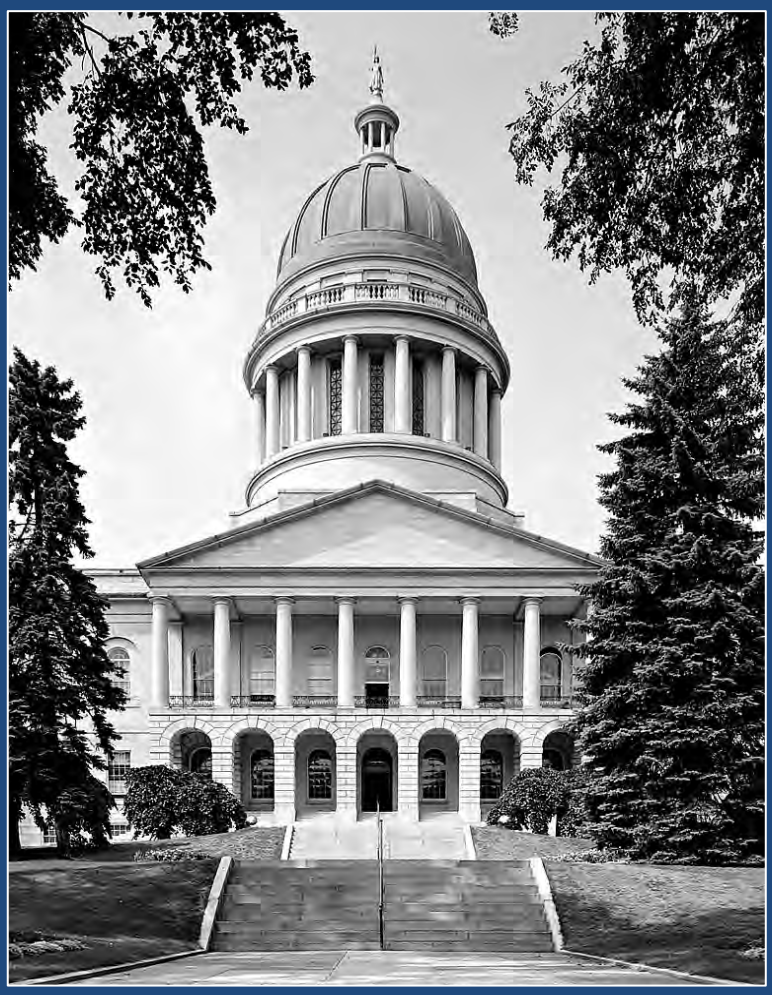

Baseline Analysis of Maine's Public-Welfare System

A Review Submitted to the Commissioner of Health & Human Services

Final Report
May 2014

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Creating and Delivering Innovative Global Solutions

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Foreword

The Alexander Group (AG) is pleased to respectfully submit this baseline analysis to the Maine Department of Health and Human Services (DHHS). The report represents more than seven months of work on behalf of AG with the close cooperation of key DHHS personnel. A project of this size normally would have taken a year or more to complete, but the extensive experience of the AG team and the input we received from the state made it possible to complete the work within a compressed timeframe.

Indeed, AG turned this report around in an expedited manner because of the commissioner's desire to move forward with reforming the system as quickly as possible. For states in general, Medicaid and welfare programs continue to grow in magnitude and proportion despite reform measures that were enacted and implemented through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This national pattern of dramatic growth has not bypassed Maine. Although the LePage administration has succeeded in moderating and declining total expenditures, Maine's welfare burden remains among the highest in the nation. Absent comprehensive policy changes at the federal and state levels, the burden will not be significantly improved.

In laying out a comprehensive overview of Maine's welfare system, this report provides specific recommendations to improve programs and initiate more meaningful reform intended to improve outcomes for recipients while enhancing cost effectiveness across the entire enterprise. While reports and studies that explore ways to improve public-assistance programs are plentiful, none of which AG is aware involves the breadth and scope of this analysis. Transition reports to help new governors establish priorities and policies may come close. However, AG believes that this report's level of quantitative detail, policy analysis to improve program functionality, and recommendations for broader reform offer Maine an opportunity to accelerate the pace of improving program outcomes at more affordable costs.

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Executive Summary

Maine's Department of Health and Human Services (DHHS) has engaged the Alexander Group (AG) to prepare a review and analysis of the state's public-welfare system, assessing the administration, delivery, and outcomes of these programs that Maine administers to help its most vulnerable populations. This assessment quantitatively measures performance, qualitatively identifies the system's strengths and weaknesses, and offers recommendations that help make Maine's human services more effective and efficient while improving quality.

The DHHS programs examined in this report include TANF, SNAP, Child Care and Development Fund (CCDF) Child Care Subsidy Program, the Division of Support Enforcement and Recovery (DSER), General Assistance, the state's welfare-to-work system, and MaineCare. Several other smaller programs are reviewed; they include Alternative Assistance, Refugee Cash Assistance (RCA), and Emergency Assistance. The AG also examined mandatory state plans submitted to federal agencies and examined how individual policies and protocols have been developed by the state in order to responsibly administer these resources.

As a baseline assessment of Maine's welfare system at a particular point in time (2013), the report highlights via extensive data analysis what is working and what needs attention; it provides both regional and national comparison data for reference, and it raises some issues and concerns discovered during the review process. For the purposes of this executive summary, we highlight our findings and recommendations for the major DHHS programs: ASPIRE-TANF, SNAP, Child Care, General Assistance, Welfare-To-Work, and MaineCare.

ASPIRE-TANF

Until DHHS implemented policy reforms in January 2012, the state's TANF program lagged second from the bottom in state rankings of caseload declines. Prior to January 2012, the state did not conform to federal rules related to sixty-month time limits for families on cash assistance. Maine carried high caseloads, even when reductions were occurring in virtually all other states. In fact, Maine's high caseloads endured during the period when federal regulations, under the Deficit Reduction Act of 2005 (DRA), increased reporting requirements and added previously omitted state MOE-funded adults to the calculation of work participation rates. Additionally, DRA narrowed the definition of countable work activities, tightened monitoring of parent activities, and imposed stricter reporting requirements for the broader work-eligible population.

Maine's policies prior to 2012, which largely disregarded time limits, exposed the state to TANF-WPR financial penalties, as the program was unable to engage a sufficient number of parents in countable activities for WPR purposes. Consequently, Maine not only saw its work participation rates decline significantly between 2002 and 2010 but also failed to meet federal standards in 2007, 2008, 2009, and 2010. However, with state-MOE funds, DHHS was able to correct some of these deficiencies in 2012 and 2013 by implementing a worker-supplement program. That initiative allows the state to count nineteen-to-twenty thousand low-income working families, who are employed at the required number of hours, toward the TANF WPR. Moreover, the state was able to experience a 20% caseload decline in all TANF programs between 2012 and 2013. Even with the recent efforts to avoid penalties, the state will continue to stand at risk with TANF in the future unless more strident changes are made.

To further ensure that Maine avoids future penalties under TANF, the department must do everything possible to comply with TANF requirements. The following recommendations are intended to build up the level of participation in approvable activities while at the same time help families gain access to the job market in the shortest time possible. To accomplish these goals, the AG recommends the following:

1. **Align Maine's ASPIRE program with federal TANF countable activities**. This would ensure that every plan conforms to TANF and any recipient approved for a vocational training and/or a post-secondary education programs would be required to work at least twenty hours per week after his or her initial twelve months in ASPIRE-TANF.

2. **Adopt a policy of universal engagement for all applicants and recipients** so that no recipient is exempt from ASPIRE-TANF participation requirements. This **recommendation would eliminate exemptions from activities** that, under current state policy, allow parents to receive benefits with no participation requirements. Full engagement assumes everyone has an activity plan, which will lead toward job readiness and future employment.

3. **Require upfront job-search activities prior to acceptance onto cash assistance**. This recommendation is intended to provide sound information and guidance backed by program support for applicants who may have opted out of the job market prematurely. Additionally, for those who do not find a job during their pre-acceptance period, the upfront job-search experience better prepares them for participation in the work-program requirements immediately upon acceptance onto ASPIRE-TANF, as opposed to deferring their engagement in a work-activity plan, improving the state's achievement of TANF work participation rates.

4. **Rigorously monitor both caseloads and participation levels by providing an early alert system if the department falls below mandatory work participation rate levels**. An early alert system allows the department the opportunity to make mid-course adjustments in order to avoid costly TANF WPR financial penalties.

5. **Reexamine MOE-caseload categories, particularly two-parent families that are currently defined as either incapacitated or unemployed.** TANF requires participation of both of these two-parent categories, and the department should focus on full engagement as soon as possible. Under TANF law, 90% of all two-parent households supported by either federal TANF dollars or state-MOE dollars are required to participate at least thirty-five hours per week.

6. **Expand the coordination and shared resources of the Maine Department of Labor and the Department of Education to strengthen welfare-to-work initiatives.** (This recommendation is developed in the Welfare-to-Work Coordination section.)

Supplemental Nutrition Assistance Program (SNAP)

From 2009 to 2013, the Maine SNAP caseload increased by 51,612 recipients (and approximately 32,500 households), a boost driven in part by the provisions of the American Recovery and Reinvestment Act of 2009. Handling such a rapid increase poses challenges to even the most efficient state agency, particularly when it comes to keeping fraud, waste, and abuse at bay. Yet Maine has performed admirably in managing the expanded SNAP caseload. In FFYs 2005, 2006, 2007, and 2008, Maine had comparatively high error rates in federal reviews of its food-stamp program. However, DHHS has since been able to reverse that pattern. For FY 2012, USDA Food and Nutrition Services published its most recent SNAP data report showing state-level breakdowns in a number of indicators. Maine compared favorably against all other states on several indicators related to payment-accuracy measures.

Maine could continue this progress by the following:

1. **Aggressively implement front-end detection protocols, with adequate systems support.** This process will significantly reduce the potential of fraud, waste, and abuse of benefits in the SNAP program before benefits are issued. Such a recommendation would mean that unlawful or improper benefit overpayments would be reduced significantly by virtue of the fact that a front-end detection process would yield more timely and accurate information about recipients, especially those with earnings.

2. **Pursue approval to become one of the ten-state pilot programs to engage adults in a mandatory work program,** an opportunity outlined in the 2014 Farm Bill. If Maine successfully competed for the pilot program, the caseload would not only expand the number of working SNAP households, but would likely reduce the SNAP caseload because more recipients would have access to paid employment presumably at wages that eliminate their eligibility for SNAP benefits.

3. **Except for those who are elderly and/or have a disability, narrow the definition of categorically eligible households to only those who have already met one of the federally defined means-tested cash assistance programs (SSI, TANF, or General**

Assistance). This recommendation would require all other applicant households to meet income and asset limits of $2,000 in order to be eligible for SNAP benefits.

4. **Identify meaningful program-integrity priorities** and establish measurable goals for fiscal years 2014, 2015, and 2016. Such ground work would contribute to responsibly administering benefits to those in need and reduce program fraud, waste, and abuse.

Child Care

Like many states, Maine's child care system follows a two-track model: one program — under the Office of Family Independence (OFI) — that administers services for parents enrolled in the ASPIRE-TANF/PaS cash-assistance program; and a second program — under the Office of Child and Family Services (OCFS) — that functions under the federal Child Care Development Fund (CCDF) and administers quality-care initiatives and care subsidies for needy parents not otherwise eligible for ASPIRE-TANF.

Within this model, Maine maintains a very generous child care program in terms of eligibility levels and reimbursement rates. The state's eligibility (250% of FPL) for receiving child care assistance is the highest in New England and the third highest in the country. Measured as a percentage of state median income, Maine's eligibility level (85%) is also the highest in New England. Moreover, the state's reimbursement rates (for 4-year-olds in center-based care) are the highest in New England and the fifth highest in the country. Those generous reimbursement rates mean that the annual per-case cost of ASPIRE and Transitional Child Care parents using a licensed child care center is $8,065; for parents using a licensed, family-based center is $6,169.

AG's policy recommendations for the state's child care program are as follows:

1. **Establish an integrated child care policy and program leadership role with responsibility across OCFS and OFI.** Strongly consider consolidation of child care administration and policy development into a single leadership function within DHHS.

2. **Create a uniform child care data-reporting capability that captures data from OFI and OCFS.** Uniformity in data reporting would effectively increase payment and data accuracy and reduce redundancy.

3. **Pay providers directly as opposed to issuing payments through parents' EBT cards.** This recommendation would bring ASPIRE-PaS method of paying for child care in line with the CCDF Child Care Subsidy program, which always pays the child care providers directly on behalf of parents, as opposed to ASPIRE-PaS, which uses the parent's EBT card to issue payments for child care services.

4. **Explore partner support to help pay for the costly investments in the state's quality-care initiatives.** Pursuing alternative support from other funding partners would relieve

DHHS from having to choose between maintaining funding for quality child care initiatives versus creating waiting lists for low-income working families.

5. **Pay after performance, based on provider invoicing system; use technology to automate billing process.** This recommendation strongly urges a change in current policies, which pay providers in advance of child's attendance. This will reduce the potential for overpayment caused when clients experience false starts in program activities, and/or in starting a new job, which may not actually materialize.

6. **Consider moving toward swipe-card technology for paying child care subsidies**. Paying for attendance is best achieved when there is a clear and verifiable process for recording and tracking attendance. Swipe-card technology has performed very well in other states. Additionally, swipe-card technology carries an added degree of authentication that the child attendance conforms to the parent's activity and the provider's accuracy in billing.

7. **Increase on-site monitoring of child care settings throughout the system**. Increased monitoring enhances the likelihood that providers — who are expected to provide high-quality care — understand they will be visited regularly and assessed on the quality and safety of the children under their care.

General Assistance

Maine requires each municipality to administer a General Assistance (GA) program which provides immediate aid, in the form of vouchers, for persons who are unable to provide the basic necessities essential to maintain themselves and their families. Eligibility criteria are based on financial need and assets, and access to these benefits is provided at the municipal level. GA is funded through a combination of state and municipal sources and is governed by the provisions of Title 22, Part 5, Chapter 1161: Municipal General Assistance.

Considering budget constraints facing the state, DHHS is encouraged to confer with the Maine legislature to seek help in containing the outflow of dollars being spent by the GA program. There is sound rationale for revisiting the mandates of the law at this time, as the current provisions have led to extraordinary growth in spending.

There are numerous concerns about how the GA program is currently administered by the more than four hundred municipalities throughout the state. There is no uniformity in eligibility and benefit criteria, there is no audit system to track if and when recipients are accessing payments through more than one municipality, and there is no data-tracking system to flag duplication of benefits issued by both state and municipal systems. Requests for reimbursement through DHHS are submitted without any person/household level data, which prohibits the ability to cross-check with other benefits issued by other programs.

These two recommendations, which have been proposed in the past, remain viable for the state to reconsider in coming to terms with this budgetary challenge:

1. **Establish a General Assistance Block Grant with a specified amount of money to each municipality — based on the average expenditure of a municipality in the last three years.** As uncapped expenditures have risen under the current funding formula, a block grant is one way to preserve adequate (capped) funding for municipalities while still providing a reasonable amount of financial resources to assist the most needy individuals and families in accord with the provisions of the GA law.

2. **Limit the funding formula to 50% of a municipality's expenditures would also offer a way to contain overall costs**. This recommendation would eliminate the current 90% yearly threshold formula that is, in effect, an entitlement funding stream that is financially unsustainable.

In addition, the following seven options — if adopted — would also result in savings for the state:

Option 1: Maine DHHS could assume total administration of the GA program and uniformly apply standards of eligibility and benefits issued on a statewide basis. A number of efficiencies can be expected by operating GA through the sixteen regional centers, where the provision of services would be done by experienced eligibility workers who have access to automated eligibility, payments/vouchers, and reporting systems. Most noteworthy is the elimination of duplication of benefits issued through two separate program operations.

Option 2: Contingent upon funding constraints**,** DHHS could work with lawmakers to follow the pattern of other states and eliminate the GA program altogether.

Option 3: Maine DHHS could consider capping GA program dollars per municipality; setting a maximum amount available for each year, based on availability of state funding. While this is similar to the already considered fixed block-grant proposal, this option would be based on available state dollars each year, which would be subject to annual allocations that may fluctuate up or down.

Option 4: Discontinue cash benefits to employable adults without children; continue MA if they are income eligible under Medicaid and have a verified need for medical services and/or prescription drugs.

Option 5: Deny GA emergency cash assistance to those who are on TANF — they already receive monthly cash benefits, SNAP, and MA through DHHS and may also qualify for emergency assistance under certain DHHS rules. Duplication of assistance is a significant possibility within the current GA benefit structure.

Option 6: Discontinue limitless renewals for General Assistance benefits. Other states limit assistance to no more than one time per year, or no more than three times per individual or family per lifetime, or one time per lifetime. Maine has no limitation on the number of times a recipient can be approved for benefits.

Option 7: Cap enrollments, effective SFY 2015. GA caseloads will decline overtime due to attrition, and savings can be realized through this limit on receipt of benefits.

Welfare-To-Work Coordination

Well planned and operated welfare-to-work programs will not only move individuals into jobs, but will also lead to sustained employment, career advancement, and self-sufficiency. No single strategy or model works for every single participant of ASPIRE-TANF and/or SNAP programs, yet our recommendations offer a range of feasible strategies that are likely to meet a broad spectrum of skills and abilities of program participants while improving the department's likelihood of meeting federal work participation requirements. Our recommendations call for greater emphasis on engaging the business sector with incentives to hire welfare recipients; they also call for reinvestment of TANF dollars into performance-based contracts that are geared toward placement and retention milestones of participants who are placed into jobs.

In addition, the report recommends specialized services for individuals with disabilities and envisions collaboration with experts from disability service organizations. These recommendations also include changes to the administrative processes that, when combined with the work focused investments, will greatly improve overall outcomes for families and individuals. And these recommendations offer promise that the state and the department will achieve the mandated work participation requirements in TANF, thus avoiding financial penalties that have loomed over the state for the past several years.

1. **Increase work opportunities through expanding investments and collaboration with the Maine Departments of Labor and Education**. Full engagement of TANF families cannot be achieved without expanding partnerships with those more closely linked to labor and industry. This would include the Maine Workforce Board, the eight Chambers of Commerce, apprenticeship opportunities, and creative worksite-learning programs available through the Department of Education.

2. **Invest in more subsidized job placements,** which are designed to appeal to employers who are interested in hiring potential participants of the ASPIRE-TANF and SNAP programs. Simplifying the process and the paperwork can enhance the potential for placing large numbers of program participants into subsidized jobs.

3. **Develop and fund only performance-based contracts with job-placement providers/vendors.** Contracts would clearly define employment services for ASPIRE-TANF participants, including skill assessment and job placements. Payments need to be

structured based on achievement of milestones that are tied to participant's skills, level of engagement in job-preparation activities, job placement, and employment retention.

4. **In accord with the Employment First Maine Act of 2013, integrate individuals with disabilities into the private-sector workforce by working with large and small employers throughout the state.** Replicate the successful models pioneered in other states by Lowes, Walgreens, and Procter & Gamble, companies that have — in creative partnership with state departments of human services, labor, and education as well as representatives of disability service organizations — demonstrated expertise in matching candidates with employers.

5. **Conduct an annual disability employment summit, involving government agencies, policymakers, families, stakeholders, and businesses, to discuss how to improve the disability work climate and opportunities.** Seeking input from individuals with disabilities offers the best chance for success, particularly for stakeholders who wish to provide appropriate and effective services to assist these individuals to access jobs.

6. **Involve all major stakeholders in achieving TANF work participation rates.** Those stakeholders would not only include ASPIRE-TANF workers but also the Maine Departments of Labor and Education, all contracted job-preparation and placement providers or vendors, and — very importantly — ASPIRE-TANF participants.

7. **Set measurable goals beyond the TANF WPR**. Goals and measures should include tracking the number of participants placed in jobs, wage levels at placement, the numbers of hours worked, the number retained jobs beyond one, three, six, and twelve months, and the number of cash-assistance cases that close due to employment.

8. **Administratively develop protocols that lead participants to more routinely attach to the labor system as opposed to the welfare system.** This recommendation includes expanding the role of MDOL in handling cases referred from the ASPIRE-TANF and SNAP programs. Allowing career centers to handle changes and adjustments to case activity, for example, would avoid unnecessary appointments with DHHS.

9. **Create a new work participation specialist position to function across agency staff to track and monitor work participation levels** by office and program and/or contracted vendor. Providing technical assistance when issues or problems emerge, this specialist would report monthly of the progress in meeting TANF work participation mandates.

MaineCare

It comes as no surprise that expenditures on MaineCare, the largest means-tested assistance program, represented 24.8% of total general-fund spending in SFY 2013, or $767

million — not counting administrative costs of $20.9 million representing salary and benefits for MaineCare personnel as well as outsourced services. When Medicaid tax revenue is included, total non-federal spending as a percent of total non-federal revenue rises to 30.6%. According to analysis by the National Association of State Budget Officers (NASBO), Maine ranked highest in New England for Medicaid state spending as a percent of total state expenditures and the fifth highest among all states.

In part because Maine has elected to cover more persons and more services than required by federal regulations, total MaineCare caseloads more than doubled between June 2000 and June 2012. Based on data from the Medicaid Statistical Information System for FFY 2010, and population estimates for states from the U.S. Census Bureau for 2010, Maine Medicaid enrollment as percent of total population was 31% exceeding every state except California and the District of Columbia.

By category of recipients served, Maine follows the national pattern. In SFY 2013, children and families comprised 74.2% of the MaineCare population but accounted for just 38.6% of the spending; elderly adults comprised 7.9% of the population and accounted for 18.5% of spending; and persons with disabilities comprised 18% of the population and accounted for 43% of all expenditures.

The biggest cost drivers of MaineCare are 1) hospitals, 2) long-term care for the elderly and adults with physical disabilities, 3) individuals with developmental disabilities, and 4) mental-health services. In SFY 2013, MaineCare inpatient and outpatient payments to hospitals amounted to $618 million; payments for long-term care of the elderly and adults with physical disabilities totaled $544 million. These two categories alone represented 58% of all MaineCare spending in SFY 2013. Payments for services for persons with autism and intellectual disabilities, which is geared much more toward community-based waiver services than large institutional providers, totaled $330 million. Finally, MaineCare spent $196 million for community mental-health services in SFY 2013.

Under the LePage administration, the state has initiated measures to curb Medicaid caseload growth, contain program cost, and improve the efficiency of services. Although these efforts have slowed the rate of growth in Medicaid enrollment and expenditures, caseloads continue to increase and budget shortfalls persist. Even with modest economic improvements, the MaineCare's fiscal prognosis projects a deficit for the biennium 2014–15 budget of $78 million. These budget projections are troublesome because MaineCare constitutes a lion's share of the state's annual budget when counting all fund sources (32.2% in SFY 2013).

Consequently, the recent success in moderating MaineCare growth will not be sufficient to overcome long-term trends and the existing program structure that favors institutional care over other, less-costly care options like home- and community-based services. When extrapolated by financial modeling, our estimates indicate that by SFY 2023–24, MaineCare will represent 36.2% of the general-fund budget, and 40.2% of the total budget, consisting of all funds.

Recommendation: A Global Waiver. The pressing challenges of Medicaid, from its entrenched institutional bias and growing caseload to its projected cost overruns and "crowding out" of state budgets, demand a proactive response. Without reforms across the entire enterprise, MaineCare's ability to serve the most vulnerable of populations — namely the intellectually disabled and indigent elderly — stands at risk, even as more and more of the abled-bodied population are added to the caseload. A global reform through a Section-1115 demonstration waiver, modeled after Rhode Island's successful experiment secured from CMS in 2009, offers the best mechanism for Maine to redesign its MaineCare program, its payment structures and entire system, and secure its future. Maine needs the flexibility to create and manage a Medicaid program that is consistent with the state's needs and culture.

By seeking a global reform, Maine, too, could achieve similar successes, assuring the sustainability of MaineCare for years to come. Under a comprehensive or single-waiver demonstration, DHHS would seek maximum flexibility to change delivery systems, increase transparency and choice, and share risk with the federal government. This would improve service delivery and promote recipient choice and independence while driving down both federal and state costs. DHHS would seek the ability to vary the amount, duration and scope of services offered to recipients — regardless of eligibility category — and the ability to target benefits to specific Medicaid populations. DHHS could also request a global cap on Medicaid expenditures, a proven motivation for reducing spending, over the life of the demonstration.

A comprehensive Section-1115 research-and-demonstration waiver, encompassing all services and eligible populations served under a single authority, would deliver flexibility to manage all programs efficiently by:

- Consolidating all Medicaid programs, services, waivers, and SCHIP under a single-waiver authority;
- Streamlining service definitions across populations;
- Committing Maine to making key improvements to the eligibility system (both processes and technology);
- Promoting increased utilization and choices of home- and-community-based services for individuals in need of long-term care;
- Integrating primary, acute, long-term care, and behavioral-health care;
- Utilizing risk-based capitation across all populations;
- Promoting efficient and value-added health care through enhancing current Medicaid accountable-care organization pilots;
- Providing flexibility to promote primary- and preventive-care access by balancing eligibility and enrollment for services, benefits, and the rate of payment for services;
- Providing flexibility in administration of the program to implement competitive contracting, management efficiencies, and purchasing strategies;
- Promoting healthier behaviors and personal responsibility for recipient health care across the enterprise; and
- Instituting greater accountability for recipients and administrators of the programs.

1. Introduction

Overview

This report provides a programmatic review of Maine's public-welfare programs, exploring details and offering recommendations throughout. During the course of work in examining these programs, a few observations are offered.

First, the LePage administration has made significant improvements to Maine's public-welfare system, including improved efficiencies, greater enforcement of program integrity, and enhancing the quality of services. For example, Maine is one of the first states to create accountable-care organizations (ACOs) — an initiative that, if fully implemented, will improve care coordination, lower expenditures, enhance the patient experience, and bring greater accountability to the health-care system. Perhaps even more importantly, based on feedback from employees, morale and pride at DHHS have improved; this has led to improved productivity and accountability throughout the department. Considering the financially constrained environment in which state agencies live, this is no small feat.

The administration has also continued to administratively streamline operations across the department and build on the departmental consolidation groundwork laid down by the prior administration — the merging of the Department of Human Services and the Department of Behavioral Development Services into the Department of Health and Human Services (DHHS) that became effective on July 1, 2004.

Secondly, despite all the recent incremental achievements, there remains room for improvement. For simplicity, these can be categorized into two broad areas. First, numerous refinements and improvements can be made on the programmatic side. Much of this report is dedicated to identifying these improvements, which include a large array of changes and initiatives. The second area consists of systemic improvements. These are more difficult to implement, but the potential benefits can be far reaching and dramatically improve how the department coordinates resources, reduces redundancies, and potentially lowers expenditures through improved payment accuracy in all DHHS programs.

