide planning.			
	"Refresh" individual budgets each year by review of consumer needs.			
	Send service orders to providers of choice (consumers) = provider open, decreasing delays.			
	Allow providers to accept plan of care without changes for at least 30 days to speed up care delivery.			
	Increase focus on "programming" for services such as better medication management.			
	Allow service order authorization for month+ at a time, encouraging communication with providers.			
	Create individual budget methodology.			
	Change self-directed services so is budget-based & not limited to PSS.			
Take into account weather patterns, location of consumers, individual consumer's condition, demographics, & cognitive & physical abilities in determining numbers of staff needed.				
<p>#6 Create and maximize flexibility in the planning and delivery of services.</p>	Define "choice." How much flexibility is OK?	8	<p>Doreen, Sharon, Leo, Lorraine, Jay, Brenda, Mollie</p>	3/15/10
	Define accountability, especially in light of current State budget.			
	Empower consumer/direct care worker to make adjustments to schedule in real time as needed w/approval as needed after the fact.			
	Base case manager service authorizations on consumer choice; not tied so tightly to task times & timing.			
	Strengthen community involvement in supporting consumers.			
	Build flexibility into the direct care worker's work—allow self-directed within defined parameters.			
	Encourage direct care workers to work together as a team for the consumer, providing coverage for each other as needed.			
	Provide for back-up coverage for call-outs/no-shows.			
	Identify results for agency & consumer of call-outs & no-show call backs.			
Develop improved staffing search efficiency (explore use of web/email/etc.)				
<p>#7 Maximize consumers' ability to make informed choices.</p>	Ensure true informed choice ("this is what you are eligible for") when eligible for more than one program. Functional assessment process is clear to consumer.	7	<p>David, Doreen, Heidi, Jay, Mollie, Leo, Lorraine, Sharon</p>	3/15/10
	Provide easily understood and easily accessible information to consumer. Offer front-end access at ADRCS.			
	Increase awareness by consumers, providers, & general public about HCBS so that they will understand the whole process regardless of their particular involvement. Provide a comprehensive view of the process.			
	Provide chain of command information to consumers so a problem can be corrected.			
	Identify partners to assist with publication of consumer education options.			

Charge	Actions	Vote	Responsible Person(s)	Due Date
#7 (continued)	Develop consumer guide regarding home care options.			
	Develop care management brochure for consumers (one page)			
	Give consumers choice of budget authority self-directed model.			
	Train assessors regarding the different modes of service.			
#8 Establish care management standards to maximize quality outcomes for consumer.	Explore care management & provision of services, including considerations of conflict of interest/doing no harm to consumer.	7	David, Doreen, Heidi, Jay, Mollie, Leo, Lorraine, Sharon	3/10/10
	Increase case manager coverage to 7 days per week.			
	Increase care management visits.			
	Emphasize the role of education & "seeing" issues firsthand.			
	Separate care plan from assessment.			
	Establish maximum care management caseloads.			
	Establish care management functions across the system.			
	Explore care management agencies providing all options for self-directed care, agency, & combo.			
	Review office-based vs. travel-based case managers.			
	Currently "care coordination"; explore development of case management.			
	Increase case manager's role with adjusting plan of care (what and how much).			
#9 Enhance options for using assistive technology in order to optimize consumer independence.	Find funding sources for assistive technology, e.g. funds for stairs, showers, etc.	7	Louise, Brenda, Jay, Leo	12/31/09
	Include assistive technology services across all programs.			
#10 Improve value & respect for direct care workers.	Provide higher incentives for direct care workers (pay, benefits, mileage, pay differentials for nights/ weekends). Raise wages to at least \$12.00/hour across all programs.	7	Diana, Helen, Worker Group	12/31/09
	Offer health insurance, vaccines to health care providers in private sector.			
	Offer CNA-certified healthcare coverage to caregivers in private sector.			
	Standardize wage rates.			
	Explore impact of leveling playing field for hourly reimbursement rates.			
	Ensure competent financial services for the workers, providers & system.			
	Explore agency model employer responsibility regarding worker compensation & liability insurance.			
Ensure that reimbursement rates are reviewed & adequate to pay for costs associated with delivery of care.				
#11 Enhance availability of staff in order to implement plan of care.	Increase availability of staff, including 24/7, best practices.		Kate, Susan, Louisa	2/15/10
	Increase number of providers/staffing hours throughout state.			