An unfortunate feature of the American welfare system is that it is uncoordinated and not integrated in any meaningful way. Perhaps it is best summarized by the opening paragraph on welfare in *The Concise Encyclopedia on Economics*:

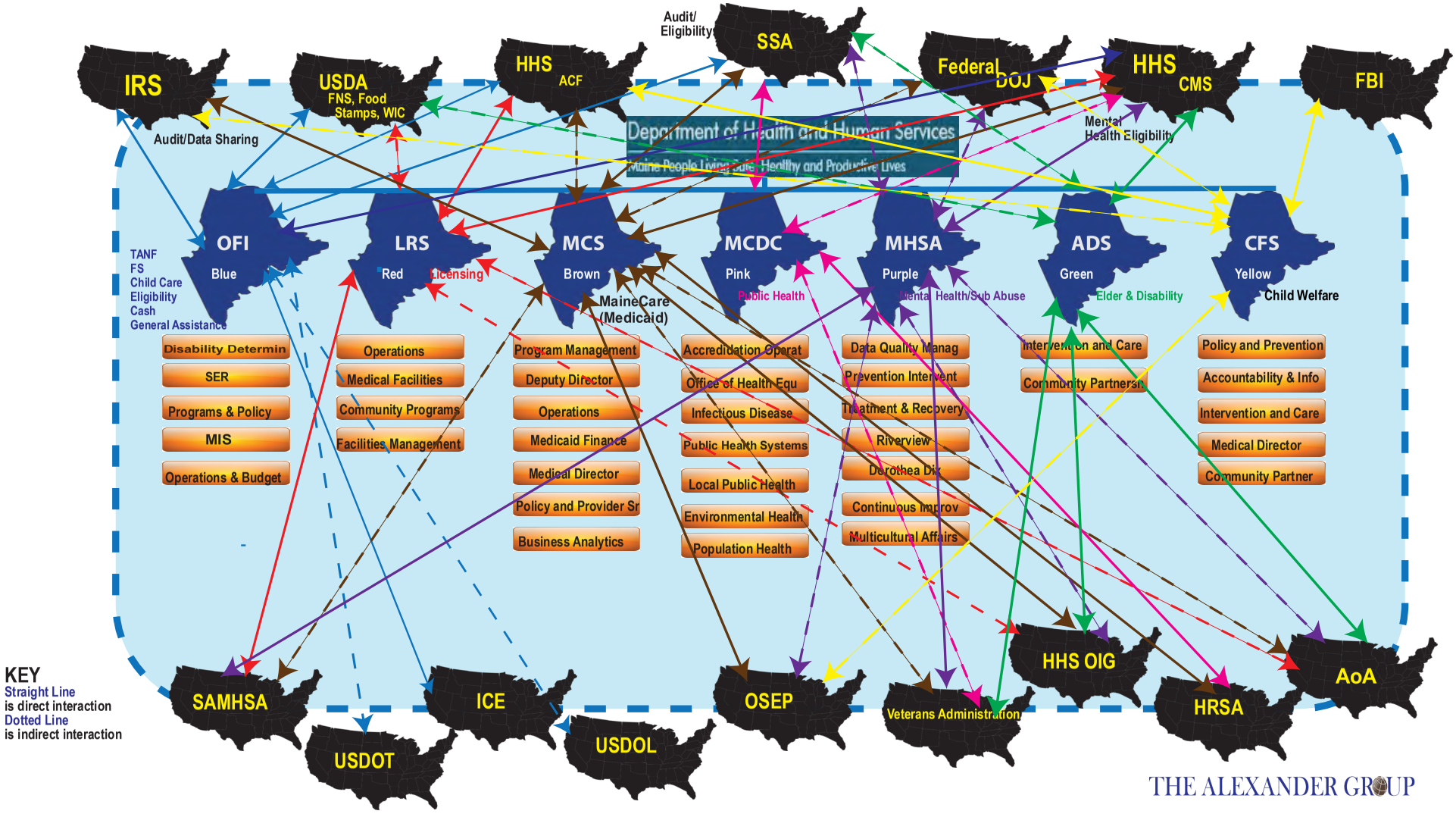
> The U.S. welfare system would be an unlikely model for anyone designing a welfare system from scratch. The dozens of programs that make up the "system" have different (sometimes competing) goals, inconsistent rules, and over-lapping groups of beneficiaries. Responsibility for administering the various programs is spread throughout the executive branch of the federal government and across many committees of the U.S. Congress. Responsibilities are also shared with state, county, and city governments, which actually deliver the services and contribute to funding.[1]

Consequently, every state must deal with a system in which numerous responsibilities for assistance to individuals are spread across multitude federal agencies. While these agencies provide funding, oversight, and technical assistance to help states improve on a programmatic level, there is little to no coordination — and no integration among the various federal programs from a systemic point of view. Furthermore, often lost in the shuffle is the impact on the individual and the family being served, and it becomes challenging for state governments to integrate their programs in any meaningful way.

Chart 1-1 on the next page graphically represents the complexity states are dealing with, using Maine as an example. There are federal agencies within agencies and departments; depending on how they are counted, there are at least sixteen federal agencies that interact with DHHS. This complex web makes it difficult to manage welfare programs in an integrated manner.

1. Thomas MaCurdy and Jeffrey M. Jones, "Welfare," *The Concise Encyclopedia on Economics*, the Liberty Fund, http://www.econlib.org/library/CEE.html.

Chart 1-1: **Complexity of the State-Federal Welfare System**



From the point of view of an individual or a family, the picture is even more complex. An impoverished person or family may have several needs, from assistance in obtaining food, securing shelter, receiving help with child care, and acquiring medical assistance. Because these forms of assistance are provided on a piecemeal basis, with conflicting and complicated eligibility rules and program structures that are delivered in a siloed fashion, they are confusing for the recipient to understand and case worker to administer.

To illustrate this point, we examined a potential situation for a single parent with two children: a toddler and a school-age child. If this family's income is low enough, it can qualify for several different assistance programs. First, there are refundable tax credits where this family can receive a refund in excess of income taxes paid. On the federal level, there is the Earned Income Tax Credit and the Additional Child Tax Credit. Maine also has a refundable Child Care Tax Credit. From a pure economic viewpoint, these refundable tax credits are not taxes at all. They are government subsidies. Economists call them "negative income taxes."[2]

Second, the family may be eligible for the Supplemental Nutrition Assistance Program (SNAP), formerly known as and commonly called food stamps,[3] and may qualify for ASPIRE-TANF cash assistance.[4] Third, the family may receive housing assistance from subsidized housing or the Housing Choice Voucher program. Fourth, the family may be eligible for child care subsidies. Finally, the family may be eligible for medical assistance through MaineCare, CubCare, or tax credits available through the Affordable Care Act (ACA).[5] The analysis incorporates the base benefits of each program identified above but does not take into consideration the plethora of special allowances available for additional needs, such as transportation, tools, and educational supplies. It also does not include several smaller programs, including energy assistance, school-lunch programs, and the supplemental nutritional program Women, Infants, and Children (WIC).

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2. Milton Friedman is credited with having originated the concept of a negative income tax, which he proposed in his book *Capitalism and Freedom* (1962).

3. The U.S. Food, Conservation and Energy Act of 2008 renamed the food-stamp program the Supplemental Nutrition Assistance Program (SNAP), effective October 1, 2008.

4. ASPIRE is Maine's TANF program, created in July 1988 to provide case management, education, training, support, and employment services. ASPIRE stands for Additional Support for People in Retraining and Employment. Temporary Assistance for Needy Families (TANF) is a federally sponsored program created by Congress in 1996 through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). It replaced Aid to Families with Dependent Children (AFDC).

5. MaineCare is Maine's Medicaid program. Maine's State Children's Health Insurance Program (SCHIP) expanded coverage to children using a combination of a Medicaid expansion and a separate child-health program referred to as "CubCare."

The analysis shows that, within a limited range for this hypothetical family, the system provides financial incentives to encourage the single parent to work. Chart 1-2 compares the economic impact on the family for four scenarios:

I. The parent does not work.
II. The parent works twenty hours a week for $7.50 an hour.
III. The parent works forty hours a week for $7.50 an hour.
IV. The parent works forty hours a week for $8.00 an hour.

Chart 1-2: **Income & Benefits Calculation to $8 per Hour**

Income and Benefits Calculation for Sample Family of Three 2013 Maine Data				
Scenario	**I**	**II**	**III**	**IV**
Hourly Wage	**N/A**	**$7.50**	**$7.50**	**$8.00**
Hours Worked Per Week	**0**	**20**	**40**	**40**
Monthly Data in Dollars:				
Net Gross Earned Income	0	600	1,201	1,281
Refundable Tax Credits	0	321	605	614
Cash and SNAP	911	565	366	361
Subtotal	**911**	**1,486**	**2,172**	**2,256**
Housing Choice Voucher	987	881	765	741
Subtotal	**1,898**	**2,367**	**2,937**	**2,997**
Child Care Subsidy	0	954	1,135	1,130
Subtotal	**1,898**	**3,321**	**4,072**	**4,127**
Medical Assistance	716	716	716	716
Total	**2,613**	**4,037**	**4,788**	**4,843**

The more the parent works (and the higher her hourly wage), the higher is her combined income and benefits. If we focus on the subtotal after the child care subsidy, which is the third line up from the bottom, the benefit to the family increases from $1,898 a month without work to $3,321 for part-time work at $7.50 per hour to $4,072 for full-time work at $7.50 per hour and finally to $4,127 for full-time at $8.00 per hour. This growth in combined income and benefits aligns with the ASPIRE program in helping families by encouraging work.

For this income range, when medical assistance is added, the effect is the same. The more the single parent works, the better off she will be financially. Medical assistance is the last item added to the analysis because it may not always be needed if the parent has an employer who provides health care as a benefit. This will be explained in further detail below.

In calculating the numbers for this analysis, it was necessary to make assumptions. The numbers represent a potential outcome, but circumstances and location may alter those numbers either upwards or downwards. The pattern, however, will likely be the same. The first assumption is that the single parent did not receive any additional income from child support or any other source. Second, it was assumed that the single parent was able to secure a housing-choice voucher in Portland from the Maine State Housing Authority. The calculation assumed a two-bedroom apartment using the standard table provided by the Authority for determining rent.[6] Third, it assumed that the parent placed the children in a quality child care center in Portland at the market rate as determined by DHHS.[7] No child care services were assumed if the parent did not work. However, if the parent worked full time, it assumed full-time child care services for the toddler but only half time for the school-age child. If the parent worked half time, then the part-time rate was determined for the toddler. Finally, it assumed the per-member-per-month costs for MaineCare and CubCare. It also assumed purchase of a silver health-care plan in the Portland area on the federal health-care exchange when the parent becomes ineligible for MaineCare, and when it becomes cheaper to switch the entire family over to the exchange.[8]

If we expand the analysis beyond the $8 per-hour wage, however, there are unintended consequences. It does not always benefit the parent to earn more money. In fact, the parent loses financially if she earns more money, shown in Figure 3. If the parent were to earn $9 an hour, instead of $8 an hour, she would lose $281 for the month. It works out this way because she would lose all her SNAP benefits, and her benefits would be reduced for the following programs: the housing-choice voucher, the child care subsidy, and the refundable tax credits. These reductions would be greater than the extra net income earned from the additional dollar per hour she might earn. These outcomes are contrary to the goals of ASPIRE.

6. There is currently a waiting list for housing subsidies.

7. Quality child care providers are defined for tax purposes as those with a quality certificate issued by DHHS Office of Child and Family Services. Regulations of the U.S. Administration for Children and Families (ACF) for the Child Care and Development Fund (CCDF) require states to conduct local market-rate surveys that establish maximum permissible reimbursement rates for care subsidies.

8. The ACA defines five levels of plans: bronze, silver, gold, platinum, and catastrophic. A silver plan pays on average 70% of the costs, with the remaining 30% coming out of pocket. The analysis assumes that when it becomes cheaper for the family to switch over to the exchange, it will do so.

Chart 1-3: **Income & Benefits Calculation to $16 per Hour**

Income and Benefits Calculation for Sample Family of Three 2013 Maine Data				
Scenario	**IV**	**V**	**VI to XI**	**XII**
Hourly Wage	**$8.00**	**$9.00**	**$10 to $15**	**$16.00**
Hours Worked Per Week	**40**	**40**	**40**	**40**
Monthly Data in Dollars				
Net Gross Earned Income	1,281	1,441	(a)	2,535
Refundable Tax Credits	614	593	(a)	302
Cash and SNAP	361	0	(a)	0
Subtotal	**2,256**	**2,034**	(a)	**2,837**
Housing Choice Voucher	741	692	(a)	383
Subtotal	**2,997**	**2,726**	(a)	**3,220**
Child Care Subsidy	1,130	1,120	(a)	936
Subtotal	**4,127**	**3,846**	(a)	**4,156**
Medical Assistance	716	716	(a)	407
Total	**4,843**	**4,561**	(a)	**4,564**
Note: (a) Data omitted for scenarios VI through XI.				

What makes this phenomenon even worse is the fact that this parent would have to earn significantly more to recover the loss. In fact, she would have to earn twice as much, that is, $16 an hour before she would recover the lost benefits from earning $8 an hour. Chart 1-4 graphically illustrates the full scope of the problem:

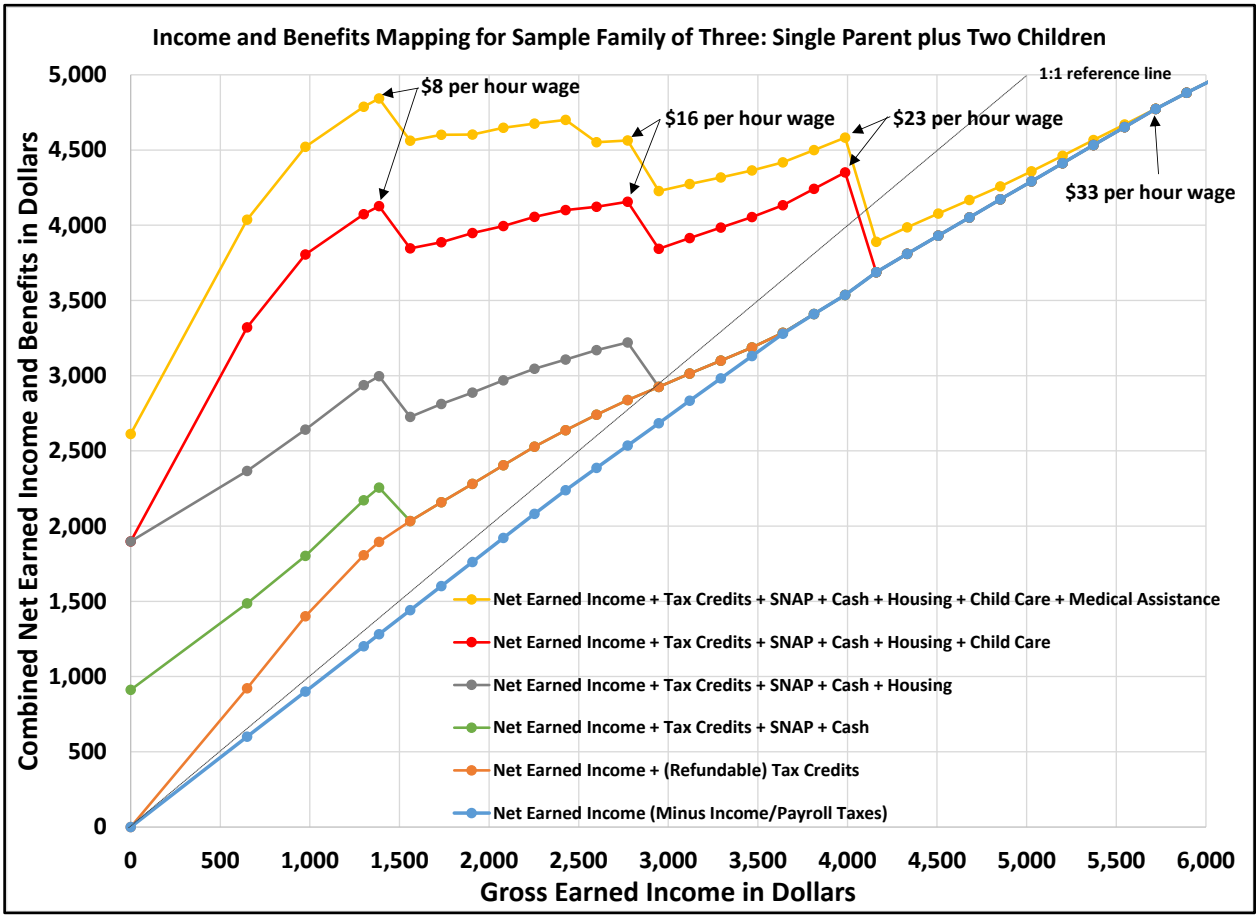
- The bottom blue line represents the net earned income, after income and payroll taxes are deducted.
- The orange line immediately above the blue line is the net earned income, plus refundable tax credits.

Each subsequent line, working upwards, adds on another benefit in a cumulative manner.

- The green line above the orange line adds SNAP and cash benefits.
- The gray line adds housing vouchers.
- The red line adds the child care subsidy.
- Finally, the yellow line adds medical assistance, in the form of MaineCare, CubCare, or the health-care insurance tax subsidy pursuant to the ACA.[9]

9. Health-care insurance subsidies were determined for Portland using the subsidy calculator provided by the Henry J. Kaiser Foundation: http://kff.org/interactive/subsidy-calculator/.

Chart 1-4: **Combined Income and Benefits Mapping for Family of Three**



Thus, the top yellow line provides all net income and benefits, consisting of net earned income, refundable tax credits, cash assistance, SNAP, housing-choice voucher, child care subsidies, and medical assistance.

A distinctive feature of Chart 1-4 is the jagged edge of the top two lines. The red line, or the second from the top, is perhaps the most important one. It represents the potential summation of income and welfare benefits without any medical assistance. The peaks illustrate those wage levels that maximize combined net income and benefits before they drop after an increase in wages. These peaks and subsequent reductions have been called welfare cliffs. These are the points where individuals get trapped because of the perverse economic incentives inherent in the federal-state public-welfare system. In this illustration, the single parent gets trapped earning $8 per hour and would lose financially if she earned higher wages, unless she earned $16 per hour. But then, however, she would hit another welfare cliff and would lose again if she earned more unless she earned at least $22 per hour. At $23 per hour, she hits a third cliff and would not recover until she earned at least $30.

The yellow line, which includes medical assistance, shows the same problem, except $8 per hour is the highest of all peaks, and the chart shows that she would require $33 per hour to recover the same level of income and benefits. The yellow line, however, needs to be viewed with some caveats. First, the analysis uses the per-member-per-month (or PMPM) cost for MaineCare and CubCare and compares that to the tax subsidies provided by the ACA. This comparison is true in terms of cost of the program, but the recipient may view it differently because she would not necessarily know the true costs.

On the other hand, the line remains by coincidence instructive. The tax subsidies under the ACA are less than the cost of MaineCare or CubCare, thus it shows a relative drop at $11 per hour when the parent loses MaineCare coverage and another drop at $15 when it would be advantageous for her to switch to a family plan on the exchange. The parent, however, would still need to weigh the risk of having out-of-pocket expenses for a policy obtained through the exchange. Second, there is the possibility that the parent would be offered health coverage through an employer. This may negate the importance of the medical assistance, especially for the higher wages. At the lower wages, however, MaineCare would likely be cheaper because there are no "premium shares," and an employer's plan would likely require an employee contribution.

Finally, Chart 1-4 underscores why the public-welfare system is broken. It is not necessarily any single program that is the problem. They each operate by complex rules that may make sense within its own-siloed purview. The refundable tax credits are notable because they, by themselves, provide no cliff effect and would exert a positive effect on labor participation. However, when you start stacking programs on top of each other, which is what happens in the real world, systemically you arrive at an irrational and illogical answer. It is doubtful that anyone would design a system where the maximum benefits accrue for an individual at $8 per hour but decline if she earns a little bit more. Or, a system where a person earning $8 per hour would have more than a person earning $24 an hour. But this is the system that has been designed over many decades by Washington in a piecemeal and siloed manner. The result is an overcomplicated system that traps individuals in low-income lifestyles by its poor design and lack of incentives to increase wealth and economic prosperity.

These unintended economic consequences affect real people and their families. From a microeconomic perspective, humans behave in rational ways that maximize their benefits. If welfare systems were to be redesigned with this fact in mind, it would be possible that the system could be truly a helping hand during times in need and help individuals and families in ways that benefit their wellbeing and move them toward financial independence from government assistance. As just demonstrated, the American system of welfare, however, has embedded perverse economic incentives that encourage dependency.

A few states have experimented with small demonstration projects in an attempt to integrate welfare programs in a more meaningful way, but none has fully integrated these services in ways that help needy families integrate into society without the need for governmental assistance. Housing assistance, for example, is practically entirely outside the

structure of any state welfare system, despite the fact that shelter is a basic human need. It makes no sense that when looking at a case for assistance that the need for housing is segregated from other basic needs.

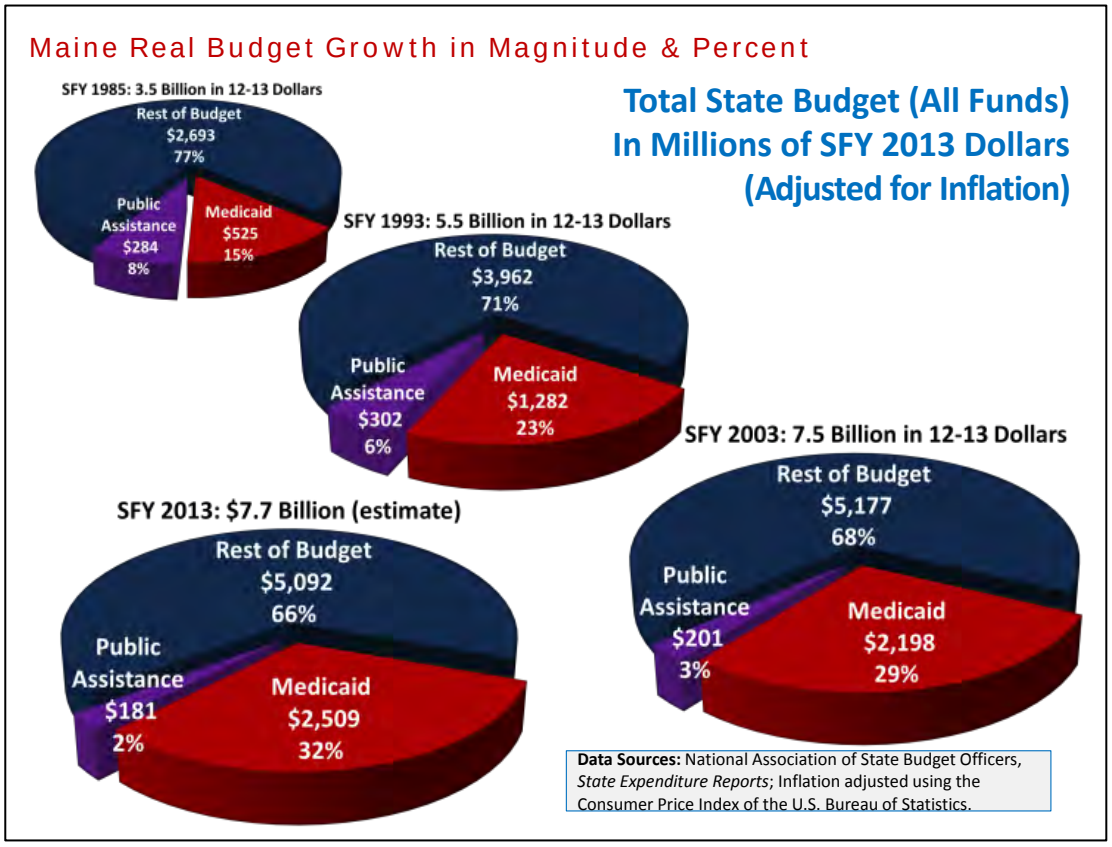
There is hope. The federal government has created limited flexibility within many of its welfare programs that allow states to experiment with better ways of doing things, although states are subject to different and, at times, contrary federal guidance, depending on the administration in Washington. Medicaid, for example, allows for several types of waivers from federal regulations. These provisions in federal law provide limited opportunities for states to seek innovations, although still in a siloed fashion. Such opportunities can allow states to experiment to find ways of better serving people and can be used to redesign the system that focus on the person and family in a more holistic manner. States, however, need much greater flexibility and integration authority if they are ever to be able to truly provide what one public welfare program, i.e., Medicaid, states as its purpose, "To furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence."[10]

In addition to the reasons of better outcomes for people and streamlining of bureaucracies, there are also economic and fiscal reasons to undertake these changes. For states in general, Medicaid and welfare programs have grown to become one of the most dominant budgetary issues. Especially when all funds are considered — state general revenue, other state revenue, and federal funds — welfare programs have grown both in magnitude and proportion. Chart 1-5 illustrates this point for Maine. It uses data collected and published as state expenditure reports by the National Association of State Budget Officers (NASBO).[11] Medicaid spending from all funds, even after adjusted for inflation, has nearly quintupled in Maine in less than thirty years. The Medicaid portion of the budget in all funds has doubled over that timeframe from 15% to 32%.

10. 42 U.S.C. § 1396 (2).

11. Values for SFY 2013 are estimated.

Chart 1-5: **Maine Real Budget Growth in Magnitude & Percent**



While all states are struggling with Medicaid spending, Maine ranks among the states with the highest budgetary burden. As a percentage of its overall budget, which includes the general fund, other state funds, and federal funds, Maine now spends the third highest proportion of all the states on Medicaid. As a matter of comparison, Maine ranks thirty-first on the proportion of its budget spent on K-12 education. See Chart 1-6.

Making some economic comparisons help put the growth into perspective. Here we compare the inflation-adjusted cost (all funds) of Medicaid and public assistance, as published by NASBO, to three factors: population, employment, and state personal income. The first comparison is to the total population, as published by the U.S. Bureau of Economic Analysis. By dividing the population into the inflation-adjusted budget, we can see that the per-capita cost has nearly tripled since 1985. The per-capita cost was $2,024 in SFY 2013. See Chart 1-7.

The second comparison is to the total number of employed persons, as measured by the current population survey of the U.S. Bureau of Labor Statistics. Again, the Maine inflation-adjusted employed person cost nearly tripled since 1985. In SFY 2013, the cost per employed person was $4,086. See Chart 1-8.

Chart 1-6: **Maine's State Ranking in Funding Medicaid & K–12 Education**

SFY 2013 Percentage of Total State Budget			
Education		**Medicaid**	
State and Rank	**%**	**State and Rank**	**%**
1. Vermont	33	1. Missouri	36
2. Indiana	31	2. Pennsylvania	34
3. Georgia	31	**3. Maine**	**32**
4. Minnesota	27	4. Arizona	32
5. Texas	27	5. Indiana	32
13. New Hampshire	**23**	**15. New Hampshire**	26
State average	***19***	***State average***	***23***
31. Maine	**17**		

Chart 1-7: **Per-Capita Cost, Medicaid & Public Assistance**

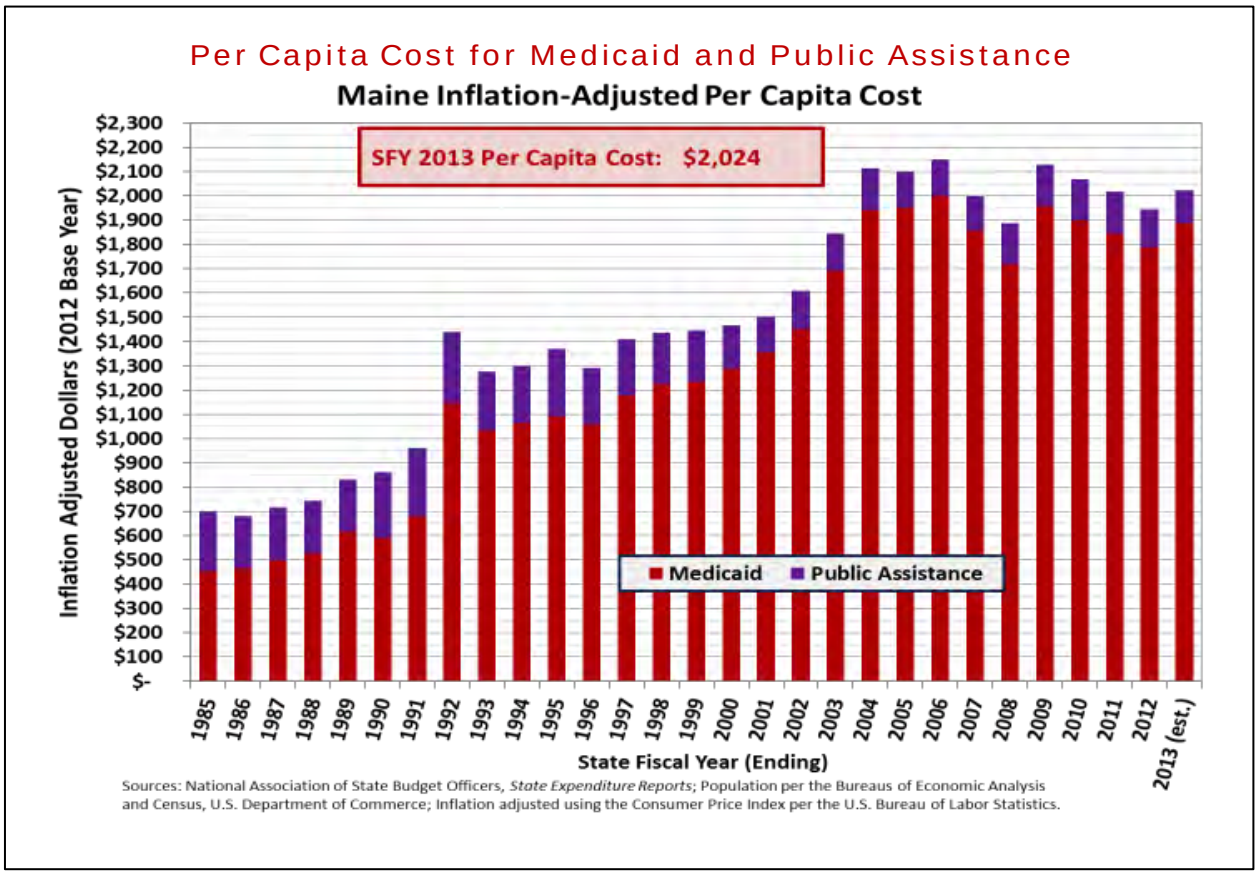
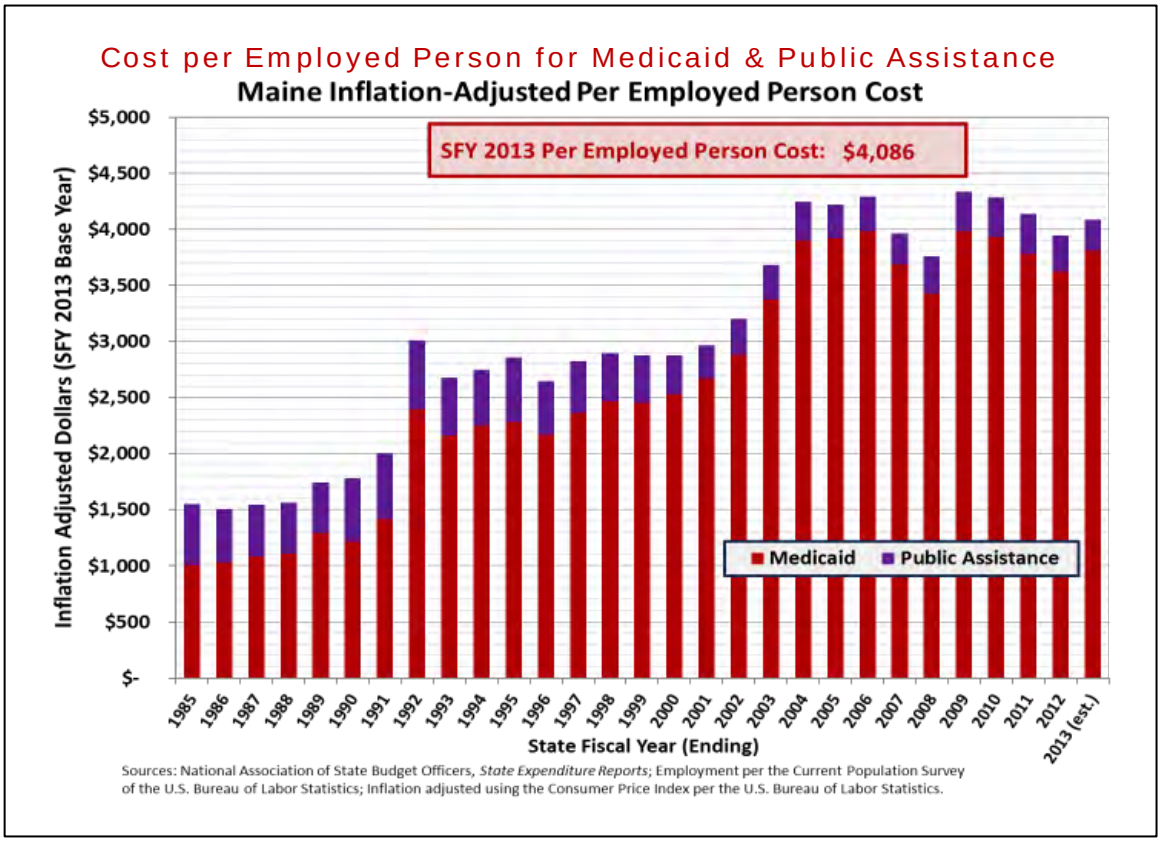


Chart 1-8: **Cost per Employed Person, Medicaid & Public Assistance**



The third comparison is to state personal income, as measured by the U.S. Bureau of Economic Analysis. State Personal Income, an overall measure of the total income within a state, is often a preferable economic indicator over State Domestic Product. As a percent of State Personal Income, the cost of Medicaid and public-assistance programs has approximately doubled since 1985. The cost of Medicaid and public assistance was 5.0% of State Personal Income in SFY 2013. See Chart 1-9.

An examination of all three comparisons — per-capita, per employed person, and percentage of state personal income— demonstrate that, in terms of economic burden, the growth has leveled off since SFY 2006 and has come down somewhat since SFY 2009. This provides evidence supporting our first observation: the LePage administration has significantly advanced reforming the system. These long-run trends are encouraging. However, there are still good reasons to be cautious in that optimism.

The first reason for caution requires looking behind those numbers. Some of the improvement can be accounted for by improved economic indicators, such as the improvement in employment from SFY 2002 through SFY 2007, or the improvement in state personal income through SFY 2008. Other improvements relate to controlling costs. Chart 1-10 shows a history

of the total budget (all funds) for DHHS since SFY 2002.[12] The dollars shown are not adjusted for inflation. Costs have been contained since SFY 2009.

Chart 1-9: **Cost of Medicaid & Public Assistance to State Personal Income**

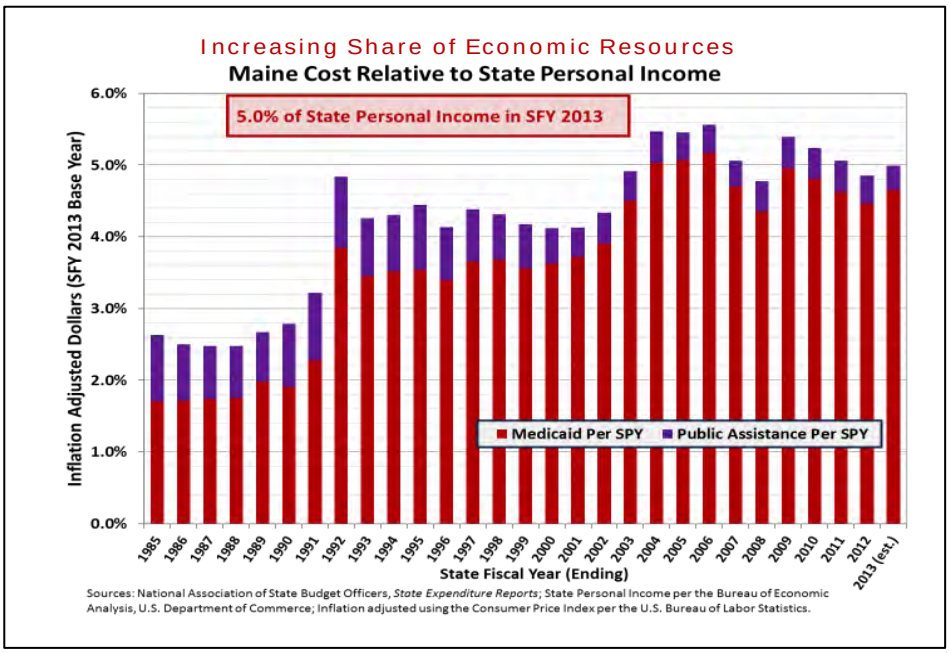
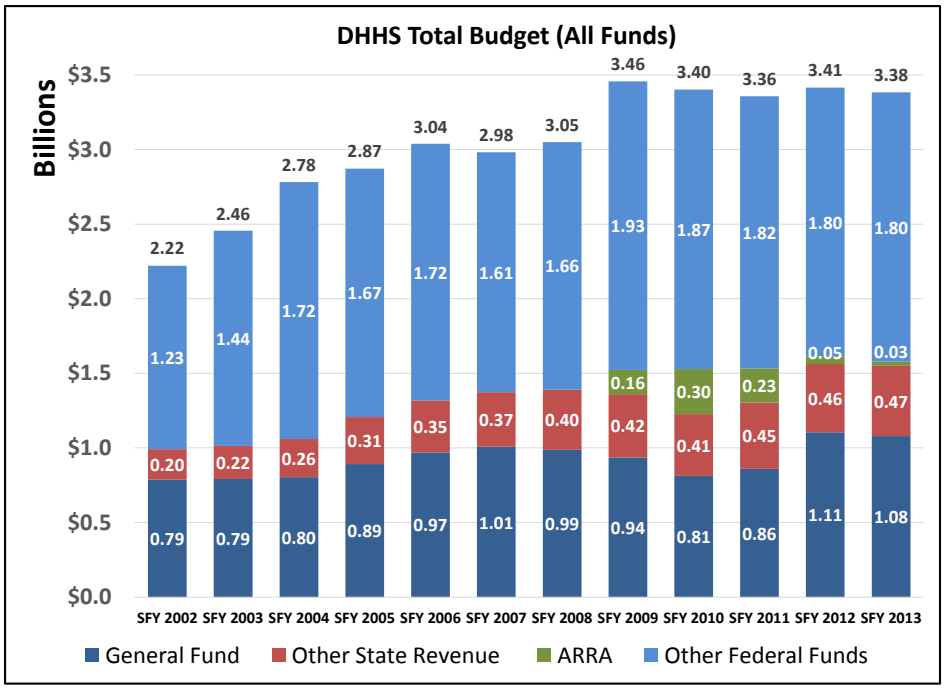


Chart 1-10: **DHHS Total Budgets by Funding Source**



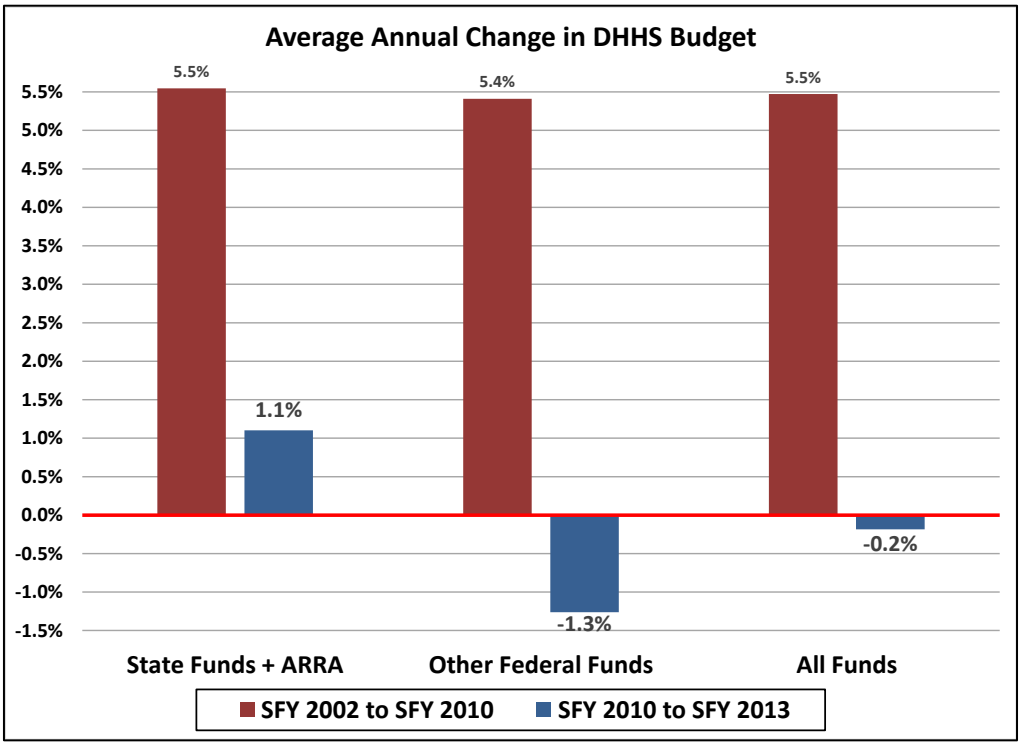
12. Budgets for SFY 2002, 2003, and 2004 are pre-merger budgets of the same program areas.

Chart 1-11 uses the same data as Chart 1-10, but it compares the growth rates between two periods: SFY 2002 to SFY 2010, and SFY 2010 to SFY 2013. For all funds, the average annual growth rates were 5.5% for SFY 2002 to SFY 2010, and –0.2% for SFY 2010 to SFY 2013. For state funds, including federal economic stimulus money from the American Recovery and Reinvestment Act of 2009 (ARRA) intended to help states meet revenue shortfalls,[13] the average annual growth rates over the same time periods were 5.5% and 1.1%, respectively. For federal funds, other than ARRA, the growth rates were 5.4% and –1.3%, respectively.

The second reason for caution is that Maine's burdens still rank high when compared to other states. Maine ranks fifth on a per-capita basis, which is $615 above the state average; tenth on a per employed person basis, which is $1,022 above the state average; and third in terms of a percentage of state personal income, which is 1.7 percentage points above the state average. See Chart 1-12. Maine, therefore, has an economic burden 51.6% to 54.9% higher than the national average, depending on which measure is chosen. A reasonable policy strategy, therefore, would be to find ways to lower the burden.

These commitments to fund Medicaid and other DHHS programs are significant. Chart 1-13 provides the total dollar commitment for SFY 2013.

Chart 1-11: **Average Annual Change in DHHS Budget**



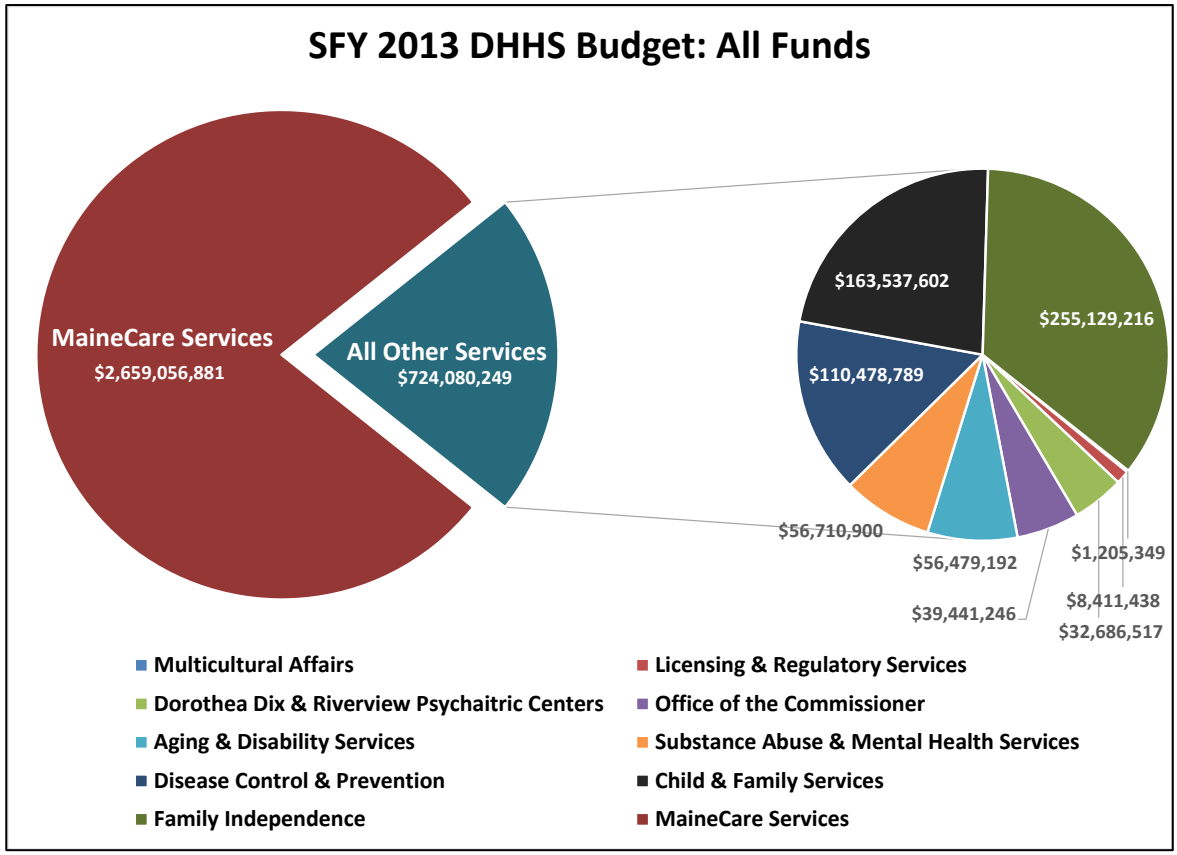
13. Because ARRA funds were intended to replace state funds, they are typically included with state funds for comparison purposes to avoid a distortion of the comparison. Otherwise, it would give a misleading trend for both state and federal funds.

Chart 1-12: **Top States for Medicaid & Public-Assistance Costs**

Top Ten States in Costs for Medicaid and Public Assistance: SFY 2013								
Per Capita Cost Rank			**Per Employed Cost Rank**			**% State Personal Income**		
1	Alaska	$ 2,434	1	Alaska	$ 5,243	1	Mississippi	5.4%
2	Vermont	$ 2,381	2	New York	$ 4,849	2	Vermont	5.3%
3	New York	$ 2,184	3	Mississippi	$ 4,650	**3**	**Maine**	**5.0%**
4	Massachusetts	$ 2,156	4	Massachusetts	$ 4,443	4	West Virginia	4.9%
5	**Maine**	**$ 2,024**	5	Vermont	$ 4,422	5	New Mexico	4.9%
6	Rhode Island	$ 1,992	6	West Virginia	$ 4,321	6	Alaska	4.9%
7	Pennsylvania	$ 1,906	7	New Mexico	$ 4,263	7	Arkansas	4.8%
8	Mississippi	$ 1,845	8	Rhode Island	$ 4,147	8	Rhode Island	4.3%
9	Connecticut	$ 1,831	9	Arkansas	$ 4,132	9	Pennsylvania	4.2%
10	New Mexico	$ 1,762	**10**	**Maine**	**$ 4,086**	10	New York	4.1%
	State Average	***$ 1,410***		***State Average***	***$ 3,064***		***State Average***	***3.3%***

Data Sources: National Association of State Budget Officers, State Expenditure Report: Examining Fiscal 2011–2013 State Spending; U.S. Bureau of Economic Analysis; and U.S. Bureau of Labor Statistics.

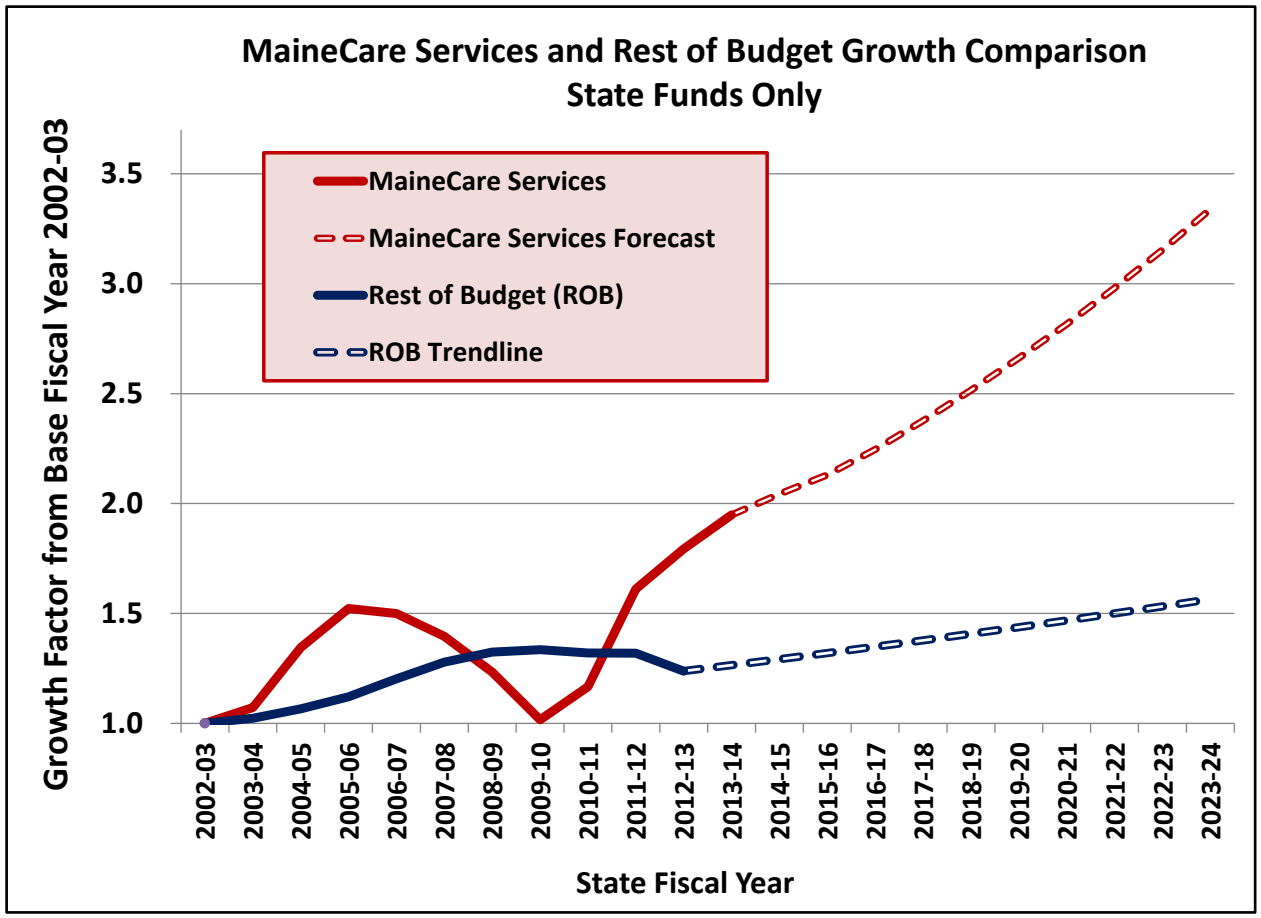
Chart 1-13: **DHHS Budget (All Funds) by Program, SFY 2013**



A fourth reason for caution is that cost-savings initiatives can be abandoned and recent improvements can be easily reversed, especially in light of demographic and economic trends.

Long-term care is a significant proportion of the cost of MaineCare, and the elderly population is forecasted to grow dramatically, by as much as 46.5%, over the next ten years.[14] Likewise, the number of persons living in poverty has continued to grow, according to Census Bureau measurements. The combination of these trends will place pressure on the department's budget. Chart 1-14 provides an illustration on how these factors may drive costs for MaineCare services related to the rest of the budget.

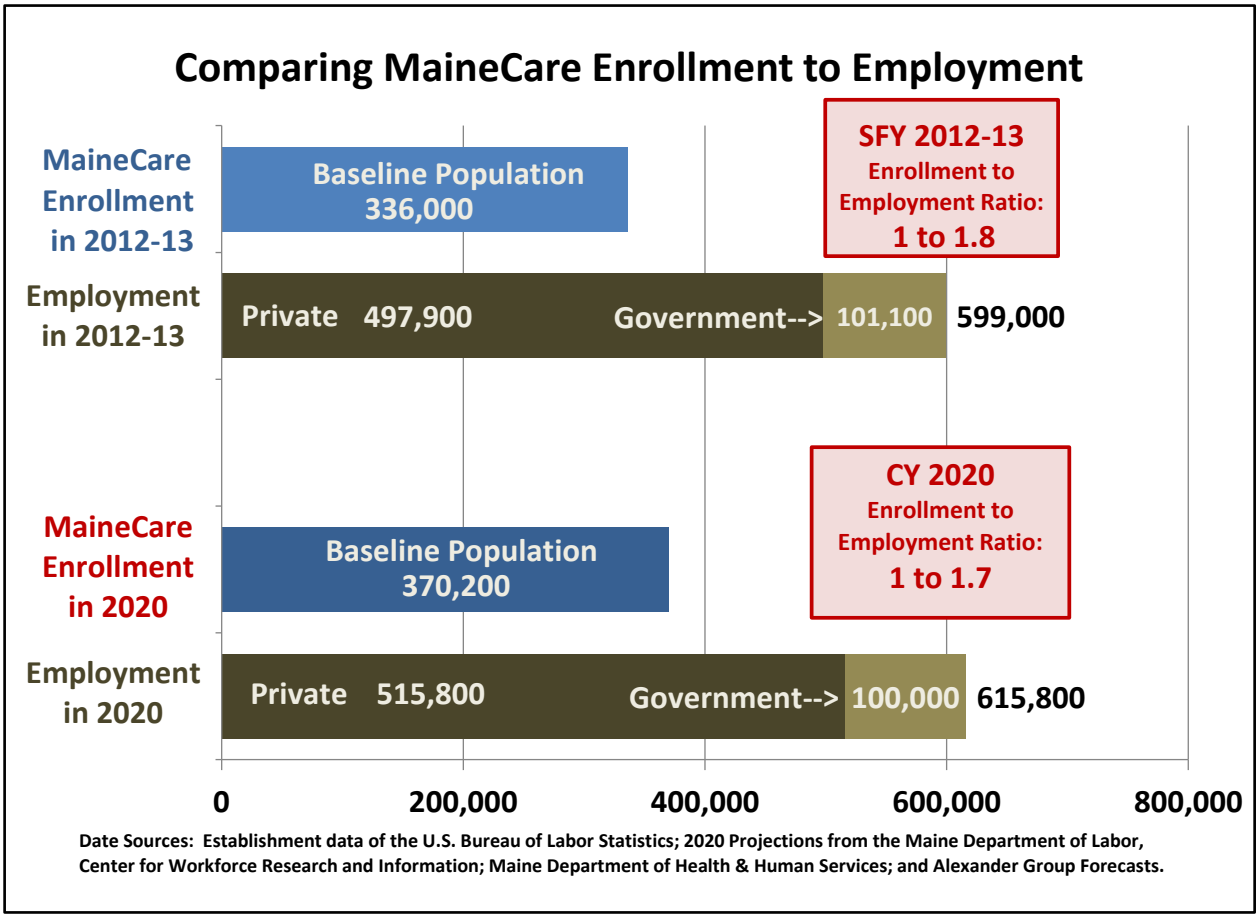
Chart 1-14: **MaineCare Services and Budget Growth Comparison**



14. Julie Fralich et. al., "Older Adults and Adults with Disabilities: Population and Service Use Trends in Maine," *Chartbook*, 2012 Edition, http://muskie.usm.maine.edu/Publications/DA/Adults-Disabilities-Maine-Service-Use-Trends-chartbook-2012.pdf. Note that the *Chartbook* reported nearly 99% of the state's population growth would be among those 65 and older. Although this calculation is correct when age brackets are aggregated in this manner, it may be misleading by giving the false impression that no category below 65 is projected to have growth when in fact four of those six age categories are projected to have significant growth. The calculation works out that way because the age categories of 15–24 and 45–54 are projected to have negative growth, which negates the growth in the remaining four categories under age 65. Perhaps a better way to represent the growth would be to exclude the two age categories with negative growth, giving the result of approximately 70% of the growth attributed to age category of 65 and older.