Charge	Actions	Vote	Responsible Person(s)	Due Date
#12 Create strategy & standards for improving & assuring work-force training for all persons accountable to LTC system in order to reach highest possible levels of professionalism.	Explore & implement expanded & enhanced training modalities: face-to-face, classroom, DVD, online, OJT, etc. for all persons accountable to the LTC system, including various service workers & family providers.	1	Diana, Betsy, Lorraine, Licensing Worker Task Force	7/1/10
	Explore impact of CNA certification and re-certification requirements and ways to provide assistance with cost of training.			
	Review training requirements & inequities, identifying how to make them more consistent and appropriate across program/modes of service and type of workers.			
	Provide training for specialty equipment for consumers & direct care workers			
	Enhance opportunities for all direct-care workers to receive training.			
#13 Identify, develop, & implement rule/policy changes to accommodate new LTC system & maximize efficiency & transparency.	Simplify & make policies consistent across all modes of service delivery/programs, including eligibility criteria, budgeting, & method of delivery.	3	Diana, Jay, Leo, Brenda, Lorraine, Betsy, Heidi, David	3/15/10
	Change rules/policies to make it easier for consumers to transition more seamlessly to a new program.			
	Remove estate recovery requirements for recipients of home care services			
	Increase FMAP for home-based services.			
	Revise policies to include updated assistive technology as being a covered service.			
	Revise policies to include updated assistive technology as being a covered service.			
#14 Design & establish effective quality management strategy across funding streams & population groups to assure a high quality LTC service system.	Develop & standardize performance, process/system, and consumer outcome measures.	2	Doreen, Louise, Susan, Kate, Heidi, Helen, Jay, Leo, Sharon	Outcomes : 3/30/10 Implement : 10/1/10
	Use one (streamlined, well-coordinated, & integrated) client & service tracking info system across programs to avoid duplication for clients moving among CM providers & improve quality of services provided.			
	Increase accountability; monitor actual service provision & need.			
	Use data to inform system, such as impact on consumers' use of services, bottlenecks, amount of NF admission decrease, impact of assistive technologies on consumer and system, status of system components' communications, time between assessment referral and service delivery, time on wait lists, etc.			
	Develop outcome measures such as what happens to people who don't get services due to lack of staffing and/or affordability of co-pay.			
	Identify mechanism for assuring that the POC is delivered & the consumer isn't forced to accept less to get some help.			
	Set up LTC consumer panel to participate in QI process.			
	Develop, tap into consumer/peer support networks.			
#15 Improve financial & functional assessment processes.	Develop initial 30-45 day assessment, then review/ reassess after more discovery.			
	Offer LTC advisory assessment capacity again (people making decisions in crisis situations).			
	Accept assessments, ROI's, HIPAA compliance, etc. from assessor to cover care agencies & providers.			
	Conduct personal care service financial eligibility at same time as initial assessment by assessor.			

Appendix 8

Comprehensive Budget Presentation for Long-Term Services and Supports

LD 400 requires DHHS to undertake a process to provide a comprehensive presentation of a budget for long-term care services and supports for adults with long-term care needs. Below is a table with information about MaineCare expenditures and service users, by program for 2008. State-funded services also could be included. If the Legislature decides to move toward a global budget, this breakdown of services could help guide the way.

MaineCare Claims Data for Long-Term Care Services

Bill Spec	Service Description	Bill Spec Breakout	Description Breakout	Expenditures
11	Home Health Services	11	Home Health Services	\$4,161,846
21	Hospice	21	Hospice	\$1,457,225
22	Waiver for Physically Disabled	22	Waiver for Physically Disabled	\$4,850,241
3	Nursing Facility	3	Nursing Facility	\$241,613,649
36	Day Health	36	Day Health	\$291,502
39	Private Non-Medical Institutions	B	Appendix B	\$8,352,183
39	Private Non-Medical Institutions	C	Appendix C	\$76,595,748
39	Private Non-Medical Institutions	D	Appendix D	\$105,154,338
39	Private Non-Medical Institutions	E	Appendix E	\$46,841,369
39	Private Non-Medical Institutions	F	Appendix F	\$12,178,763
55	Consumer-Directed Attendant Services	55	Consumer-Directed Attendant Services	\$3,505,084
57	OES Waiver	214	Adults with Disabilities	\$7,026,387
57	OES Waiver	57	OES Waiver	\$10,979,871
58	Private Duty Nursing	349	Adult PDN Services - Agency	\$2,078,756
58	Private Duty Nursing	58	Private Duty Nursing	\$2,903,164
Personal Care Services Sub-Total				\$11,330,582
169	<i>Adult Family Care Homes</i>	169	<i>Adult Family Care Homes</i>	\$2,064,293
479	<i>Housing with ALS</i>	479	<i>Housing with ALS</i>	\$2,700,744
59	<i>Personal Care Services</i>	351	<i>Adult PDN Services - Personal Care Agency</i>	\$6,181,937
59	<i>Personal Care Services</i>	59	<i>Personal Care Services</i>	\$383,609
Total				\$539,320,708

Appendix 9

Waiting Lists for Home-Based Services (January 2010)

Program	Number of People Waiting
Functional assessments for state-funded services	<p style="text-align: center;">559 people</p> <p>It is estimated that 40% (224) will be found eligible for Home-Based Care and 60% (335) will be found eligible for Independent Support Services</p> <p>33 of the 559 people have been waiting since September 2009</p> <p>An average of 167 people are placed on the waiting list each month</p>
State-funded Home-Based Care provided by Elder Independence of Maine	<p style="text-align: center;">265 people</p> <p style="text-align: center;">142 are waiting for services for the first time</p> <p style="text-align: center;">123 are waiting for increases in services</p>
MaineCare-funded Waiver Consumer-Directed Care provided by Alpha One	<p style="text-align: center;">109 people</p>
State-funded Consumer-Directed Home-Based Care provided by Alpha One	<p style="text-align: center;">31 people</p>
State-funded Independent Support Services Provided by Catholic Charities Maine	<p style="text-align: center;">248 people</p>
Total Number of People Waiting	1,212 people