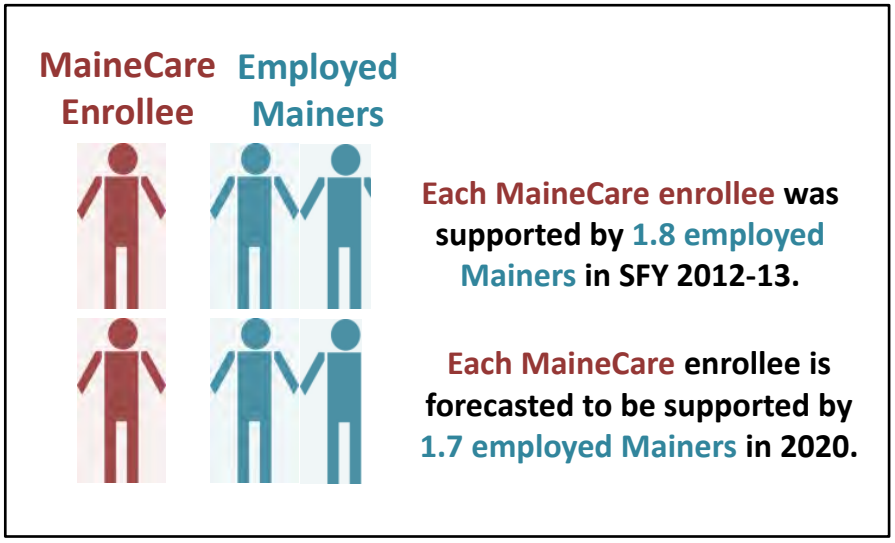
There is a related comparison that can be made. For each person on MaineCare, there were 1.8 employed Mainers in SFY 2012–13. For obvious reasons, it is advantageous to have a higher number of employed persons supporting persons on MaineCare. Because enrollment is expected to grow, there is risk that the ratio could drop in SFY 2020 to 1.7 employed persons to each person on MaineCare.[15] See Charts 1-15 and 1-16.

Chart 1-15: **Comparing MaineCare Enrollment to Employment**



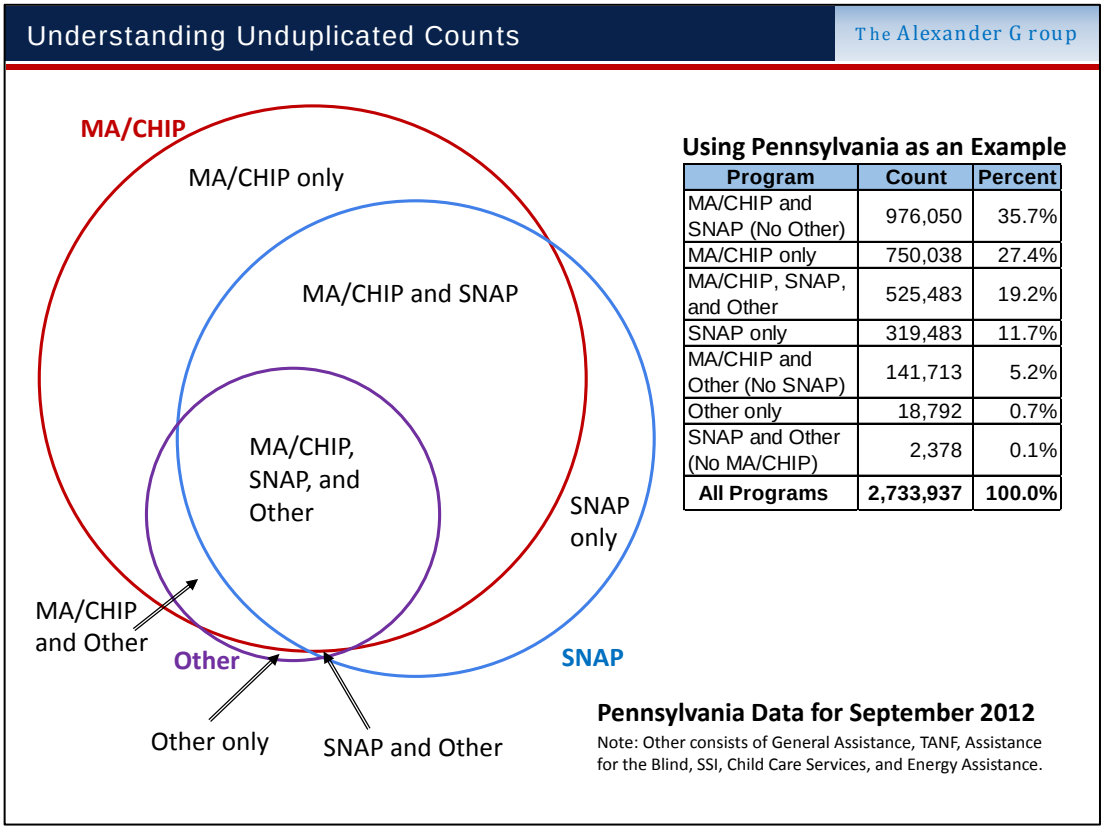
15. Note that the employment numbers in Chart 1-15 are slightly different from those in our January report because the U.S. Bureau of Labor Statistics revised its estimates. The ratios, however, remain unchanged. See Vidalina Abadam, Nicole Havins, and Liza Kelly, "Revisions in State Establishment-based Employment Estimates Effective January 2014," U.S. Bureau of Labor Statistics, http://www.bls.gov/sae/benchmark2014.pdf.

Chart 1-16: **Forecasted MaineCare-to-Employed Mainers Ratios**



Although MaineCare is the largest welfare program, it does not represent the entire welfare population. Not all persons on welfare, including those receiving SNAP benefits or child care subsidies, are on MaineCare. Chart 1-17, using Pennsylvania data, provides a Venn diagram to illustrate how welfare programs serve overlapping caseloads.

Chart 1-17: **Understanding Unduplicated Counts**



In the case of Maine, we did not independently produce an unduplicated number using DHHS's data system to generate a Venn diagram. Although the department has produced unduplicated numbers on an *ad hoc* basis, the counts were in the aggregate on an annual basis as opposed to a point-in-time calculation by program intersection. First, the *ad-hoc* unduplicated counts do not provide intersection data among the programs and do not include all programs, including child care services through the Child Care and Development Fund (CCDF). These counts, therefore, cannot be used to produce a Venn diagram.

Second, in order to make a comparison to employment data, we need the unduplicated count data on a point-in-time basis, which requires some explanation. An annual-basis count provides the number of persons who receive assistance at any time within a course of a year. A monthly count provides the number of persons who receive a benefit at any time within the course of a month. A point-in-time count selects a particular day and counts the number of recipients. Because of the churn, i.e., persons coming on and off programs over time, an annual-basis count will always produce the largest number. Likewise, a point-in-time count produces the smallest number. Each timeframe has its own purpose. For example, the department produced an unduplicated count for a December 18, 2011, radio address by the governor.[16] In this case, the unduplicated number was for calendar year 2010 in order to compare to the number of taxpayers who paid income taxes for the same year.

Because we did not have system-generated data on overlapping programs, we estimated the overlap using U.S. Census Bureau data. The 2012 American Community Survey (ACS) included questions on whether respondents received food stamps/SNAP benefits and whether they are enrolled in Medicaid, defined as any government medical assistance "plan for those with low incomes or a disability." MaineCare and CubCare are included in this definition. Chart 1-18 provides the 2012 survey results for Maine. According to the survey, an estimated 28.7% of the population is enrolled in Medicaid, or receive food stamps, or both. An estimated 23.6% of the population is enrolled in Medicaid, an estimated 20.5% of the population receives food stamps, and an estimated 15.5% of the population receive both food stamps and is enrolled in Medicaid.

16. See Governor LePage's Radio Address for December 17, 2011, available online: "Tough Questions Deserve Honest Answers," http://www.maine.gov/tools/whatsnew/index.php?topic=Gov_Radio_Addresses&id=326536&v=article. See also Eric Russell, "LePage's Taxpayer Versus Welfare Recipient Numbers Mostly Right," Bangor Daily News, December 19, 2011, http://bangordailynews.com/2011/12/19/politics/lepages-taxpayer-versus-welfare-recipient-numbers-mostly-right/.

Chart 1-18: **Percentage Break Out Receiving Medicaid and SNAP**

2012 American Community Survey Results for Maine				
		Do respondents receive food stamps/SNAP?		
		Yes	No	Total
Are respondents enrolled in Medicaid*?	Yes	15.5%	8.1%	23.6%
	No	5.1%	71.3%	76.4%
	Total	20.5%	79.5%	100.0%
Enrolled in Medicaid or Receives Food Stamps or Both				28.7%
* The survey defines Medicaid as "any kind of government assistance plan for those with low incomes or a disability." It includes MaineCare and CubCare.				

The Census Bureau data are not precise, but offer a good indication of the overlapping programs. It is not possible to calculate an exact margin of error using ACS data, but the Census Bureau provides a methodology to approximate the margins of error. In the case of Chart 1-18, the approximate margin of errors, at 90% confidence intervals, varies from 1.85% (for the population that receives neither benefit) to 12.34% for the population on food stamps but not enrolled in Medicaid. The estimate of 23.6% for total population receiving Medicaid in 2012 compares well to our calculation of 24.7% for SFY 2012–13, using enrollment data.[17]

In addition, there is another reason why the Census data may be less accurate. As is true with all survey data, the survey responses are not independently verified, which allows the possibility for respondent error. Because the Census estimate of 23.6% is less than the calculated value of 24.7%, it appears there may be an underreporting, although the error could also be due to statistical sampling.

We can further use the Census data to estimate the total population receiving either medical assistance or food stamps. From Chart 1-18, it can be calculated that 82.34% of the population that enrolled in Medicaid or received food stamps or both, are enrolled in Medicaid. The enrollment in SFY 2012–13 was 336,000, giving us an estimated population of 408,100 for the unduplicated count of welfare recipients.[18] Had we applied the percentage of 28.7% to the

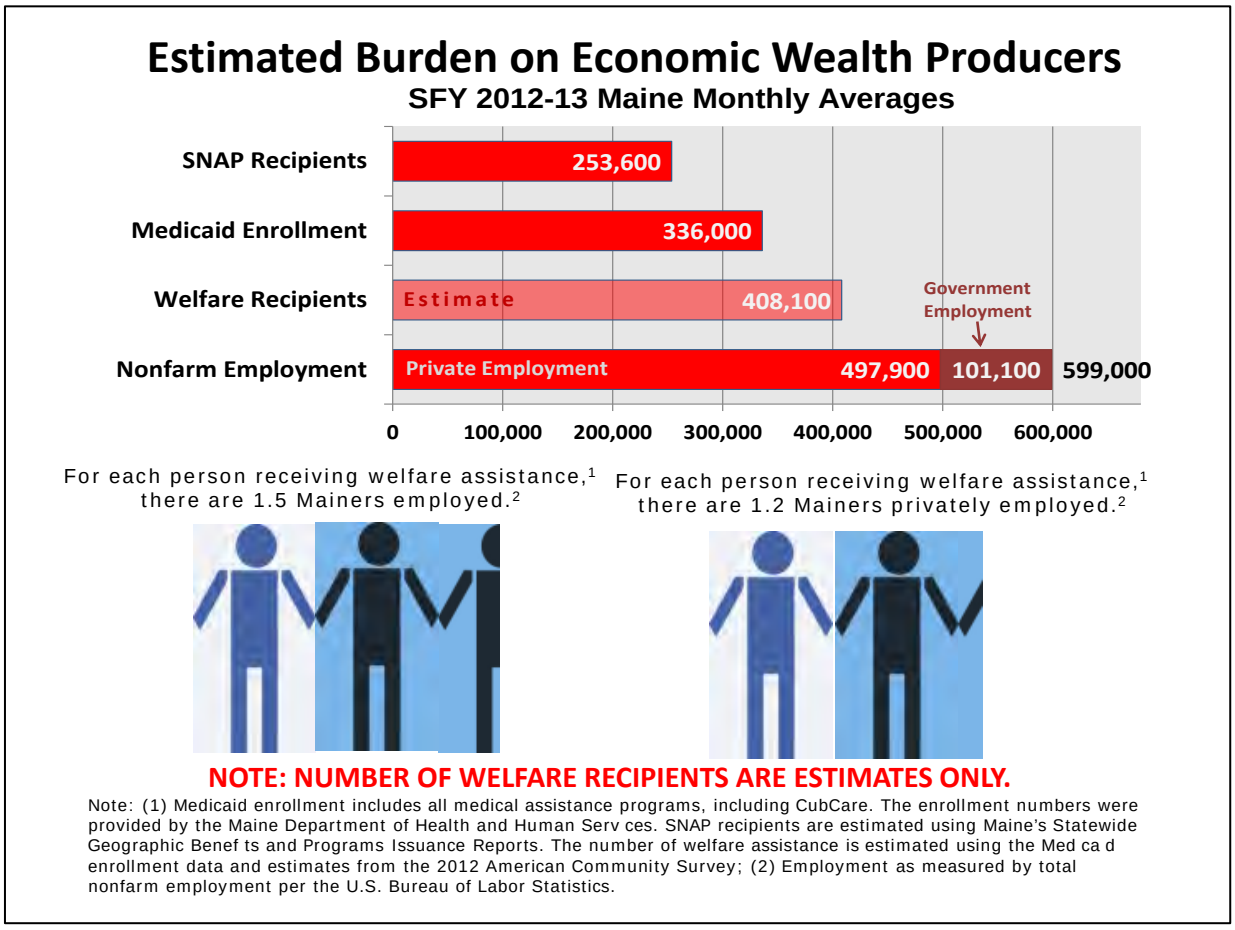
17. The Alexander Group, "Feasibility of Medicaid Expansion under the Affordable Care Act: A Review Submitted to the Maine Department of Health and Human Services," January 10, 2014, p. 59.

18. These numbers are rounded to the nearest 100.

total estimated population, the estimate would be 389,800. We chose to use the higher estimate because of statistical reliability reasons explained above.[19]

In addition, because medical assistance and SNAP are the largest programs, we assume that the unduplicated count includes all persons receiving welfare assistance. This is not unreasonable when one considers that data for Pennsylvania for those two programs comprised 99.3% of the welfare-dependent population in September 2012. (See Chart 1-17.) The U.S. Bureau of Labor Statistics recently revised its estimates for State Establishment-based Employment,[20] giving 497,900 average monthly private employment for Maine in SFY 2012–13 and 101,100 in government employment. These numbers give us the following estimated ratios: for each person receiving welfare assistance, there are 1.5 Mainers employed or 1.2 Mainers privately employed. See Chart 1-19.

Chart 1-19: **Estimated Burden on Economic Wealth Producers**



19. Comparing the Census estimate from the ACS to the known enrollment for those on Medicaid produces a number 4.5% too low. If we adjust accordingly to estimate the total either enrolled in Medicaid or receiving food stamps or both, we also derive an estimate of 408,100.

20. See Footnote 16.

Background to Report

In developing this report, the AG has taken into account the mandates of the federal government, the priorities of the state government, and the range of resources which have been brought to bear on the needs of children, families, and other special populations served by DHHS. With the assistance of the department, every effort has been made to understand all programs and services and to identify root causes of any underperformance indicators identified within respective programs. Where appropriate, the report offers options and recommendations to assist the department with global reforms and strategies to improve services and processes throughout the system.

This baseline report is being compiled with the assistance of many key staffers of the Maine DHHS and the Maine Department of Labor (MDOL), who have been willing to share their knowledge, expertise, and vision for improving both policies and outcomes for all recipients served through DHHS. Their cooperation and input to date has provided vital information used in the first phase of this analysis.

In addition to state-level administrators and field staff, we acknowledge our appreciation to the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), the U. S. Department of Agriculture, Food and Nutrition Services (FNS), and the U.S. Department of Labor for their assistance and guidance in better understanding the laws and regulations of various federal welfare programs and benefits.

A core value used in guiding this review began with a basic understanding of DHHS's clearly articulated mission statement:[21]

> To promote safe, healthy, independent lives for all, while ensuring efficient and effective use of resources for Maine's most vulnerable.

The Maine Department of Health and Human Services has worked long and hard to achieve a balance within its administrative and budgetary responsibilities while maintaining a strong focus on the needs of the most vulnerable populations: pregnant women, children and families, individuals with disabilities, veterans, and elders. The project review thus far has taken into account a number of well-developed initiatives currently being implemented throughout DHHS under the direction of Commissioner Mary Mayhew.

21. Department of Health and Human Services Strategic Plan 2013–2015, October 2013, p. 4.

One important achievement to date is the early progress by the Office for Family Independence (OFI) in redesigning field operations. This redesign of workflow process throughout the sixteen regional centers has meant that the AG can focus its efforts in other areas of concern to the Department, such as highlighting emerging issues in federal and state programs and policy directions; examining DHHS policies and regulations to determine possible areas for restructuring in order to optimize the administration and service delivery of benefits provided through DHHS. Additionally, the AG is working with Maine's OFI and other divisions to assess and fortify effective principles of program integrity. Virtually every publicly supported benefit on both the state and federal level is confronting the need for greater emphasis on internal systems controls and program integrity. It is a mandate with new meaning and the department has articulated strong interest in identifying methods of tightening controls and accountability, including systems enhancements.

Even the early phases of process improvements such as the new telephone system, and soon to be implemented centralized document-imaging center, are being met enthusiastically at the field level. Both are discussed in greater detail in this report. The importance of this redesigned eligibility process for all public assistance holds tremendous promise for all involved, including the administrative level, field operational level, and very importantly, at the recipient level by those who rely on DHHS for help.

Also noteworthy are the continuous improvement efforts of the Division of Child Support Enforcement and Recovery (DSER), which demonstrates historical dedication to policy and systems upgrades, all of which effectively streamline and simplify the process for collecting and distributing child-support payments to custodial parents on behalf of their children.

Contents and Data Sources

Since the enactment of PRWORA in 1996, the sweeping reforms of this law have reverberated throughout virtually all public-welfare programs offered in the country. PRWORA not only reformed cash assistance for needy families through the creation of TANF, but also changed food assistance, child care assistance, and medical assistance for all populations. PRWORA defined how and when immigrants could qualify for assistance across programs, and has brought about important impacts within civil-rights regulations, as well as job training, and employment programs for adults.

This report contains a review of the public-welfare programs administered by the Maine DHHS. These programs include TANF, SNAP, the Child Care and Development Fund (CCDF) Child Care Subsidy Program, General Assistance, Medical Assistance (MA), as well as DSER.

Several other programs were reviewed; however, these programs served specific populations and were on a smaller scale in terms of numbers served and dollars expended. They include the Alternative Assistance Program, Refugee Cash Assistance (RCA) Program, and

Emergency Assistance. The Alexander Group (AG) examined mandatory state plans submitted to federal government agencies and examined how individual policies and protocols have been developed by the state in order to responsibly administer these resources.

As a baseline report, AG has attempted to highlight through data analysis what is working and what needs attention; it provides both regional and national comparison data for reference, and it raises some issues and concerns discovered during the review.

Considering the broad spectrum of programs covered in this review, data sources used included various federal and state specific data reports, U.S. Census Bureau, national research organizations that specialize in studying welfare and health care on a national scale. Every effort has been made to base observations, comparisons, and conclusions on the most recent, up-to-date data available. Admittedly, some references cover periods relating to pre-PRWORA. However, as footnoted below each chart, the primary focus of information pertains to state and federal fiscal years 2011, 2012, and 2013.

Methodology

After introductory meetings with DHHS administrative staff, AG began gathering program information through face-to-face interviews with specific program administrators from ASPIRE-TANF/PaS, SNAP, Medicaid, and Child Care Development Fund (CCDF), which is administered through the Office of Child and Family Services (OCFS). Additional face-to-face interviews and/or telephone interviews were with DHHS administrative staff from DSER and MaineCare. Additionally, interviews were held with representatives of the Maine Department of Labor (MDOL). Ongoing communication with the department's Division of Business Technology and its respective systems contractors took place in order to obtain essential data reports and expenditure information related to the various programs' eligibility, participation, monthly expenditures, and data reports emanating from the Medicaid Management Information Systems (MMIS) and the Automated Client Eligibility System (ACES).

In addition to state and department experts, federal representatives of TANF, SNAP, child care, child-support enforcement, and Medicaid have been contacted in order to glean useful information on current and anticipated developments within U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

Another important aspect of carrying out this review, site visits were made to the Portland Regional Center and the Farmington Regional Center, where informative interviews were conducted with management and service-delivery staff at all levels who shared both their knowledge and expertise on multiple areas of policy, programs, systems, and service delivery. A significant area discussed was technological support available now and anticipated in the future, which will help the field staffers to carry out their jobs with a high degree of efficiency and sensitivity to the needs of recipients being served by DHHS.

PART I: GENERAL PUBLIC-WELFARE PROGRAMS

2. Temporary Assistance for Needy Families (TANF)

The 1996 welfare-reform law entitles states to a basic TANF block grant equal to peak expenditures for pre-TANF programs during the FY 1992–95 period when cash-welfare rolls were at their all-time high. The basic block grant is legislatively fixed, which means the grant amount does not change when the cash-assistance caseload decreases or increases, nor is it adjusted for inflation. The total amount of the federal TANF block grant is $16.4 billion each year, which is appropriated to the fifty states and the District of Columbia. Maine's yearly allocation is $78.1 million.[22]

The yearly TANF basic block grant to Maine is $78.1 million.

TANF requires all states to maintain spending from their own funds on TANF or TANF-related activities. This requirement is called the "maintenance-of-effort" (MOE) level, and that spending must represent at least 75% of what was spent from state funds in FY 1994 in TANF's predecessor programs AFDC, Emergency Assistance, job training, and welfare-related child care spending. Another TANF mandate is that states must meet specific work participation levels, or face spiraling financial penalties that may result in the loss of federal dollars. If a state fails to meet TANF work participation requirements, the MOE requirement increases to 80% of state expenditures in FY 1994.

- 75% of Maine's required MOE level is $37.5 million
- 80% of Maine's required MOE level is $40.0 million
- 80% MOE is required if state fails to meet the TANF 50% work participation rate for all families and the 90% work participation rates for two-parent families.

22. Gene Falk, "TANF Block Grant: A Primer on Financing and Federal Requirements," Congressional Research Service, April 2, 2013, pp. 3, 4, 8.

Chart 2-1: **Annual TANF Block-Grant and State-MOE Expenditures**			
Category	**FFY 2011**	**FFY 2012**	**FFY 2013**
Total TANF Block Grant	**$78,120,889**	**$78,120,889**	**$78,120,889**
Total Transferred to CCDF	0	0	$ 2,000,000
Total Transferred to SSBG	0	0	$ 7,812,089
Total Adjusted SFAG	**78,120,889**	**78,120,889**	**$68,308,800**
State TANF-MOE Expenditures	17,450,025	13,260,868	19,396,917
MOE Expenditures Separate State Programs	30,715,730	27,035,171	20,899,121
Total Expenditures to Meet Required MOE	**$48,165,755**	**$40,296,039**	**$40,296,038**

Chart 2-2: **Combined TANF and MOE Expenditures by Categories**			
Category	**FFY 2011**	**FFY 2012**	**FFY 2013**
Cash Assistance To ASPIRE/PaS Families	$77,208,895	$73,050,951	$46,404,754
Child Care Assistance	6,563,467	5,718,480	4,332,305
Transportation & Other Support Services	11,480,718	10,273,842	9,188,170
Non-Assistance (Other Work Related Act)	26,113,064	24,899,553	19,546,219
Non-Recurrent Short-Term Benefits	1,095,037	795,784	503,897
Administration	3,650,271	3,370,793	2,688,177
Systems	175,192	307,525	42,257
Total Expenditures	**$126,286,644**	**$118,416,928**	**$82,705,779**

Sources: ACF-196 financial reports submitted by Maine DHHS: FY 2011 submitted February 15, 2012; FY 2012 submitted February 14, 2013; FY 2013 submitted February 2014.

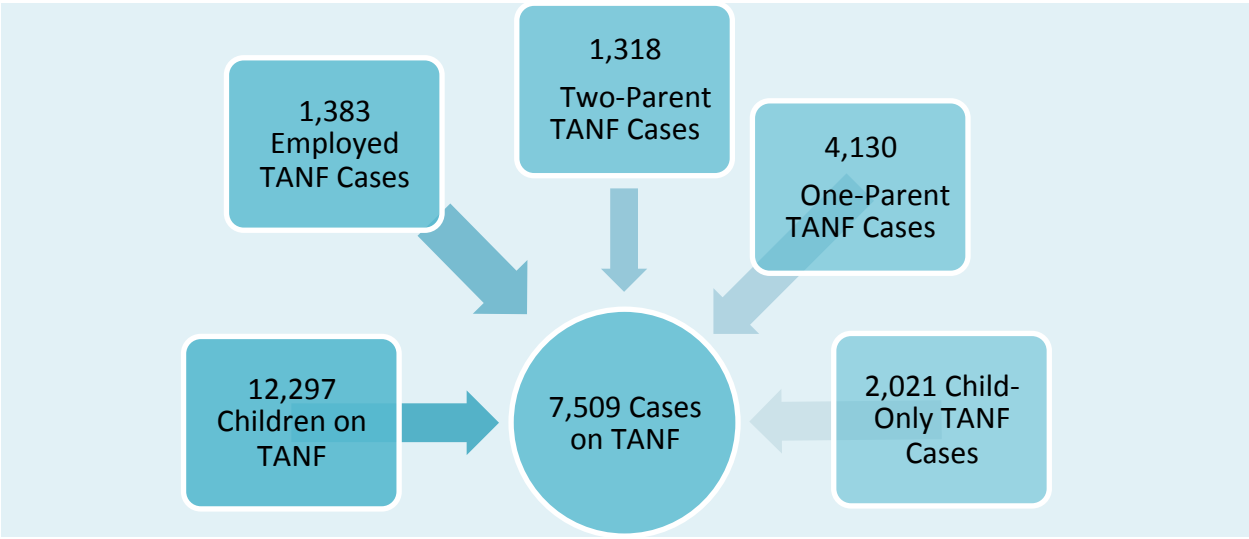
As reflected in Chart 2-1, Maine met 80% of its TANF-MOE requirement for all three years. The only year where "excess" MOE ($8,165,755) was expended was FFY 2011.

Currently, states must maintain a block grant amount that is equal to the amount of money spent in 1994. If a state operates the program more effectively and efficiently resulting in lower expenditures, it must spend money that advances one or more of the four legislative purposes of TANF, making up the expenditure difference according to the MOE rule. If the state fails to spend a sufficient level of MOE funds, and falls below the MOE minimum spending level, it will incur a penalty for failing the MOE requirements. This penalty is equal to a dollar-for-dollar loss in federal dollars, making it financially imprudent to fall below the 80% MOE threshold of $40 million. Maine is now bumping up against that threshold and is at risk of falling

below its MOE requirement, unless the state identifies additional ways to spend state dollars in TANF supportable programs and services. Federal rules incentivize states like Maine to spend more state money even when they accrue some savings through reduced caseloads. However, if the MOE penalty were avoided, both the state of Maine and the federal government would share in the savings. (See Title 45 CFR § 263.1)

In Maine, the TANF program is called ASPIRE (Additional Support for People in Re-training and Employment) and is administered through the DHHS Office of Family Independence (OFI) along with numerous other public-assistance programs. Uniquely integrated into Maine's TANF system is the Parents-as-Scholars (PaS) program, which provides financial aid to parents, found eligible under TANF rules, who are enrolled in a formal post-secondary education plan. According to point-in-time data provided by OFI, the ASPIRE-PaS caseload reflected the following:

Chart 2-3: **TANF Caseload Data, December 2013**



Source: DHHS OFI, Data Reports, December 2013

Origins of the TANF Law

In 1996, Congress passed legislation to replace the AFDC program as the primary federal welfare program with TANF (PL. 104-193). The most significant aspect of this reform was that cash assistance for needy families was no longer an "entitlement" but rather a "time-limited" benefit designed to help families to become economically self sufficient. In passing TANF, Congress created a block grant to states which was equal to peak expenditures for pre-TANF programs during the FY 1992–95 period. Because the mid-1990s were a period when cash-welfare rolls were at their all-time high; the block-grant amount was based on federal expenditures on the AFDC cash-assistance program, the Emergency Assistance program, and Job Opportunities and Basic Skills (JOBS) program for AFDC families — all of which existed at that time. Changing from an entitlement-funding structure to a block-grant structure means

that the basic block grant amount to states is legislatively fixed; it does not change when a state's cash-assistance caseload decreases or increases, nor is it adjusted for inflation.

From a policy and administrative perspective, the TANF block grant provided states greater flexibility as a funding stream than the former AFDC program by allowing a wide range of services and support for low-income families with dependent children. However, in exchange for increased program flexibility, states forfeited their entitlement to receive increased federal funds for cash payments, no matter how high caseloads increase.

With certain restrictions, states may use TANF funds for any benefit or activity reasonably related to one of four statutory purposes, which are to:

1) provide assistance to needy families so that the children may be cared for in their homes or in the homes of relatives;
2) end dependency of needy parents on government benefits by promoting job preparation, work and marriage;
3) prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
4) encourage the formation and maintenance of two-parent families.

While the TANF block-grant program has broad flexibility, its financing is extremely complex and attaches many strings to a state's use of federal and state TANF-MOE funds. The amount that a state is required to spend of its own funds each year must be used for benefits and services that are consistent with at least one of the four purposes of TANF.

Changes to TANF under the Deficit Reduction Act

TANF was reauthorized in 2005 as part of the Deficit Reduction Act (DRA). As a budget containment measure, DRA affected many aspects of public-welfare assistance throughout the country. DRA significantly changed the structure of TANF federal-work requirements not only by adopting narrow definitions of work activities that count toward the work rates but also by instituting significant new requirements related to state monitoring of recipients' participation in work activities. These changes put new requirements on states in order to successfully meet federally mandated work participation rates.

Some major changes to TANF under DRA included a new requirement to submit a state work-verification plan which must include stringent definitions of "approvable" work activities; specific methods of "documenting" weekly hours of each parent's participation in activities, and significantly, DRA expanded the population of adults required to participate, defined as work-eligible individuals (WEI), to include adults not receiving cash for themselves but who are living with a minor child on cash assistance; even those families whose cash assistance is funded

through a state's MOE funds. Prior to DRA, states were not required to include these adults in their work participation rate.

TANF Work Participation Requirements

TANF work participation rate (WPR) requirements are defined as: 50% of all families on TANF or in receipt of TANF-MOE services; and 90% of two-parent families on TANF or in receipt of TANF-MOE services. These families have at least one work-eligible individual in the household who is not disregarded from the participation requirement.

To be counted for work participation purposes, the work-eligible individual (usually a parent) must be in one or more of the twelve TANF countable activities (listed in law), for a minimum number of hours per week each month, and these activities must be verified and documented by the agency. Moreover, the agency must follow complex and convoluted rules to calculate WPR, a measure that does not accurately reflect full caseload participation. For example, the WPR does not reflect the percentage of cases that close to TANF due to unsubsidized employment. At the same time, some participants can meet the WPR by participating in a mix of "core" and "non-core" activities without ever finding employment.

Meeting the all-families rate (50%) — and, in particular, the two-parent-family rate (90%) — has been a challenge for all states. The majority of states meet their WPR only after they apply a caseload-reduction credit to their countable cases in activities. Failing to meet these rates can result in financial penalties on the state's TANF block grant.

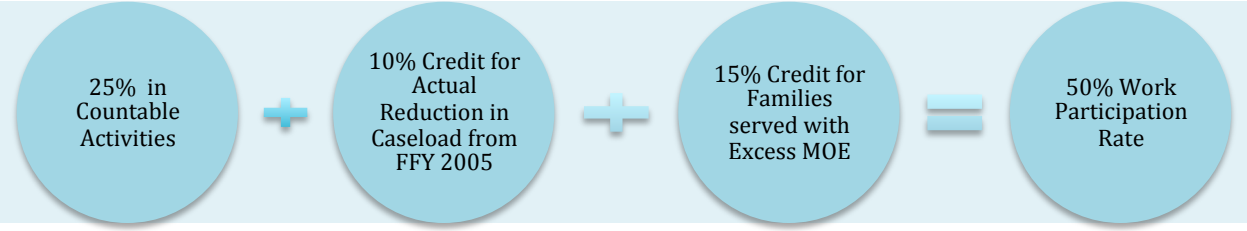
Caseload-Reduction and Excess-MOE Credits

The caseload-reduction credit reduces a state's 50% and 90% standards based on the caseload-reduction measure from FY 2005. In effect, the caseload-reduction credit reduces a state's numerical standards by one percentage point for each percent decline in the caseload. Additionally, under HHS regulations promulgated in 1999, states also may receive credits for spending state dollars in excess of what they are required to spend under their MOE requirement. States may consider families assisted by excess MOE as "caseload reduction," and hence receive extra caseload-reduction credits for such families. However, TANF does not assign credit to states whose caseload decline resulted from changes in eligibility policies. Caseload reduction credits are very specific.

For example, if a state achieves a caseload reduction of 25% (including the effect of caseload reduction from excess MOE), the state's work participation rate standard for the all-family rate of 50% is reduced by twenty-five percentage points, from 50% to 25%. If a state achieves a caseload reduction of 50%, its all-family standard is reduced by fifty percentage points, from 50% to 0%. It is typically the combination of actual participation in countable

activities plus credit for caseload reductions, combined with credits for excess-MOE expenditures, which will result in a state reaching its WPR targets.

Chart 2-4: **Calculating Work Participation Rates**



Understanding the Impact of TANF-Penalty Provisions

States can incur one or more fiscal penalties under TANF. When those penalties are imposed, there is a substantial (and negative) implication for the TANF program, administrative agency, and a state's budget, which in most cases would be required to replace any loss in federal dollars resulting from a TANF penalty. States that fail the TANF work participation standards are at risk of a financial penalty. The TANF statute penalizes a state by 5% of its block grant for the first year that it fails to meet the work participation standards, with the penalty increasing two percentage points for each subsequent year's failure, up to a maximum of 21% penalty on the block grant. For Maine, these penalties can be substantial: A 5% penalty represents $3.9 million; a 21% penalty represents $16.3 million.

Chart 2-5: **Fiscal Penalties under TANF Law**

Misuse of TANF funds	Amount of misused TANF funds
Intentional misuse of TANF	Amount of penalty +5% of adjusted State Family-Assistance Grant (SFAG)
Failing to submit report	4% reduction of adjusted SFAG for each quarter state fails to submit report(s)
Failing to meet work participation rate	5% Reduction in TANF Block Grant (up to 21% of adjusted SFAG)
Failing to participate in the Income Eligibility Verification System	2% of adjusted SFAG
Failing to meet TANF-MOE requirement	Dollar-for-dollar reduction in SFAG
Failing to sanction recipients for non-cooperation with DSER	1% to 5% of adjusted TANF block grant

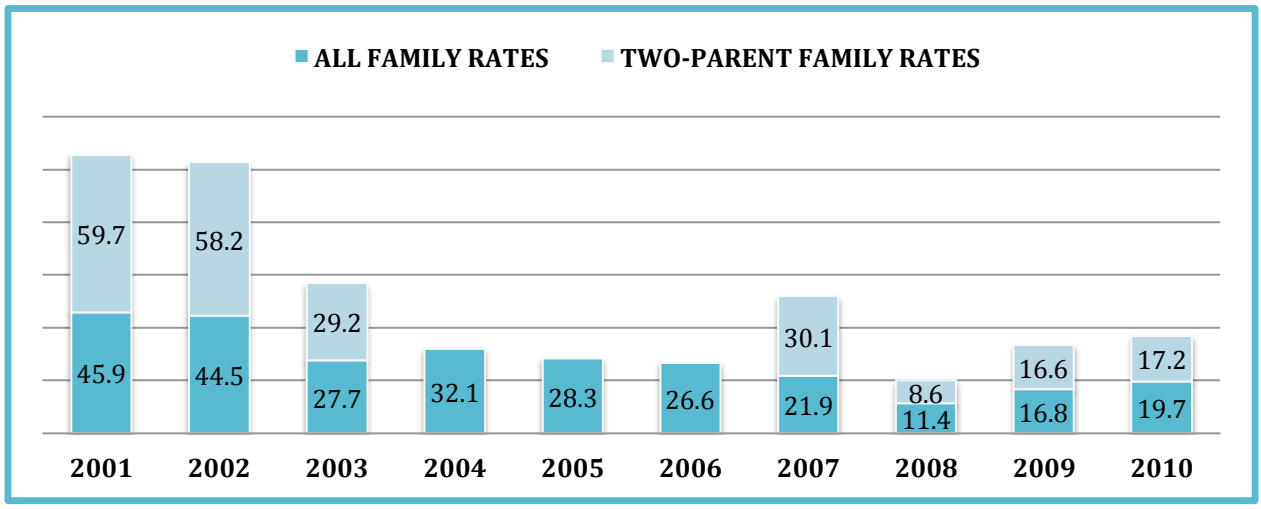
Sanctioning parents w/child under 6 who need child care in order to work	Up to 5% of adjusted SFAG
Failing to sanction parents who refuse to engage in work requirements	1% to 5% of adjusted SFAG
Failing to replace penalty reduction with state funds	No more than 2% of adjusted SFAG, plus the amount of the Shortfall
Failing to enforce the five-year time limit	5% of adjusted SFAG
Failing to repay federal loan	Outstanding loan amount plus interest
Failing to remit contingency fund if this MOE is not met	Amount of contingency funds not remitted
Failing to meet TANF-MOE level of welfare-to-work formula grant paid	Reduction of SFAG payable in the amount welfare-to-work grant was received (N/A)
New Penalty Added under DRA of 2005	
Failing to implement procedures and internal controls consistent with federal regulations.	Up to 5% of adjusted SFAG

Source: Public Law 104-193, PRWORA, Section 409.

Until DHHS implemented policy reforms in January 2012, the state's TANF program lagged second from the bottom in experiencing caseload declines. Prior to January 2012, the state did not conform to federal rules related to sixty-month time limits for families on cash assistance. Maine carried high caseloads, even when reductions were occurring in virtually all other states. In fact, Maine's high caseloads endured during the period when federal regulations, under DRA, increased reporting requirements and added previously omitted state MOE-funded adults to the calculation of work participation rates. Additionally, DRA narrowed the definition of countable work activities, tightened monitoring of parent activities, and imposed stringent reporting requirements for the broader work-eligible population. It is not unreasonable to conclude that Maine's previous policies, which for the most part disregarded time limits, exposed the state to TANF-WPR penalties, especially when the program was unable to engage a sufficient number of parents in countable activities.

Chart 2-6 chronicles how the ASPIRE program fared out on the TANF-WPR standards.

Chart 2-6: Work Participation Rates for Maine



A report published by the Congressional Research Service outlines which states failed to meet TANF all-families work participation standards between FY 2002 through FY 2010.[23] In this report, only a few jurisdictions failed to meet the all-families work participation rate standards through FY 2006. In fact, in FY 2006, only three jurisdictions failed the standard, and that was the greatest number that failed the WPR between FY 2002 through FY 2006.

However, in FY 2007, fifteen jurisdictions failed to meet the all-families WPR standard. This number declined to nine in FY 2008 and eight in FY 2009. In FY 2010, eight jurisdictions failed to meet the standard. Of these, six (California, Maine, Ohio, Oregon, Puerto Rico, and Guam) failed standards in all years since FY 2007 for two-parent families and a number of states reported "No Two-Parent Families" were subject to the work participation standard. These states, like Maine, are indicated with "N/A" for that year.

In FY 2010, twenty-five jurisdictions reported that no two-parent families were included in the TANF work participation standard calculation. Of the twenty-nine jurisdictions that included two-parent families in their TANF work participation calculation, twenty-three met the standard; six did not.

The following chart, which was taken from the Congressional Research Service report, indicates that Maine met its two-parent family rate, but not its all-families rate for 2007, and that Maine did not meet its WPR standards in FY 2008, FY 2009, and FY 2010.

23. Gene Falk, "The Temporary Assistance for Needy Families (TANF) Block Grant: Responses to Frequently Asked Questions," Congressional Research Service, October 17, 2013.

Chart 2-7: **Maine's Work Participation Rates, 2001–2010**

			Pre-DRA Policies				Post-DRA Policies			
WPR Group Results by Year	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
All Family Rates	45.9	44.5	27.7	32.1	28.3	26.6	21.9	11.4	16.8	19.7
Two-Parent Family Rates	59.7	58.2	29.2	N/A	N/A	N/A	30.1	8.6	16.6	17.2
Met Standard All-Family Rates	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
Met Standard Two-Parent Rates	Yes	Yes	Yes				Yes	No	No	No

Maine corrected the overall WPR through a corrective-compliance plan as required under 45 CFR 262.6. This was achieved by the end of FFY 2012. Maine achieved this compliance by adding a worker-supplement benefit ($15 per month), which allowed Maine to count families that have transitioned from TANF and are working the required number of hours to meet the work participation requirement. This benefit is provided to approximately twenty thousand families per month and is included as part of the TANF-MOE caseload. The following charts provide data on how these cases were added to the monthly MOE caseload beginning 2012. Without this new initiative, Maine would not achieve its WPR.

Chart 2-8: **TANF and MOE Cash-Assistance Cases**

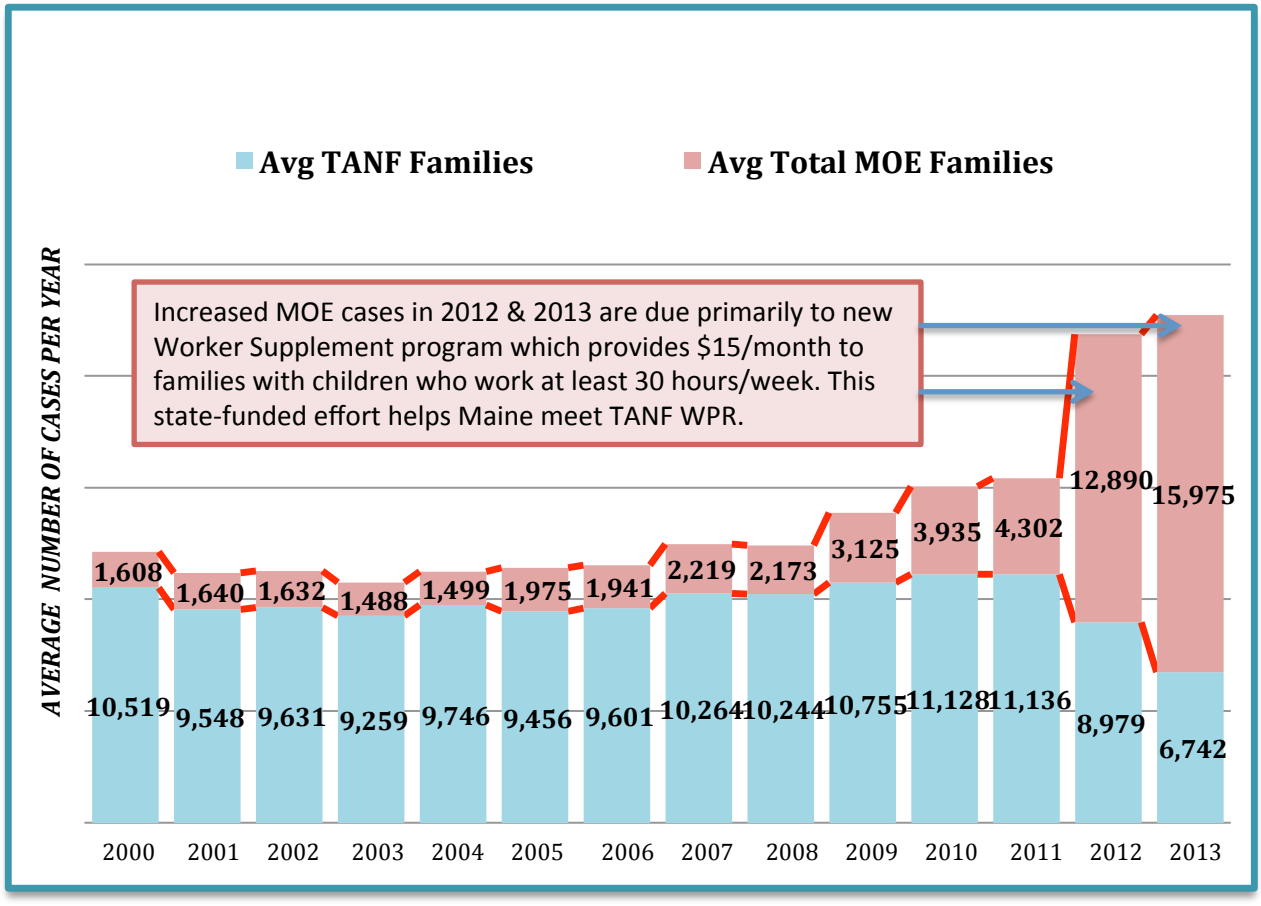


Chart 2-9: TANF and MOE Caseload, 2000–2013

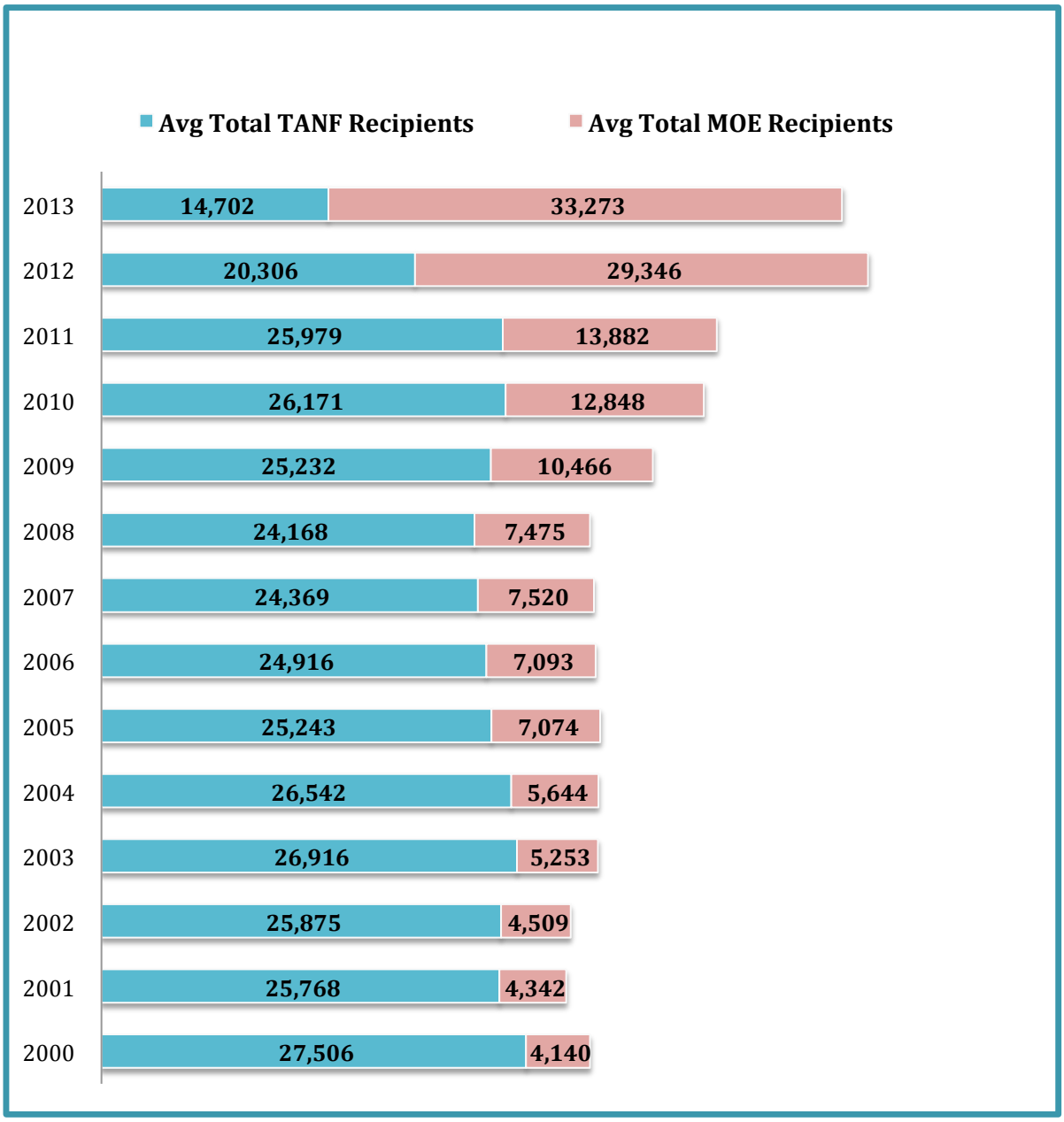


Chart 2-10 delineates, by funding stream, families and services supported under either federal TANF and/or state-MOE dollars:

Chart 2-10: **TANF Verses State-MOE Funding**

Federally Funded Programs and Services	State-Funded MOE Programs and Services
• TANF basic cash-assistance families	• Non-citizen families not eligible under federal TANF
• ASPIRE-TANF supportive services	• PaS families after first twelve months in post-secondary two-year or four-year degree programs
• Parents-as-Scholars families for first twelve months of post-secondary education	• ASPIRE state-funded support services for TANF families
• Emergency-assistance payments for families below 100% FPL, or eligible TANF, PaS, SSI, or worker-supplement program	• Underemployed two-parent families
• Alternative aid (non-recurrent short-term vouchers)	• Incapacitated one- and two-parent families
	• Child Care Development Fund
	• Students, ages 18, 19, and 20, and their parents
	• Worker supplement for TANF leavers who close due to earnings.
	• Post-TANF transitional transportation and transitional child care for working families
	• Child-support pass-through (gap) payments
	• State refundable tax credits, Circuit Breaker program, and child care tax credits
	• General Assistance for short-term crisis-prevention assistance

Source: MOE information obtained from Maine's ACF-204 Report for FFY 2013

The LePage administration has effectively addressed the threat of penalties for failing the all-families work participation rate. In fact, the department received notification from HHS that the ACF has accepted Maine's corrective action plan covering 2008, 2009, and 2010. However, the state still faces potential penalties for failing the two-parent family WPR of 90% in FFY 2008, FFY 2009, and FFY 2010.

According to the Congressional Research Service, HHS has not announced the status of penalties for any state for failing to meet the all- families standard since FY 2007.

Maine may need to reconsider its accounting of two-parent families as part of TANF or TANF-MOE. It may be prudent to fund these families under a separate state (non-MOE) funding stream, thus avoiding the difficulties in meeting the 90% WPR altogether; or the DHHS could modify policies related to two-parent families who are not meeting their individual work participation requirements.

Work-Eligible Individuals and Work Participation Requirements

A work-eligible individual (WEI) is an adult (or minor head-of-household) recipient of TANF cash assistance, or a non-recipient parent living with a child that is receiving cash assistance unless the parent is:

- a minor, but not the head-of-household;
- a non-citizen who is ineligible to receive assistance due to his or her immigration status;
- a Supplemental Security Income (SSI) recipient;
- a parent providing care for a disabled family member living in the home; or
- a parent receiving Social Security Disability Insurance (SSDI) benefits.

To count towards the work participation rate, the WEI must have verified participation in countable activities for a specific number of hours each month. Parents with children, 6 years of age and older, must participate in a countable activity for thirty hours a week for each week they are receiving a TANF benefit. Parents with children under 6 must participate for twenty hours. Families with two parents must participate an average of thirty-five hours a week.

Engagement of Work-Eligible Individuals

Both eligibility workers and social-service staff located in sixteen regional offices throughout the state offer ASPIRE/PaS program benefits to parents with children on cash assistance. The goals and objectives of the program are the same as the goals and objectives of the families seeking assistance: family and child wellbeing combined with economic independence in the shortest time possible. How much and how long assistance is needed is often the intersection where expectations differ.

TANF is a work program for low-income parents with children. While education and training activities are allowed, they can only be counted for a limited period of time, after which parents are expected to work. More than any of its predecessor programs, TANF is prescriptive about how success is attained and measured, both for participants and program administrators. Even though TANF permits a period of time (up to twenty-four months) before requiring participation in countable work activities, experience has demonstrated that immediate engagement strategies, as a condition of eligibility, is an effective way to increase participation in countable activities and also emphasize the mandatory nature of this program.

The following table offers a breakdown of education and training expenditures for ASPIRE-TANF cases during 2013:

Chart 2-11: **Education & Job-Training Services, 2013**	
Education Programs	$275,277
Adult Education Courses/Programs	$123,110
College And University Programs	$23,141
GED Courses/Programs	$12,438
Other Education/Training Programs	$81,855
Vocational/Technical College Programs	$34,733
Job Preparation Programs	$476,691
Field Training Expense	$29,812
Job Club Training Expense	$199,837
Job Development	$12,165
Job Placement & Retention	$5,641
Occupational Tools/Equipment	$42,832
On-The-Job Training	$1,430
Trades Training Courses/Programs	$37,686
Uniforms/Occupational Clothing	$51,829
Vocational Evaluation	$95,459
Total Expenditures	**$751,968**

One observation is that the ASPIRE-TANF/PaS program — comparatively speaking — expended limited dollars ($751,968) directly on training and/or job-placement services.

Fortunately, new collaboration with Maine's Department of Labor is likely to enhance access to jobs and thus improve the state's overall work participation rate for ASPIRE-TANF parents.

TANF funding allows for proper supports to be provided such as child care, transportation, and other family supports, but solutions must be found to help TANF parents move forward into employment and ultimately economic independence. Maine's sixteen regional offices are set up to provide assistance by well-trained eligibility workers and ASPIRE/PaS support staff who understand the importance of their roles and responsibilities and the potential effect they have on each person they are assigned to serve.

Charts 2-12 and 2-13 compare Maine's TANF caseload in December 2012 and December 2013. In virtually every category, the numbers have decreased substantially. Many of these cases were closed due to the sixty-month time-limit policy that took affect in 2012. Other case closures may have occurred due to: increased earnings, increased child support or both; closures due to youngest child reaching the age of ineligibility; out-of-state moves, and for some, closures due to the new full-family sanction policy.

Chart 2-12: **TANF Caseload Declines, 2012–13**

Program	December 2012	December 2013	Change	Percent
TANF Unemployed Parent, Two-Parent Family	860	563	–297	–34.5
TANF Incapacitated Two-Parent Family	831	755	–76	–9.1
TANF Two-Parent Households	1,691	1,318	–373	–22.1
TANF One-Parent Household	5,284	4,130	–1,154	–21.8
TANF Child Only	2,199	2,021	–178	–8.1
Alternative Aid Cases	67	67	0	0.0
Refugee Cash Assistance Cases	76	83	7	9.2
Parents-as-Scholars Program	402	243	–159	–39.6
Transitional Child Care	1,742	1,580	–162	–9.3
Transitional Transportation Program	911	565	–346	–38.0
Emergency Assistance	706	524	–182	–25.8
Special Needs Allowance	2,856	2,236	–620	–21.7
TANF Caretaker	89	74	–15	–16.9
All Programs	**17,786**	**14,224**	**–3,562**	**–20.0**

Source: DHHS-OFI Data Report, December 2013.

Chart 2-13: **Comparison of Two-Parent & One-Parent TANF Households**

Office	December 2012			December 2013		
	Two-Parent Households	One-Parent Households	Percent of Two-Parent Cases	Two-Parent Households	One-Parent Households	Percent of Two-Parent Cases
Augusta	214	576	27.1%	143	423	25.3%
Bangor	173	561	23.6%	122	476	20.4%
Biddeford	61	233	20.7%	53	193	21.5%
Calais	22	70	23.9%	15	55	21.4%
Caribou	52	193	21.2%	50	207	19.5%
Central Office	0	0	0.0%	0	5	0.0%
Ellsworth	21	75	21.9%	17	66	20.5%
Farmington	38	121	23.9%	25	88	22.1%
Fort Kent	15	68	18.1%	25	64	28.1%
Houlton	39	130	23.1%	24	53	31.2%
Lewiston	282	818	25.6%	220	669	24.7%
Machias	12	68	15.0%	12	51	19.0%
Portland	370	929	28.5%	338	741	31.3%
Rockland	152	562	21.3%	107	388	21.6%
Sanford	58	357	14.0%	50	288	14.8%
Skowhegan	85	273	23.7%	60	219	21.5%
South Paris	97	250	28.0%	57	144	28.4%
Totals	**1,691**	**5,284**	**24.2%**	**1,318**	**4,130**	**24.2%**

Source: DHHS-OFI Data Reports, December 2013.

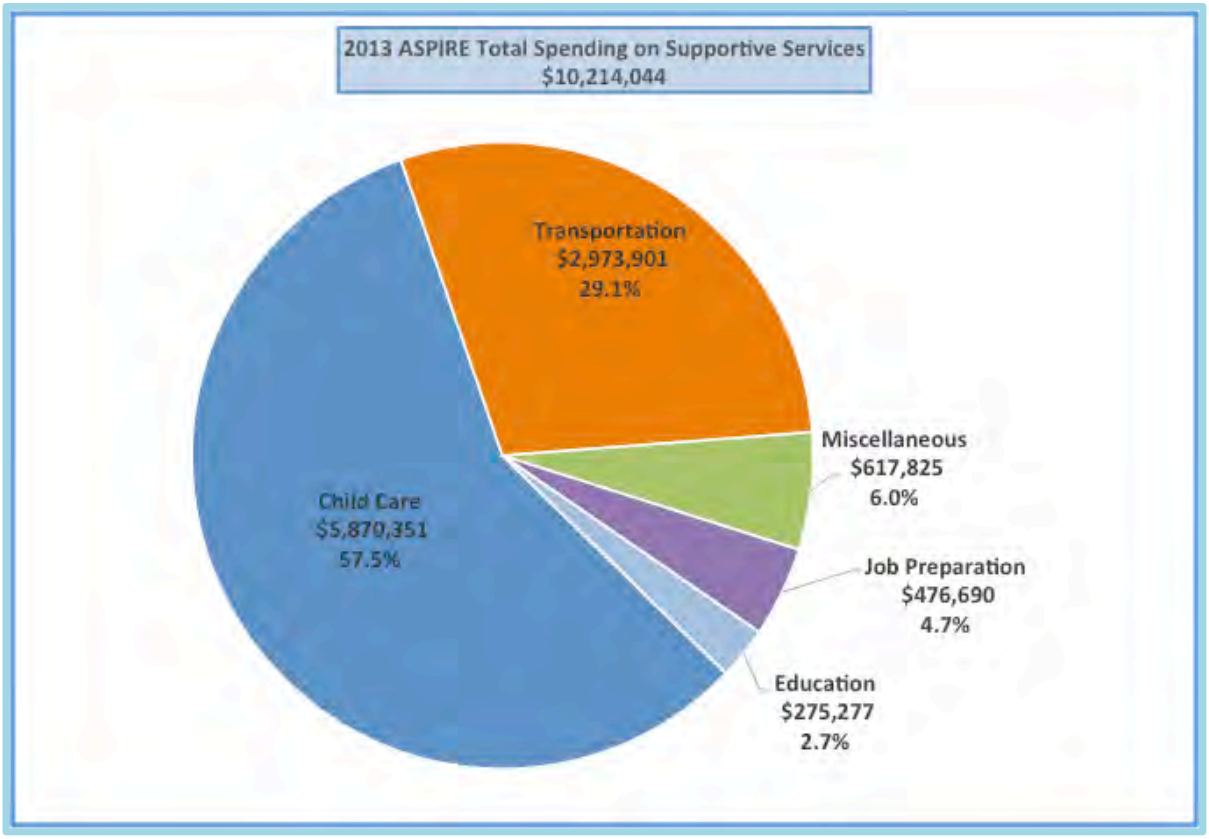
Chart 2-14: **ASPIRE-TANF Employed Cases, 2013**

January	1,690	July	1,672
February	1,649	August	1,654
March	1,633	September	1,616
April	1,670	October	1,563
May	1,788	November	1,510
June	1,752	December	1,383

To assist parents on ASPIRE-TANF/PaS to participate in programs leading to employment, a broad range of supportive services are provided to remove barriers to participation. Those who successfully close to ASPIRE-TANF and PaS due to employment continue to need support until their earnings are above the ASPIRE-TANF eligibility levels.

On average, approximately 1,855 ASPIRE/PaS parents receive supportive services monthly. The following chart provides a breadown on the total expenditures for 2013 in accord with the categories of expenditures provided by ASPIRE/PaS:

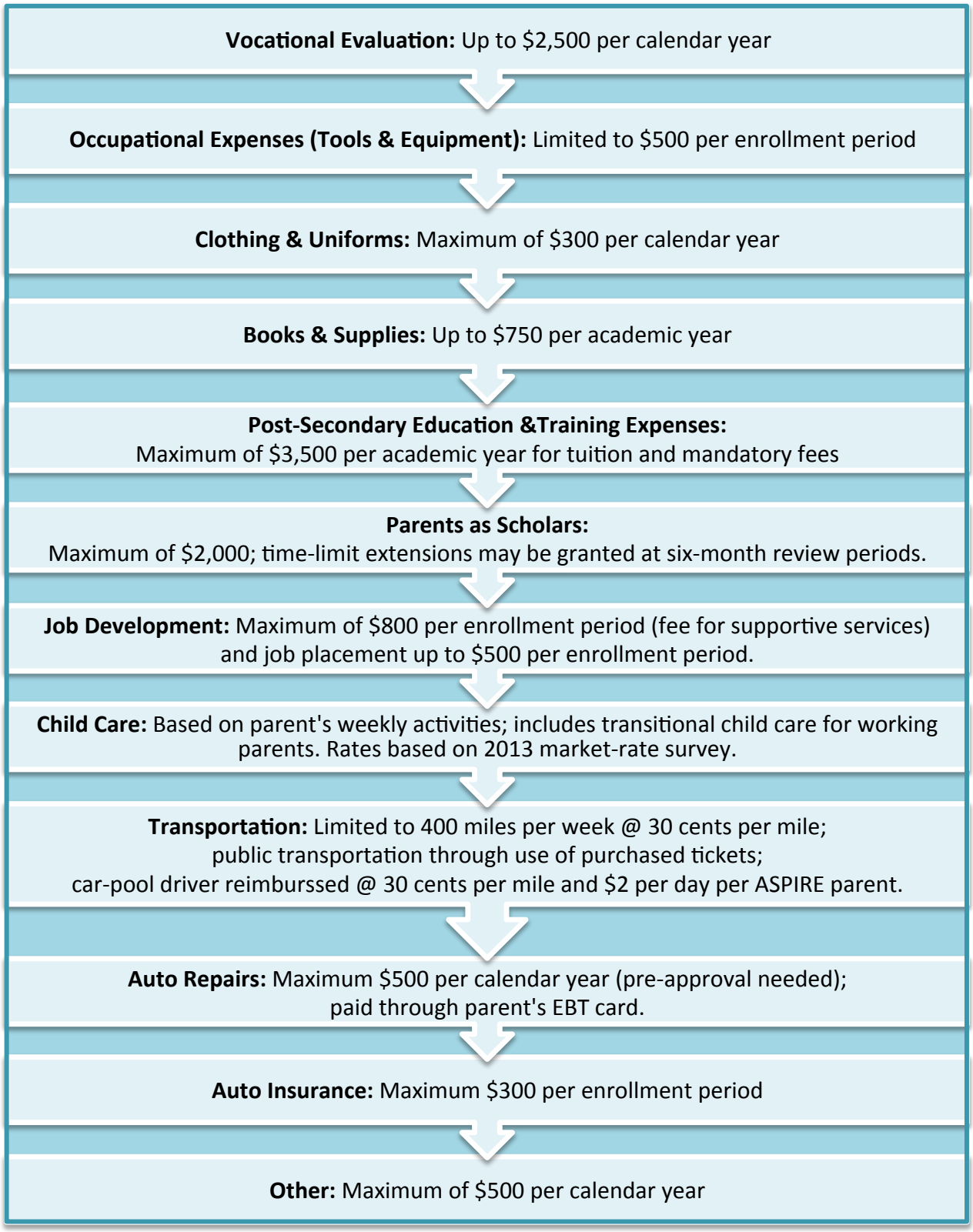
Chart 2-15: **ASPIRE Supportive Services Spending**



Source: DHHS-OFI Data Reports, December 2013.

Chart 2-16 represents supportive services which are provided to ASPIRE-TANF and PaS participants who are in receipt of, or recently closed to, cash assistance due to increased earnings. One or more of these supports may be provided in order to help parents participate in pre-approved education and employment activities. It is not possible to discern how many of these separate supports may have been issued to a single ASPIRE-TANF or PaS participant.

Chart 2-16: Supportive Services for ASPIRE-TANF and PaS



Transitional Child Care (TCC) is part of a continuum of support provided to parents who have closed to ASPIRE or PaS but need child care assistance to remain in the workforce. Table 2-17 provides a breakdown of cases and expenditures under the TCC program:

Chart 2-17: **Transitional Child Care Program, CY 2013**

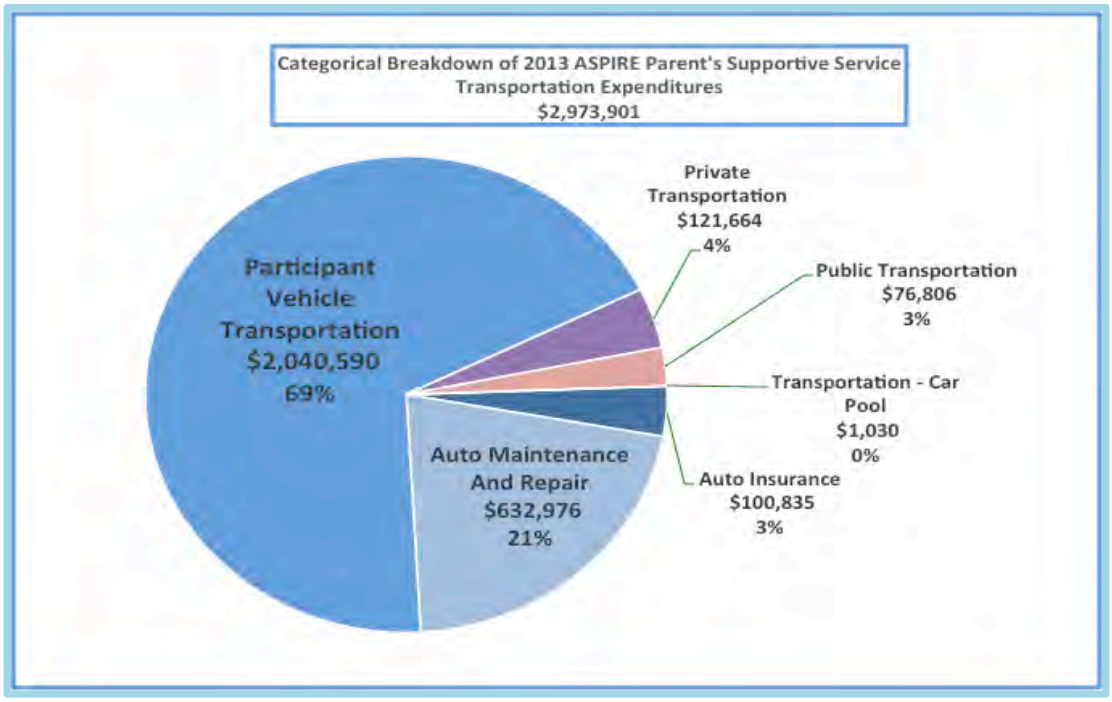
Month	Cases	Expenditures	Cost Per Case
January	2,707	$1,005,126	$371
February	2,591	$786,015	$303
March	2,563	$783,858	$306
April	2,543	$779,963	$307
May	2,616	$987,198	$377
June	2,606	$821,608	$315
July	2,634	$902,032	$342
August	2,675	$1,098,440	$411
September	2,464	$768,514	$312
October	2,398	$882,997	$368
November	2,359	$555,712	$236
December	2,422	$879,700	$363
Average Number of Cases	**2,552**	**$10,251,162**	**$4,017**

On the following page, Chart 2-18 displays the number of cases per month and the average expenditures per month in supportive services, while Chart 2-19 breaks down transporation expenses paid through ASPIRE.

Chart 2-18: **Average Number of Families Receiving Supportive Services**

Source: DHHS-OFI Data Reports, December 2013.

Chart 2-19: **ASPIRE Transportation Expenditures**



Source: DHHS-OFI Data Reports, December 2013.

Through the end of 2013, OFI had no direct purchase of service contracts devoted to preparing ASPIRE/PaS participants for work. The state's somewhat unique approach has been to provide individual tuition-assistance payments on behalf of participants who pursued a wide range of career-training programs considered best suited to the parent's goal for long-term employment. The program has also placed a number of participants (primarily two-parent families) into community work-experience activities. Moreover, the ASPIRE/PaS program has provided a significant amount of financial support in the form of child care subsidies, transportation assistance, auto repairs, uniforms and clothing for work, and emergency-assistance payments — all of which families may need during and after closing to the ASPIRE/PaS program.

Maine's PaS is a model that is unique to TANF. DHHS should examine its long-term return on investment. A study conducted by the Center for Budget Policies and Priorities demonstrated favorable results; however, the study did not measure outcomes of the program in terms of jobs and wages but rather emphasized the value of parents achieving post-secondary degrees. It would be useful to conduct a longitudinal study of PaS and derive firsthand data as to how these parents fared in the job market, and whether recidivism has been diminished relative to other parents who were not in the PaS program.

Chart 2-20 provides a comparison of TANF child-only cases, a category that occurs when no adult is included in the benefit calculation for TANF cash assistance. There are two broad categories of child-only cases: those in which no parent lives in the household (which is called non-parental child-only cases) and those in which a parent lives in the household but does not qualify for TANF for certain nonfinancial reasons (parental child-only cases). Some of these nonfinancial reasons are common to all or most states and others are state-specific.[24]

For Maine, the number of child-only cases decreased between December 2012 and December 2013, a pattern consistent with other types of TANF-caseload declines during the same period. However, if Maine is typical of other states, tracking Maine's child-only cases over time will become more important than ever, particularly since the state has implemented the sixty-month time limit on TANF cash assistance.

Where most other states enforced a five-year time limit from the beginning of TANF, the average child-only caseload grew from a previous norm of 20% to 24% (pre-TANF) to a current norm of 40% to 50%. Maine is behind the national curve, but it will presumably experience a similar increase in the number of child-only cases receiving cash assistance in future years.

Chart 2-20 shows a 22.1% decrease in child-only cases between 2012 and 2013.

24. Olivia Golden and Amelia Hawkins, "TANF Child-Only Cases," Brief No. 3, The Urban Institute, November 2011.

Chart 2-20: **TANF Child-Only Cases by Regional Offices**				
Office	**December 2012**	**December 2013**	**Change**	**Percent Difference**
Augusta	214	226	12	5.6
Bangor	331	319	–12	–3.6
Biddeford	87	98	11	12.6
Calais	41	32	–9	–22.0
Caribou	71	68	–3	–4.2
Central Office	0	3	3	N/A
Ellsworth	40	39	–1	–2.5
Farmington	63	48	–15	–23.8
Fort Kent	15	13	–2	–13.3
Houlton	42	39	–3	–7.1
Lewiston	276	290	14	5.1
Machias	30	26	–4	–13.3
Portland	396	339	–57	–14.4
Rockland	170	152	–18	–10.6
Sanford	158	149	–9	–5.7
Skowhegan	133	116	–17	–12.8
South Paris	132	64	–68	–51.5
Total	**1,691**	**1,318**	**–373**	**–22.1**

Source: DHHS-OFI Data Reports, December 2013.

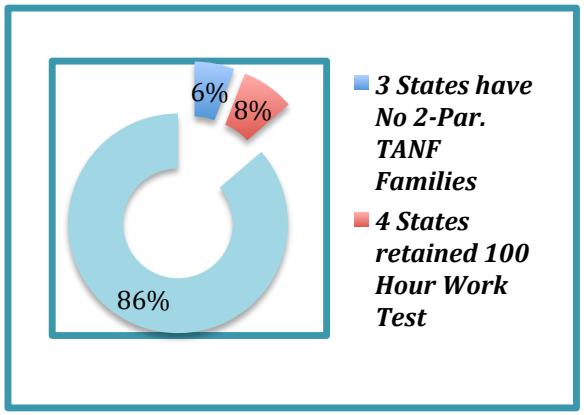
Maine's TANF Policy Choices, Relative to other States[25]

Policy Option 1: Two-Parent Family Requirements

States can retain previous AFDC rules for two-parent households as an additional eligibility test, which limits the number of hours a principal wage earner can work without losing eligibility. This rule, in effect, discourages two-parent households from applying for assistance.

25. Source for this section: DHHS TANF policies as of July 2012.

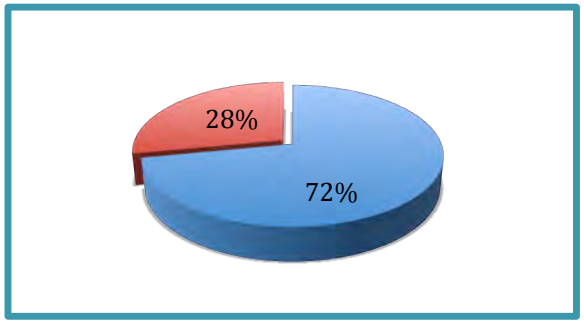
Chart 2-21: **Two-Parent Family Eligibility under TANF**



- Maine is one of only four states to retain the previous AFDC work-hour rule for two-parent families.
- 44 states dropped the work-hour rule as a burdensome policy, which also undermines TANF family-formation interests.
- Three states, which do not have two-parent families in receipt of TANF or TANF-MOE, avoid the 90% WPR standard.

Policy Option 2: Upfront Job Search at Application

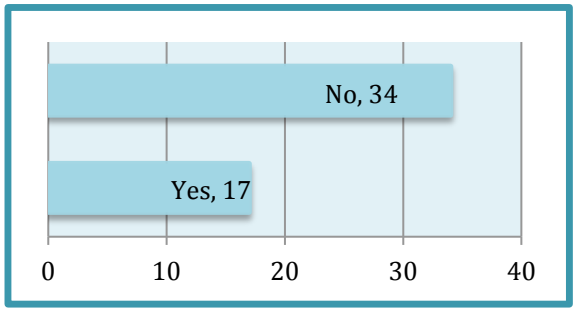
Chart 2-22: **State Policies Requiring Upfront Job-Search Activities**



- 19 states (28%) require upfront job search as a condition of eligibility. Typically, parents must participate in job search for up to three weeks and provide documentation of the results of this activity.
- Maine is one of 32 states (72%) that does not require up-front job search.

Policy Option 3: Family-Cap Option

Chart 2-23: **Family-Cap Policies among States, July 2012**

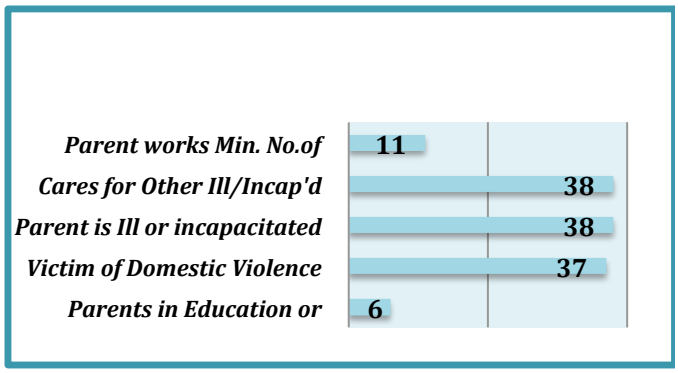


- Maine is one of 34 states that does not have a family-cap policy.
- 17 states have TANF family-cap policies.

Policy Option 4: State Time-Limit Extensions

States have the option to extend families beyond the sixty-month federal time limits (TL) if they meet state policy conditions.

Chart 2-24: **Number of States with Time-Limit Extension Policies**

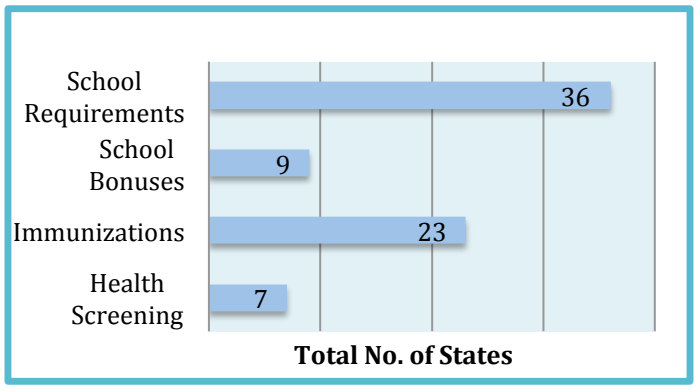


- Maine is one of six states to extend TLs for parents in education or vocational training.
- Maine is one of 37 states to allow extension for victims of domestic violence.
- Maine is one of 38 states to allow extensions based on illness or incapacity of parent.
- Maine is one of 38 states to allow extensions based on illness or incapacity of another household member.
- Maine is one of 11 states to allow extensions for parents working the minimum number of hours per week.

Policy Option 5: Behavior Requirements and Children

States have policy options that are intended to incentivize parents toward health and wellness of their children by requiring health screenings and assuring that children receive proper immunizations and attend school regularly. In some states, bonus payments can be earned by the family for school attendance and educational achievements, as defined by state policies. Chart 2-25 provides a count of states choosing one or more of these policies.

Chart 2-25: **State TANF Requirements for Dependent Children, July 2012**



- 36 states have school requirements.
- 23 states have adopted immunizations as a requirement.
- 7 states require health screenings.
- 9 states offer school-achievement bonuses.
- Maine has not adopted any policies tying behavioral requirements to TANF.

While most of Maine's policies tend to be advantageous for eligible families, the cash-assistance benefit levels rank lowest in New England and twenty-first nationally. The last time Maine's benefit level was raised was in 2006. Chart 2-26 offers specifics on this indicator.

Chart 2-26: **New England TANF Monthly Cash-Assistance Levels**

Family Size	**Maine**	Connecticut	Massachusetts	New Hampshire	Rhode Island	Vermont
Family of 2	**$363**	$470	$518	$606	$449	$536
Family of 3	**$485**	$576	$618	$675	$554	$640
Family of 4	**$611**	$677	$713	$738	$634	$726
Family of 5	**$733**	$775	$812	$798	$714	$817
Family of 6	**$856**	$877	$912	$879	$794	$879
Maine's monthly benefit amount is the lowest in New England but the 21st highest (for family of three) compared to all other states.						

Source: David Kassabian et al., "Welfare Rules Databook: State TANF Policies as of July 2012," The Urban Institute, submitted to ACF Office of Planning, Research and Evaluation, Final Report 2013, Table II.A.4, http://www.urban.org/UploadedPDF/412973-2012-wrd.pdf

Maine's TANF High-Performance Measures Relative to Other States

ACF compiles data reports on states to determine whether TANF goals are being met. Using complex formulas within electronic data-matching files, these measures indicate how each state compares on work-related, child care, SNAP, and family-formation measures. Sources of data include: TANF administrative data, unemployment-insurance wage records, National Directory of New Hires, SNAP administrative data linked to TANF, American Community Survey data, Census Bureau, and state administrative data. While this list is not all-inclusive, it covers sources related to work-and-family well-being high-performance measures.

Chart 2-27: **Maine's Performance under TANF High-Performance Standards**

Measure	**Rate**	**State Ranking**
Job Entry Rate	26.54%	33rd
Job Retention Rate	65.32%	22nd
Earnings Gain Rate	27.63%	40th
Rate of Low-Income Working Families on SNAP	73.10%	1st
Family Formation/Stability Rate	66.05%	26th

Source: Administration for Children and Families, High-Performance Measures, Performance Year 2011; Tables 3(a), 3 (b), 3 (c), 5, and 7.

NOTE to Chart 2-27: These measures are based on the most recent data reported in FFY 2011 by HHS' Administration for Children and Families. Until TANF high-performance bonus funds were exhausted, these measures were used to award the top ten performing states in one or more of the specific measures with bonus dollars. ACF continues to measure state-performance indicators but strictly for purposes of informing states how they compare with national data.

Chart 2-28: Comparison of TANF Law vs. Aspire-TANF Program Policies

	TANF Law	ASPIRE-PaS	Problems and/or Inconsistencies with ASPIRE Program
Work-activity Requirements	State must meet annual work participation rates: • 50% all-family rate • 90% two-parent family rate	Same as TANF	State failed WPR in FFY 2007, 2008, 2009, and 2010
Weekly participation requirements by family type	**1-Parent Requirements** 30 hours per week if parent's children are 6+ years old 20 hours per week if parent's children are under 6 **2-Parent Requirements** 35 hours per week if two-parent household	Same as TANF Same as TANF Same as TANF	Maine's work-eligible individuals (74%) participated in activities but only 14.4% had enough hours to count.
There are 12 work activities under TANF law. Nine of these 12 are core categories that can count toward hours of participation; participation in the three non-core categories can only count if the individual also participates in the core activities for at least 20 hours per week (30 hours for two-parent families). In addition, under a special rule, secondary or GED-related school attendance, or education directly related to employment can count as participation for parents under age 20, even if it would otherwise be a non-core activity that can only count after 20 hours per week of core participation.			
	Core Activities under TANF — Single Parents	**Core Activities under ASPIRE or PaS**	**Countable?**
TANF 12 Countable Work Activities	1. Unsubsidized employment	Unsubsidized employment; includes "paid employment," self-employment, on-the-job training, Work Study, ASPIRE child care employment, and apprenticeship.	Yes
	2. Subsidized private-sector employment	Subsidized private-sector employment	Yes
	3. Subsidized public-sector employment	Subsidized public-sector employment	Yes
	4. Work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private-sector employment is not available	Work experience; includes field training (skills)	Yes

	5. On-the-job training	On-the-job training, which considered to be unsubsidized employment	Yes
	6. Job-search and job-readiness assistance	Job search & job readiness (6 weeks in any 12-month period; 12 weeks in any 12-month period for states such as Maine, with Needy State status); job-search and job-readiness activities include individual job search, group-job search, pre-vocational (ASPIRE), pre-vocation (referred), substance-abuse/mental-health treatment, field training (readiness), placement assistance, and job development.	Yes
	7. Community service programs	Community-service programs: Activities include TEMP (regular), TEMP (UP), and volunteering.	Yes
	8. Vocational-educational training (not to exceed 12 months with respect to any individual)	Vocational-educational training: Activities include associate's degree (PaS); BA/BS degree (PaS); college courses; community-college degree (PaS); community-college certificate; community-college courses; adult ed (skills); employer-sponsored training; and technical/trades courses. Participants are limited to 12 months of vocational-educational training in their lifetime. One hour of study time will be counted toward participation for every verified hour of classroom participation.	Countable up to 12 months. Only 10 states allow 2 year/4-year post-secondary stand-alone programs. Majority of other states approve only if parent first works 20 hours per week.
	9. Provision of child care services to an individual who is participating in community-service program	Provision of child care services to an individual who is participating in community-service program.	Yes
	Plus Countable Non-Core Activities		
	10. Job-skills training directly related to employment	Job-skills training directly related to employment; activities include all activities listed in vocational-educational training. There are no time limits on job-skills training activities.	Yes
	11. Education directly related to employment, in the case of a	Education directly related to employment; activities include adult	Yes

	recipient who has not received a high-school diploma or GED	basic ed (ABE), English as a second language (ESL), adult ed (diploma); high school, and G.E.D. preparation.	
	12. Satisfactory attendance at secondary school, or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.	Satisfactory attendance at secondary school, or a course of study leading to a certificate of equivalence, in the case of a TANF custodial parent under 20 years of age and who has not completed secondary school or received such a certificate, regardless of age of youngest child	
	Assessment/client evaluation is not a recognized activity under TANF.	Assessment/client evaluation process for up to 90 days is not a countable activity (approximately 20% to 23% of caseload pending review and assessment).	Not countable
		Awaiting disability determination for SSI approval, or may have a short-term illness/disability.	Not countable
	Post-secondary degree programs are not listed as a TANF activity.	PaS two- to four-year degree programs (beyond 12 months).	Not countable after 12 months.
	Must fit within the job-readiness parameters.	Mental health, substance abuse, domestic abuse services.	Not countable after 12 weeks.
		Basic education, literacy, and ESL programs that are not directly related to employment.	Not countable unless directly related to employment.
		Miscellaneous activities such as child-welfare mandates or meeting requirements of probation.	Not countable as stand-alone activities.
Limitations on Counting Work Activities under TANF	• To be countable, parents with thirty-hour requirement must participate in core activities for at least twenty hours per week; and must also participate for ten additional hours in non-core activities (job-skills training, education directly related to employment, or satisfactory attendance of secondary school/GED). • Participants in vocational educational programs can account for no more than 30% of recipients meeting their work requirement, and an individual's participation in vocational education, including PaS, can be counted toward the work participation rate for no more than 12 months in his or her lifetime. • Job Search/Job Readiness is limited to 6 weeks in a 12-month period, unless a state — such as Maine — is determined as a “needy state,” which means they can count up to 12 weeks in a year for Job Search/Job Readiness. • In two-parent families, 35 hours a week is required for families not receiving federally funded child care, and 55 hours a week for families receiving federally funded child care. (The hours for two-parent families are for the family as a whole and can be divided between the two parents.) • If an individual’s average weekly hours of participation in a given month do not reach the minimum requirements, the state gets no partial credit.		

Time limit on cash assistance	Maximum of 60 months. States may waive up to 20% of cases.	Maximum of 60-month time limit (unless parent qualifies for an extension).	
Exemptions from time limit	Child-only cases not subject to time limit.	Child-only cases not subject to TL. Parents of child under 12 months may be exempted for no more than 12 months.	Same as TANF
Extensions to time limit	No TANF extensions.	Parents working minimum number of hours per week can be extended on ASPIRE/PaS. Participating in an approved education or vocational; this includes PaS participants. Parents who are ill or incapacitated. Caring for an ill or incapacitated person. Victim of domestic violence.	State needs to monitor that it does not exceed the maximum of 20% under waiver provisions.
Sanction policy	Must sanction non-participating family with children 6 and older. May not sanction non-participating family with children 5 and younger if child care is not available. First three months, sanctioned household is not considered in the work participation rate calculation. After three months, counts against WPR.	First 90 days of sanction, parent is removed from payment. After 90 days, full family sanction imposed (closes to cash assistance) until parent agrees to comply and sign a new contract. Appeal rights are defined in policy, and include good-cause provisions.	TANF does not have any good-cause provisions.

Recommendations for Maine's TANF Program

1. Align the ASPIRE program with federal TANF program activities.

Eliminate exemptions from ASPIRE policies. A significant percentage of ASPRIRE cases are exempted from any planned activities, which outline strategies leading to improvement in family life and gradual improvement in job readiness. This may cover health services, mental-health services, mandatory child-welfare activities (parenting classes) as appropriate, and other activities to help the parent and children achieve positive outcomes. Exemptions, a leftover strategy from previous welfare programs, may seem best for a parent at application. But too

often, exempted families are ignored when intervention services combined with monitored activities are more effective in helping than leaving such families to fend for themselves.

Tighten up allowable activities in accord with TANF countable activities. Currently, the APIRE-TANF program appears to emphasize the long-term benefits of two- and four-year degree programs (providing extensions to time limits and extensions to participation in the state-supported post-secondary activity) knowing that it does not count beyond the first twelve months for TANF. This recommendation does not discount the value placed on acquiring post-secondary degrees, but there are several obvious concerns:

- The state is in severe trouble financially by failing TANF WPRs. It has failed to achieve these rates for five consecutive years. (Note: The most recent information is that Maine was notified in April 2014 that it failed WPR in FFY 2011.) This is due to the fact that the state has not been successful in engaging enough participants in countable activities to offset the number who are either unengaged or are engaged in activities that do not count for TANF work participation rates.
- The investments made thus far in supporting post-secondary degrees earned under the PaS program have never been evaluated to determine how many complete their degrees; how many have become employed in their degree field; how much they have been able to earn; have they closed to TANF due to wages; and is their a recidivism rate related to PaS participants? Without such data to offset the problems in the program, it is truly difficult to argue the value of PaS when the value has not been measured in terms of return-on-investment.
- When considering the strident adjustments to the overall policies which must be made to prove to ACF that ASPIRE-TANF should not lose federal dollars, it is difficult to ignore the overwhelming exposure the state has in supporting such a stand-alone long-term support to PaS families when funds may be lost to other families that have never, or could never, be part of the post-secondary track to self-sufficiency.

For PaS, follow TANF rules — approve PaS for twelve-months and require PaS parents to work a minimum of twenty hours per week after twelve months, while they complete their post-secondary degree programs.

2. Fully engage applicants and recipients.

Adopt a policy that everyone should have an active plan that, in the shortest time possible, will develop into activities and hours which conform with TANF core and non-core activities. **This recommendation assumes everyone can be doing something to prepare for and acquire a job, and no one is left behind.** The approach to TANF, while challenging, means no one is accepted onto the programs without expectations and services. To create a mutually agreed upon plan — that meets each individual where he or she is — including a plan to find

permanent housing or to address health-related needs is doable. As part of a sound welfare-to-work model, full engagement is regarded by experts in the field as the best family support approach and leads to better outcomes for children and families.

3. Require upfront job-search activities prior to acceptance onto cash assistance.

Upfront job search is sometimes the best method of assessing a person's job readiness, compared to all the testing and assessment tools available, because a job offer trumps full ongoing welfare assistance. Even in a tight labor market, overcoming discouragement at not having a job may be a self-imposed faulty conclusion on the part of the applicant. For some, providing sound information backed by simple program support can make a significant difference for those who have opted out of the labor market prematurely. Even if 3% to 5% of the applicants who conduct a mandatory job search find employment, those few can gain positive affects to their self esteem and to an important extent, their family life.

4. Continuously monitor caseload and participation levels.

Establish a Dollar/Data Work Team comprised of financial management, TANF fiscal officer, TANF administrator, TANF policy specialist, a regional office manager, and importantly, an IT data-reporting specialist. This team would be able to provide up-to-the minute information on TANF caseload dynamics such as:

- ✓ Monthly applications counts — received/accepted/denied/sanctions/closures in TANF-ASPIRE, PaS, SNAP, child care, medical assistance, and general assistance;
- ✓ Tracking of number of families reaching TANF time limits along with the number receiving extensions to time limits;
- ✓ Characteristics of all families new to TANF (family size, number of children, one-parent/two-parent/child-only cases) and number of work-eligible cases;
- ✓ Monthly number of employed families;
- ✓ Trends in type of child care being used and billed (infant care, toddler care, school-age care, and monthly-expenditure amounts;
- ✓ Trends in the state's unemployment rates for each month;
- ✓ Other indicators of current or future impacts on the caseloads for each program referenced above, measures that can assist DHHS to better forecast and adapt to changing trends in the caseload.

An effective dollar/data team can learn to function with a unified purpose and ensure that all fiscal and programmatic decision-making is shared and analyzed on a regular basis (no less often than monthly). Predicting exposures to shortfalls or potential penalties provides for an informed and prepared administration, and offers leadership the advantages of a built-in "early-alert" system on all benefits administered by DHHS. Conversely, the disconnect amongst and between these crucial functions within the department (fiscal, program, policy, service, and IT) can result in missed opportunities to adjust expenditures, change policies, and — importantly — avoid costly financial penalties from the federal government.

5. Reexamine MOE-caseload categories, particularly the two-parent families, all of whom are included in the TANF-WPR calculation. Under TANF law, 90% of all two-parent households supported by either federal TANF dollars or state MOE dollars are required to participate.

Reassess and engage as many as possible in approvable activities and at the level required under federal law. TANF does not recognize a two-parent "incapacity" category and therefore expects full participation (at least thirty-five hours per week), or the case counts against the state's WPR.

Reassess activity levels of all two-parent Unemployed Families and engage as many as possible in approvable activities and at the hourly requirement outlined in federal law. Both parents can participate and their blended hours of participation, which meet or exceed 35 hours per week, can be counted.

6. Expand the coordination and shared resources of the Maine Department of Labor and Department of Education.

Building and strengthening the connection to MDOL helps the ASPIRE-TANF program link more participants to the labor force as opposed to being attached to the welfare system. A natural offshoot of this linkage begins to make participants more comfortable to be at the Career Centers throughout the state. Some long-term unemployed are intimidated to walk into the state's Career Centers and thus feel severely limited in choosing to go to work. Closer linkage such as the new collaborative partnership will only enhance the shared roles in helping Maine's unemployed, many of whom may feel uninvited to the centers and thus unlikely to successfully compete for jobs, which may be available through MDOL.

Collaborate with the Maine Department of Education to establish learning environments that are work-site based, or are work-like designed, and combine basic education and work-place skill knowledge in activities that can still be countable for TANF WPR.

Chapter 8, Welfare-To-Work Coordination, provides additional recommendations that are designed to meet the unique challenges of TANF while at the same time creating more effective ways of helping low-income families of Maine.

3. Supplemental Nutrition Assistance Program (SNAP)

Overview

SNAP (formerly known as the food-stamp program) provides food assistance to low-income individuals and families who meet income and household needs, as determined by application and eligibility determination system. Federal funding is driven by caseload size: In 2012 Maine's federal and state SNAP expenditures were:

Chart 3-1: **Federal and State Expenditures for SNAP, 2012**

Category of Expenditures	Total Expended	Funding Source
SNAP Benefits to Households	$376,752,999	100% Federal
State Share of Administrative Costs	$ 8,762,475	50% State
Federal Share of Administrative Costs	7,849,850	50% Federal
Total SNAP Administrative Costs	**$16,612,325**	

Source: USDA, FNS SNAP State Activity Report, Fiscal Year 2012, Issuances, p. 9.

SNAP benefits are paid 100% by federal USDA; administrative costs are primarily based upon a fifty-fifty matching requirement. Administrative costs are affected by a number of factors including participation levels, the number and salary level of state staff, inflation, the location of state agency office(s), type of issuance system, worker-training costs, degree of automation, level of fraud-control activity. While all states strive to achieve the most appropriate balance between service delivery and accountability, it becomes even more critical in times of budgetary constraints.

Changes in the SNAP Caseload

Chart 3-2 chronicles how the Maine SNAP caseload, from 2009 to 2013, increased by 51,612 recipients (and approximately 32,500 households), a boost in part driven by the provisions of the American Recovery and Reinvestment Act of 2009.

Chart 3-2: **Maine SNAP Facts, 2009 to 2013**

	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Recipients	201,248	229,731	247,943	252,860	249,119
Households	98,557	114,211	126,184	131,153	130,374
Benefits Issued	$292,704,585	$356,097,335	$382,131,426	$376,750,999	$367,069,888
Average Monthly Benefit Per Person	$121.20	$129.17	$128.43	$124.16	$122.79
Average Monthly Benefit Per Household	$245.01	$259.83	$252.36	$239.38	$234.66

Source: USDA, FNS SNAP Program Data, Annual State Level Data For FY 2009–13, http://www.fns.usda.gov/pd/snapmaine.htm

The number of SNAP recipients increased in every state; states that were hit hardest by the recession saw the largest caseload increases. For example, Nevada, Florida, Idaho, and Utah — the four states with the greatest growth in the number of unemployed workers between 2007 and 2011 — also had the greatest growth in the SNAP caseload.

The figures demonstrate a slight decline in 2013: from 252,860 recipients in 2012 to 249,119 recipients in 2013, a decrease of 3,741 recipients; and 131,153 households in 2012 to 130,374 in 2013, a decrease of 779 households. A paper published by the Center for Budget and Policy Priorities finds a similar pattern in 2013, identifying Maine among six states showing the largest caseload declines. These states include Utah (–6 percent), North Dakota (–6 percent), Maine (–3 percent), Michigan (–3 percent), Missouri (–3 percent), and Idaho (–3 percent).[26] If the economy improves, the Congressional Budget Office expects that the number of SNAP recipients will fall by 2% to 5% each year over the next decade: from 47.7 million nationally in FY 2013 to 47.6 million in 2014, 46.5 million in 2015, and 34.3 million by 2023.

Maine's DHHS Office of Family Independence (OFI) "Program and Benefits Distribution Report" for December 2012 and December 2013 confirms that a modest decline is occurring.

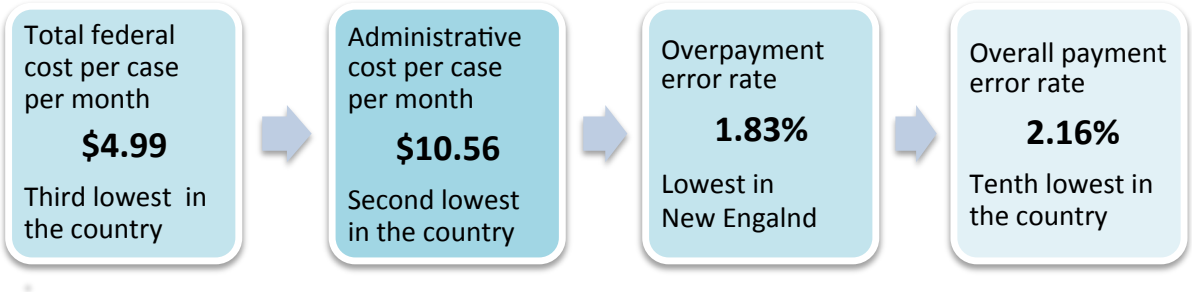
Maine SNAP Performance Indicators

Applying for SNAP benefits has become simplified in recent years because of the state's on-line application process and on-going efforts to make access to assistance for those truly

26. "SNAP Costs are Leveling Off, Almost Certain to Fall Next Year; Trends Reflect Flat Caseloads and Recent Benefit Cut," Center for Budget Policies and Priorities, November 2013.

eligible as straightforward for residents of Maine as possible. Additionally, state staff report recertification policies and procedures are designed to be recipient friendly; and field operations are responsive and committed to a high degree of efficiency and sensitivity to recipient services. However, handling large caseloads in any assistance program, particularly SNAP, creates challenges to even the most-efficient agency. Looking at FFYs 2005, 2006, 2007, and 2008, Maine was found to have comparatively high error rates in federal reviews of the food-stamp program. However, DHHS has been able to reverse that pattern in recent years. For FY 2012, USDA Food and Nutrition Services published its most recent SNAP data report showing state-level breakdowns in a number of indicators. Maine compares favorably against all other states on several indicators related to payment-accuracy measures:

Chart 3-3: **Maine SNAP Performance Indicators, 2012**

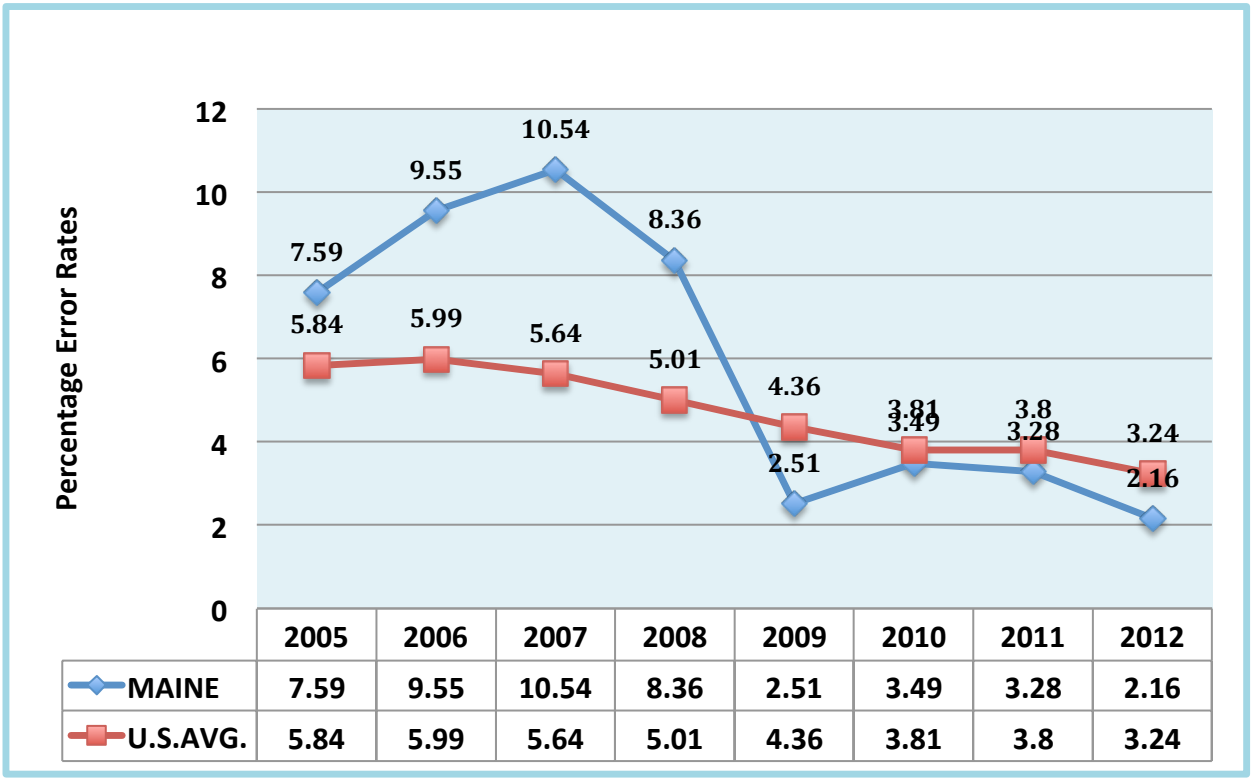


Source: USDA, SNAP State Activity Report, Fiscal Year 2012, Page 53, Table 39; USDA FNS Quality Control Error Rate Chart, FY 2012, http://www.fns.usda.gov/pd/snapmain.htm.

Maine's SNAP Error Rates Decline

The SNAP error rate is calculated for the entire program, and is a combination of overpayments to those who are eligible for smaller benefits, overpayments to those who are not eligible for any benefit, and underpayments to those who do not receive as much as they should. Chart 3-4 demonstrates just how effective the OFI efforts have been in reducing error rates over the most recent five-year period.

Chart 3-4: **Maine SNAP Error-Rate Decline, 2005 to 2012**



	2005	2006	2007	2008	2009	2010	2011	2012
MAINE	7.59	9.55	10.54	8.36	2.51	3.49	3.28	2.16
U.S.AVG.	5.84	5.99	5.64	5.01	4.36	3.81	3.8	3.24

Source: USDA, FNS SNAP Multi-Year Quality Control Error Rates, http://www.fns.usda.gov/pd/snapmain.htm.

Moving from a high error-rate status over four years, which is considered a penalty phase in SNAP, to a significant decrease in error rates in the subsequent four years in a row, is evidence that the department altered its focus toward payment accuracy and should be credited for effectively bringing this measure into compliance.

Fraud Investigations

Another area of concern is the incidence of fraud in the SNAP program. Both nationally and within each state, there is wide interest in assuring that better controls are in place to identify any potential issues of fraud, waste, and abuse. USDA examines how states address this matter and reports annually on how states approach fraud investigations and recovery, when fraud is verified.

According to the SNAP State Activity Report, fraud investigations are broken into two categories: pre-certification investigations and post-certification investigations. Pre-certification investigations are cases that are referred and investigated prior to being approved/certified for SNAP benefits.

Chart 3-5: **New England SNAP Fraud Investigations, FY 2012**

State	Pre-Cert. Negative	Pre-Cert. Positive	Post-Cert. Negative	Post-Cert. Positive	Total Investigations Completed
Connecticut	1,148	677	45	54	1,924
Maine	5	3	151	201	360
Massachusetts	0	0	4,114	413	4,527
New Hampshire	263	239	622	156	1,280
Rhode Island	49	36	906	156	1,147
Vermont	22	13	143	219	397

Source: Food and Nutrition Service, Supplemental Nutrition Assistance Program, Program Accountability and Administration Division, "Supplemental Nutrition Assistance Program State Activity Report, Fiscal Year 2012," September 2013.

Pre-certification investigations obviously provide a measure of inoculation from having to chase and collect on payout errors that have already occurred. Fortunately, Maine is in the process of implementing a front-end detection system for all of its assistance programs.

One cautionary note relates to SNAP applications and the timeliness standards defined in federal regulations. The new front-end detection system must be set up to accommodate processing standards for determining eligibility of SNAP applications. Falling short on application-processing standards can easily place the state in jeopardy of facing penalties from USDA. Adequacy of staffing levels at the point of application as well as within the investigative unit is the only way to strike the proper balance in issuing benefits only to those who qualify.

Food-Stamp Reforms under the 2014 Farm Bill

Although the "farm bill" was due for reauthorization in October 2013, Congress was unable to reach agreement on proposed changes to the legislation until February 2014. On February 7, 2014, President Obama signed into law the Agricultural Act of 2014. States can begin the work of implementing SNAP (food-stamp) reforms, the first in the program since the welfare reforms of 1996, which are delineated below:

- Closes the "heat-and-eat" loophole that artificially increased benefit levels when states provided the nominal Low Income Home Energy Assistance Program (LIHEAP).
- Establishes a ten-state pilot to empower states to engage able-bodied adults in mandatory work programs.

- Prohibits USDA from engaging in SNAP recruitment activities, including advertising SNAP on TV, radio, and billboards and through foreign governments.
- Ensures that illegal immigrants, lottery winners, traditional college students, and those who are deceased, do not receive benefits.
- Ensures SNAP recipients are not receiving benefits in multiple states.
- Prevents abuses such as water dumping to exchange bottles for cash.
- Demands outcomes from existing employment and training programs.
- Prohibits states from manipulating SNAP benefit levels by eliminating medical marijuana as an allowable medical expense.
- Allows states to pursue retailer fraud through a pilot investigation program and to crack down on trafficking through data mining, terminal ID, and other measures.
- Increases assistance for food banks.[27]

Program Integrity in SNAP

According to USDA, program-integrity efforts of FNS and its state partners are yielding results and trending in the right direction. Two areas showing excellent results relate to certification errors: when an eligibility worker authorizes benefits in the wrong amount; and trafficking, which occurs when SNAP benefits are traded for cash. In FY 2012, FNS redoubled efforts to prevent and identify fraud, and hold violators accountable for misuse of funds.

Much of FNS efforts are focused on improving integrity at the retail level. However, no state is exempt from tightening various aspects of its program, such as fortifying efforts to screen out individuals who are ineligible for benefits; working with EBT processors to strengthen fraud-detection system reporting; following up individuals found to have involvement with trafficking at the retail level, working within the state system; continuing to strengthen and improve the quality-control system and to perfect any methods being used to implement the new rule regarding avoiding of negative errors (improper denials, suspensions, or termination of benefit); and working with federal partners in targeting technical assistance to states where poor performance is noted.

Assuring responsible administration of this admittedly costly program to America's taxpayers is imperative. For this reason, the USDA and Congress have established measures to avoid, detect, and act aggressively to mitigate fraud, waste, and abuse in this program.

With the support of Governor LePage and DHHS Commissioner Mayhew, the OFI added ten full-time staff to the department's fraud, investigation, and recoveries unit (eight fraud investigators and two fraud-investigation supervisors), bringing the total number of investigators in the field to seventeen. With the additional investigators, the unit director, with

27. Frank Lucas, Press Release, February 7, 2014, https://agriculture.house.gov/

his support staff, trained and created specialized teams composed of individuals with law enforcement backgrounds, and individuals with experience in program policies and services, in May 2013. The combination of such expertise enabled the unit to launch a major effort toward investigating a greater number of cases for possible fraud, waste, and abuse.

These investigators have increased the number of investigations carried out, with results being reported as follows:

- A comparison of overpayments established in 2012 versus 2013 show that the number of intentional-program-violation (IPV) overpayments that were detected increased by 79% — from 169 in 2012, to 303 in 2013. The amount represented in IPV overpayments in 2013 was $688,828.28, an increase of $188,000 over 2012.
- Since each IPV case created results in a twelve-month sanction, it is reasonable to extrapolate an actual cost-avoidance amount due to the work of this unit.

Assuming that each case was a single individual receiving $200 per month in benefits amounts to $2,400 per case over the course of twelve months, we can estimate that 303 confirmed and sanctioned cases, multiplied by $2,400, amounts to $727,200 in cost avoidance for those affected cases.

SNAP Policy Recommendations

If caseload trends continue their modest declines, DHHS can successfully implement the already planned process redesign and may expand automation to the point where meticulous aspects of program integrity and payment accuracy is within reach, including greater assurance that costs are being responsibly contained throughout all areas of SNAP.

1. Aggressive implementation of front-end detection protocols, with adequate systems support, is urged, as the long-term yield to the state, the SNAP program, and the taxpayers cannot be overstated.

2. Pursue approval to become one of the ten-state pilot programs to engage adults in a mandatory work program. Coordinate this effort with the full-engagement TANF initiative.

3. Except for those who are elderly and/or have a disability, narrow the definition of categorically eligible households to only those who have already met one of the federally defined means-tested cash assistance programs (SSI, TANF, or General Assistance). This recommendation would require all other applicant households to meet income and asset limits of $2,000 in order to be eligible for SNAP benefits.

4. Identify program-integrity priorities for 2014, 2015, and 2016, and establish measurable goals for each fiscal year. Build upon the already successful efforts to reduce errors throughout the SNAP program, and involve the entire workforce in a focused commitment toward improving accuracy in eligibility determinations and benefit issuances.

4. Child Care Assistance Programs

According to the 2014–15 Child Care Development Fund (CCDF) state plan, DHHS is the designated lead agency to administer the CCDF program and the chief executive officer for CCDF is Commissioner Mary Mayhew.

2014-15 Child Care Development State Plan Funding
Federal CCDF allocation: $16,157,880
Federal TANF transfer to CCDF for 2013: $2,000,000
Direct TANF and state spending on child care: $20,691,243
—Maine CCDF State Plan, 2014–15.

No more than 5% of the aggregate CCDF funds can be expended on administration costs; however once all FY 2014 funds have been liquidated, state MOE funds are not subject to this 5% limitation. Also noted in CCDF plan, State Purchased Social Services Grant, the state general fund, and Fund for Healthy Maine are used to meet the CCDF state-matching requirement.

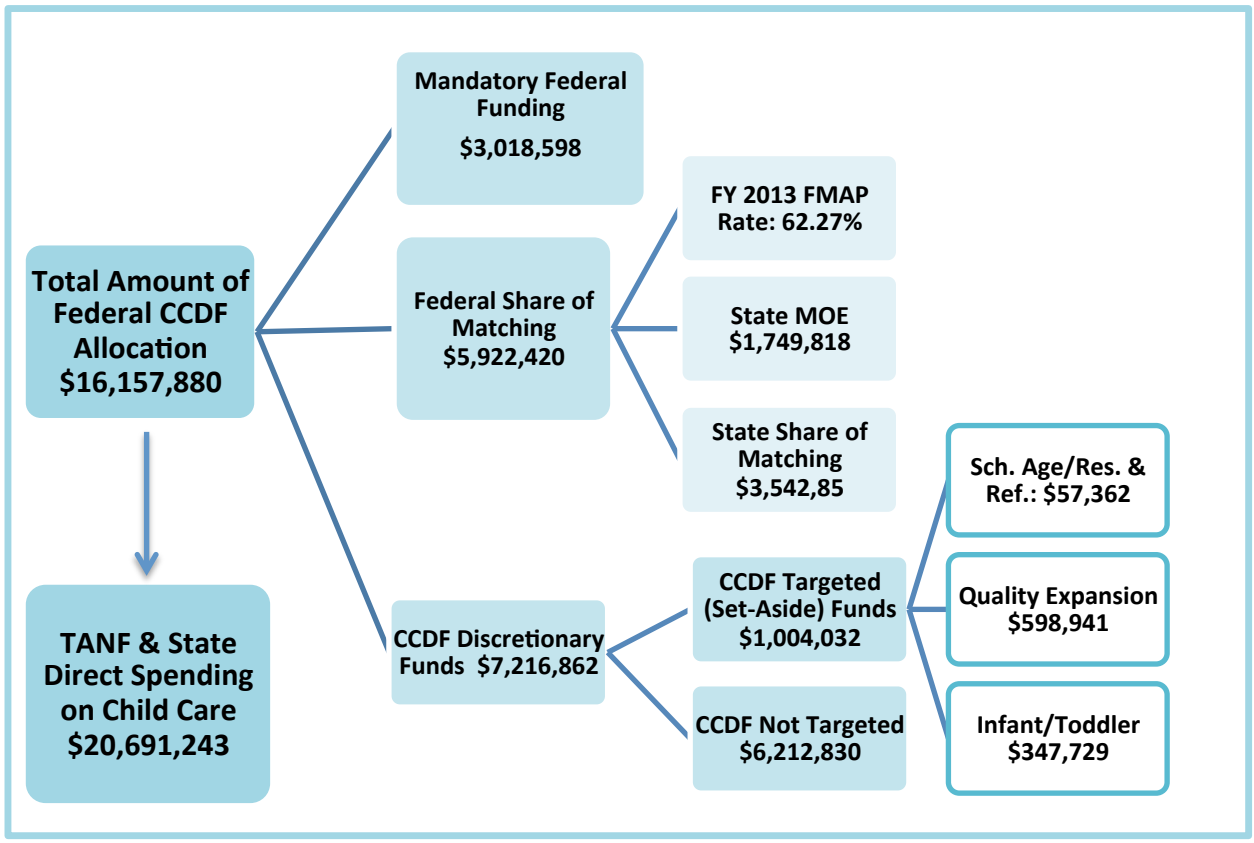
Chart 4-1 provides a three-year perspective on how federal CCDF dollars are allocated. While mandatory dollars remain level, as do state MOE dollars, other allocations vary, and are affected by changes in Maine's FMAP rates each fiscal year.

Chart 4-1: **CCDF Funding Allocations for Maine**				
		2011	**2012**	**2013**
Mandatory		$3,018,598	$3,018,598	$3,018,598
Federal Share Matching		5,849,296	6,025,942	5,922,420
State MOE		1,749,818	1,749,818	1,749,818
FMAP		63.80	63.27	62.57
State Share Matching Funds		3,318,880	3,498,227	3,542,851
Discretionary Funds including Targeted (Set-Aside) Funds		7,347,802	7,791,183	7,216,862
Targeted (Set-Aside) Funds	School-Age Child Care Resource & Referral Programs	63,004	63,301	57,362
	Quality Expansion	610,227	647,263	598,941
	Infant & Toddler	353,402	374,854	347,729
Discretionary Funds Excluding Targeted (Set-Aside) Funds		6,321,169	6,705,765	6,212,830
Total Federal-Only Funds		**$16,215,696**	**$16,835,723**	**$16,157,880**

Source: Annual CCDF allocation tables show allocations, or the amount of funding awarded to each state, territory, or tribal grantees based on congressional appropriations for each fiscal year. http://www.acf.hhs.gov/programs/occ/resource/fy2011, fy2012, fy 2013-ccdf-final-allocations-including-realloted-funds.

Chart 4-2 displays the CCDF state plan funding levels for FFY 2014–15 by category, including the total amount of child care funding planned through ASPIRE-TANF and TCC programs. These projections include both state and federal dollars.

Chart 4-2: **CCDF Funding Plan, FFY 2014**



Source: HHS, ACF Office of Child Care, CCDF Final Allocations Chart Issues July 2013; http://www.acf.hhs.gov/programs/occ/resource/fy2012-ccdf-final-allocations-including-realloted-funds, ACF CCDF ACF-196 Financial Report, FY 2013 submitted by DHHS Service Center, and CCDF state plan for 2014–15.

Administering government funded child care programs is complex, expensive, and fraught with challenges. It is a benefit intended to support primarily working parents, but it is a service that is provided to and for low-income children up to the age of 13. The federal Administration for Children and Families, through its regulations and technical guidance, offers every state specific guidance to ensure a uniform understanding that child care must be safe, affordable, accessible, and of the highest quality possible.

Structure of DHHS Child Care Programs

Under the umbrella of DHHS, there are three offices with responsibilities related to child care in Maine. They are interconnected by virtue of laws, regulations, and operational tie lines, all of which ensure that the oversight of this program is carried out responsibly.

The Division of Licensing and Regulatory Services is responsible for issuing child care center licenses, family child care certificates, and nursery school licenses. This includes monitoring compliance with regulations set by DHHS under direction of the state legislature.

With regard to the provision of child care services, the state administers policies, programs, and subsidies for families through two separate but coordinated service-delivery structures:

- **The Office of Child and Family Services (OCFS)** administers quality program initiatives and child care subsidies under the federal Child Care Development Fund (CCDF), which is used by low-income working parents or low-income parents in training or education and whose income renders them ineligible for child care through ASPIRE-TANF.

- **The Office of Family Independence (OFI)** administers child care assistance for parents on ASPIRE-TANF/PaS cash assistance, and/or parents who have recently closed to cash assistance (within the recent three months) due to increased earnings from work or because they have recently entered the job market. ASPIRE-TANF/PaS child care is a supportive service to parents who must fulfill their TANF work participation requirements, while Transitional Child Care is a temporary subsidy for former ASPIRE-TANF/PaS recipients who close to cash assistance due to employment.

Chart 4-3: **Maine's Two-Track Child Care Program Structure**

Child Care Development Fund (CCDF) Office of Child and Family Services (OCFS)	**ASPIRE-TANF Child Care Office of Family Independence (OFI)**
Administers CCDF Child Care Subsidy Program for low-income working families (and) income-eligible families attending vocational education or training.	Administers ASPIRE child care supportive services and Transitional Child Care supportive services for working families recently closed to TANF/PaS cash assistance.
Primary Payment Method • Providers paid after performance • Biweekly billing based on child attendance • OCFS-CCDF authorization unit • Payments primarily via direct deposit	**Primary Payment Method** • Paid one week in advance of services used • Payments issued primarily to parents on EBT card or if requested, payments made directly to child care (CC) providers • Typically, OFI reimburses parent who then pays provider for CC services.
Eligibility for CCDF Child Care Subsidy Program and ASPIRE-TCC is determined by OFI eligibility workers in 16 regional centers. OCFS child care staff monitor and renew CCDF CC subsidy cases OFI-ASPIRE specialists monitor and renew ASPIRE-TCC cases	
Reasons for parents receiving CC subsidies • 85% – employment • 4% – training/education • 11% – parents in both employ. & training	Reasons for receiving CC assistance • 51% – employment (TCC) • 49% – education/training
Average number of families: 1,800/month Average number of children: 2,700/month	Average number of TCC families: 2,552/month Average number of ASPIRE-CC cases: 1,035/month
99% CCDF families use licensed/regulated CC settings 1% CCDF families use unlicensed CC settings	60% ASPIRE & 62% TCC parents use licensed CC 24% ASPIRE & 38% TCC parents use unlicensed CC
1,041 providers received CCDF funds in FY 2012 **390 were licensed child care centers** **651 were regulated child care family homes** Approximately 40% of ASPIRE-TCC parents choose informal/unregulated child care settings; total number not quantifiable.	

The Office of Child and Family Services/CCDF Child Care Subsidy Program staff adheres to written policies on monitoring child care (CC) providers who participate in the subsidy program. The following is a set of guidelines followed by CC subsidy program staff:

Goal 1: Auditing files of 10% of providers with child care subsidy authorizations each quarter. Files must be checked for:

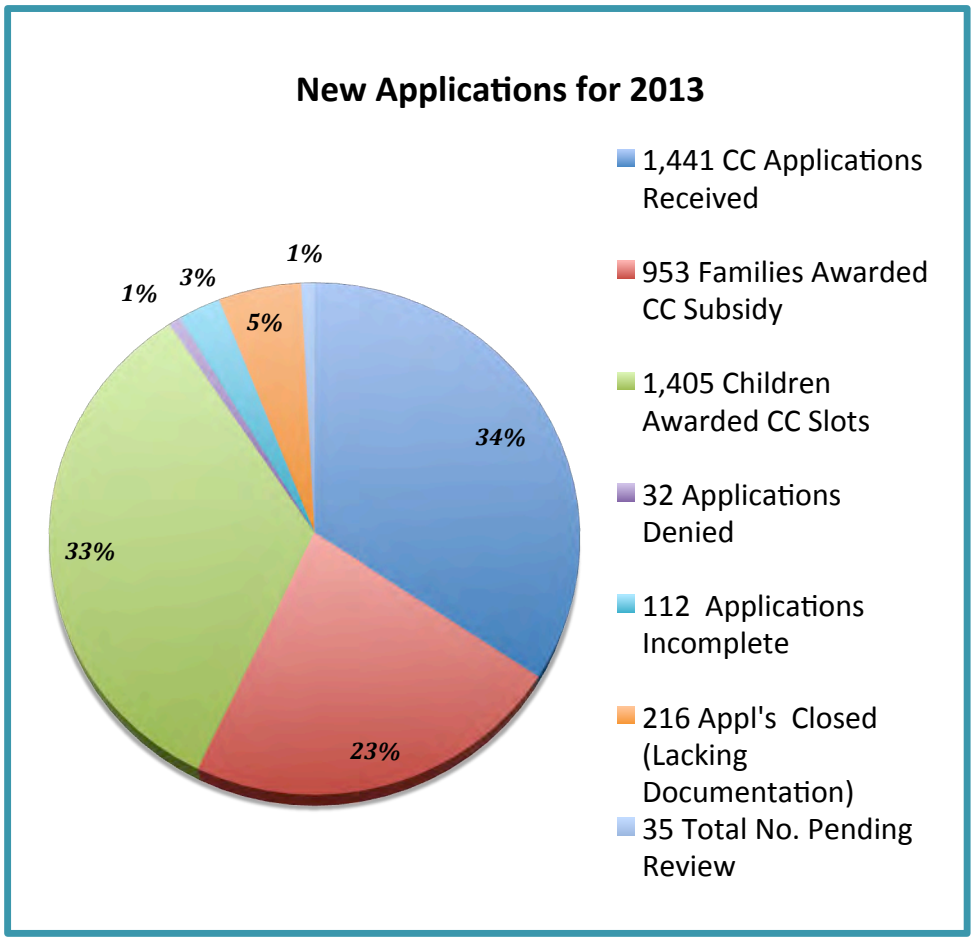
- Completed and signed provider agreement
- Child care contract and policies including holidays, vacation, and inclement-weather closures, and payment policies for each
- Copy of the DHHS license
- Provider's Quality-for-Maine certificate
- Attendance records used
- Water analysis test results (unlicensed providers)
- Immunization records of children in care (unlicensed providers)
- Completed health and safety checklist (unlicensed providers)

Goal 2: Field auditing of 5% of child care providers per year — random selection from pool of child care provider attendance and reporting/billing per month. Field audits include:

- Comparison of billed hours and attendance sheets
- Parents' signatures on attendance sheets
- Discussions with facility management regarding any areas of concern or confusion related to
  - ✓ Provider agreement requirements
  - ✓ Provider policies on holidays, vacation, and weather-related closures, and payment policies for each
  - ✓ Receipts for parent co-payment fees
  - ✓ Child care subsidy program award letters

Chart 4-4 provides a breakdown of the child care applications received by DHHS Office of Child and Family Services for CY 2013. This chart also provides a breakout of determinations made on the 1,441 new applications received in 2013:

Chart 4-4: **CCDF Child Care Subsidy Program**



Those who apply for child care through the Office of Child and Family Services must fill out a paper application, and as instructed at the bottom of the form, must mail the application to the OCFS Child Care Subsidy Program office located at 2 Anthony Avenue, Augusta, Maine. Applicants may also be referred to CC subsidy program through sixteen OFI regional offices as well as referrals through outside resources that work with the low-income working families.

Financial eligibility is determined by the OFI-eligibility workers who are located throughout the regional centers. OFI eligibility workers notify the OCFS CCDF Child Care Subsidy Program staff that a family is financially eligible; CCDF subsidy staff then takes ownership of the case and monitors ongoing need for child care, i.e., employment, changes in family circumstances, and verifies that family is connected to provider. Different from the OFI-ASPIRE TCC program, the OCFS-CC subsidy program staff also has an active role with child care providers. The typical caseload size in the CC subsidy program is approximately four hundred and fifty cases per worker.

Quality Initiatives in Maine's Child Care Programs

Under Section 658G of the Child Care and Development Block Grant Act and existing regulations at §98.51(a)(1), lead agencies must use not less than 4% of CCDF funds for activities that are designed to provide comprehensive consumer education to parents and the public, activities that increase parental choice, and activities designed to improve the quality and availability of child care, including resource and referral services. Lead agencies have broad flexibility to determine what may constitute quality activities as long as those definitions fit within the broad statutory requirement.

Maine CCDF administers a Child Care Quality Rating and Improvement System (QRIS) on a statewide basis. Also referred to as "Quality for ME," the four-step improvement system is designed to increase awareness of the basic standards of early care and education, recognize and support providers that are providing care above and beyond those standards, and educate the community of the benefits of higher quality care. The QRIS was also created to identify those programs that may need additional resources or supports to increase their level of quality as measured by the Quality for ME system. All staff and providers working in facilities that participate in Quality for ME are required to register in the Maine Roads to Quality Registry.

The Maine QRIS Includes multiple-provider incentives, which include:

- Priority access to scholarships for income-eligible staffers that wish to pursue early-childhood education degrees.
- A reimbursement differential for each child whose care is subsidized by DHHS' Office of Child and Family Services:
  1. 10%-quality differential for programs that have reached Step 4 in the QRIS
  2. 5%-progress differential for programs that have reached Step 3
  3. 2%-quality differential for programs that have reached Step 2
  4. Double child care state income-tax credit for parents whose child is enrolled in a program at the Step 4 level
  5. A child care tax credit for expenses made to improve quality for programs that pay state taxes and have a QIP status.

According to a statewide report compiled by OCFS, the Maine QRIS data showed that of the 1,234 licensed family child care providers, 502 (40.7%) are enrolled in QRIS, and 12 (1.0%) of these providers have waivers.

Of the 713 licensed center-based providers, 452 (63.4%) are enrolled in QRIS and 19 (2.7%) licensed center-based providers have waivers. Chart 4-5 provides a breakdown of provider enrollment levels by setting type and quality step:

Chart 4-5: **Child Care Enrollments by Settings, as of November 4, 2013**

Care Quality	Family Child Care Providers	Family CC Percentage	Center-Based CC/Head Start Providers	Center-Based CC/Head Start Percentage
Step 1	345	68.7	204	45.1
Step 2	78	15.5	89	19.7
Step 3	52	10.4	39	8.6
Step 4	27	5.4	120	26.5
Total	502	100.0	452	100.0

The CCDF state plan shows that approximately $3.4 million is being allocated for quality initiatives as follows:

- $500,000 – allocated for infant-toddler child care (targeted/set-aside)
- $300,000 – allocated for school-age CC and CC resource & referral (targeted/set-aside)
- $1,300,000 – allocated for training, tech. assistance, & prof. dev. (targeted/set-side)
- $1,300,000 – allocated for child care licensing (quality funds, not including set-aside)

Maine appears to be expending a significantly higher percentage of its CCDF funds on quality initiatives than the 4% minimum required by child care regulations; especially when compared to other states, which may expend at or somewhat above the 4% mandate.

Why is this Noteworthy?

During early 2012, due to funding constraints, Maine was forced to establish a waiting list of low-income families who needed child care in order to work. Yet the ongoing investments in quality child care initiatives, which were far above the 4% minimum federal requirement, remained intact even during difficult budgetary decision-making. Notwithstanding the fact that the ACF Office of Child Care has identified quality initiatives and program integrity as its two primary goals for 2014, the policy choices in Maine of continuing to maintain significant investments in infrastructure when the state decided to institute a wait list, is a choice that may need to be reconsidered in the future.

As one alternative, the department has the option to establish a fiscal formula which scales back a portion of quality initiative spending in order to avoid establishing wait lists of low-income working families. Such an alternative may offer better balancing of resources between infrastructure and child care subsidies and is a conversation that should take place, especially considering that one of Maine's primary goals is to support strong, healthy, working families. In addition, it may be prudent to explore any potential for financial contributions from major stakeholders who have been active partners in QRIS. This may include Head Start, the

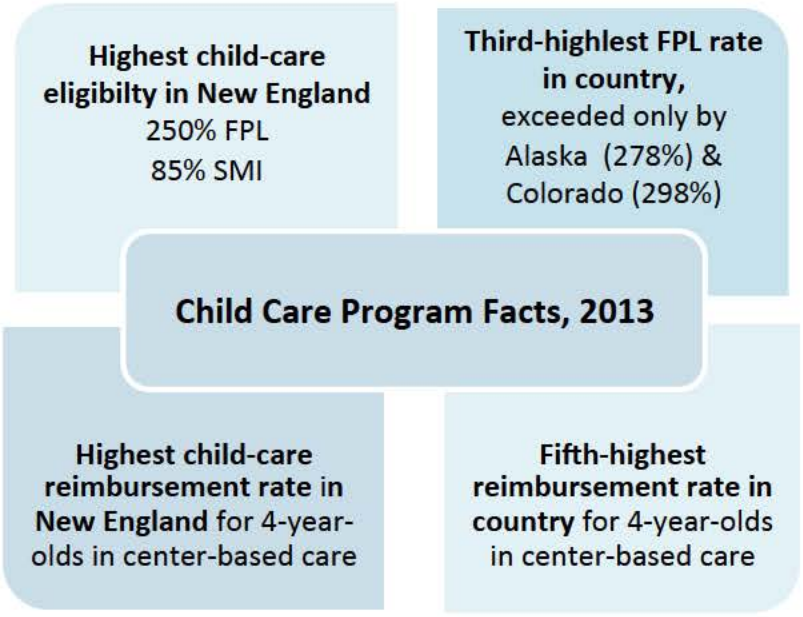
Maine Department of Education, early-childhood education programs, and other vested partners who participate in the state's CCDF quality initiatives. Developing this potential may represent a broader and more sustainable future for Maine's commitment to early care and education through Quality for Me.

Further analysis is needed to determine the exact ratio of dollars devoted to quality initiatives versus child care subsidies, especially in the environment of budgetary constraints, and the state should consider adjustments and/or alternatives to how quality investments are supported going forward

Maine's CCDF Policy Choices Relative to Other States

In terms of other choices, the DHHS child care program maintains very generous eligibility criteria and reimbursement rates. According to the National Women's Law Center, which analyzed child care assistance policies in all states, Maine's FPL-eligibility levels and reimbursement rates are the highest in New England and among the top five in the country.[28]

Chart 4-6: Maine Child Care Program Facts



28. Karen Schulman and Helen Blank, "Pivot Point, State Child Care Assistance Programs," National Women's Law Center, 2013.

Chart 4-7 compares eligibility rates, policies on state median-income levels, and actual gross-dollar amounts that are in effect in each of the six New England states.

Chart 4-7: **New England Child Care Policies, Income-Eligibility Levels**

	Maine	Connecticut	Massachusetts	New Hampshire	Rhode Island	Vermont
Percentage of FPL for CC Eligibility	250	219	216	244	176	187
Percentage of State Median Income (SMI)	85	50	50	62	46	57
Actual Gross Income	$48,828	$42,829	$42,096	$47,725	$34,362	$36,131

Source: Karen Schulman and Helen Blank, "Pivot Point, State Child Care Assistance Programs," National Women's Law Center, 2013.

Parent's Co-Payment Rate

According to the DHHS Office of Child and Family Services Policy Manual, Section 6.02.5 (Child Care Subsidies), a graduated fee percentage of gross family income will be applied to each of the income ranges highlighted in the chart below: Consistent with CCDF rules, the total amount of parent fees assessed to a family should not exceed 10% of the family's gross income, irrespective of the number of children enrolled in the subsidy program.

Chart 4-8: **Child Care Co-Payment Fees**

Poverty Guideline Range	Parent's Co-Payment Fee as Percentage of Gross Family Income
Up to 25%	2%
26% to 50%	4%
51% to 75%	5%
76% to 100%	6%
101% to 125%	8%
126% to 150%	9%
151% to 200%	10%
201% to 250%	10%

Child Care Reimbursement Rates

The following charts highlight findings from national studies on policy choices, and how those policies compare with Maine. Considering the unique circumstances throughout the country, states differ in their child care program designs, policies, and rate structures. Charts 4-9 and 4-10 compare rates of reimbursement for 4-year-olds in six New England states and throughout the country.[29]

Chart 4-9: **Maine Leads New England in Reimbursement Rates**

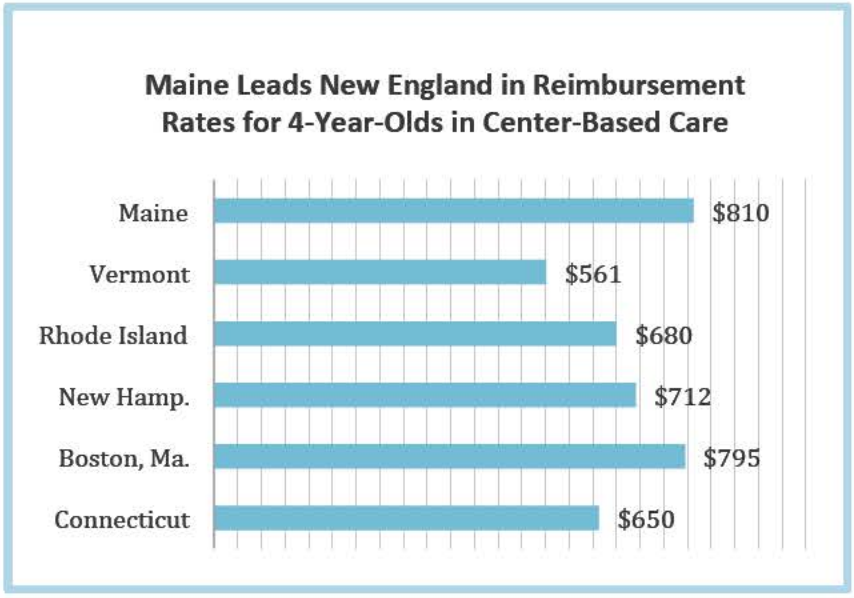
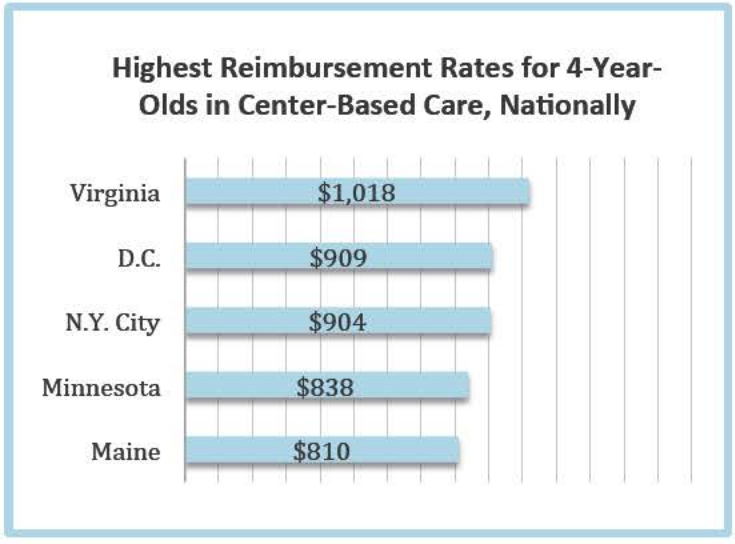


Chart 4-10: **Highest Reimbursement Rates for Center-Based Care**



29. Ibid., pp. 30–31.

All states must conduct a biennial market-rate survey (MRS) in accord with CCDF regulations. Results of each state's MRS are used to "guide" states in determining a reasonable level of reimbursement based on the rates paid by non-subsidized payees. Empirical evidence indicates that the biennial MRS has increased access to quality child care for low-income families. While surveys are mandated by CCDF regulations, the results are intended to be used only as a guidepost; CCDF rules "recommend" that states pay up to the seventy-fifth percentile of market rates, but it is left up to each state to set its own rates.

National studies have shown there is great variability in reimbursement rates. Like Maine, many states have large differences in rates, which are influenced by employment rates, local and municipal economies, geographic conditions, and other factors that may affect supply and demand for child care. Maine's MRS resulted in sixteen rate areas across the state. The matrix of child care reimbursement rates cover full-time/part-time care, age groups of children needing care (i.e. infants; toddlers; pre-school; and school age); in-school/out-of-school care; as well as before-and-after school care. (See Appendix C for a complete list of Maine child care reimbursement rates.)

Chart 4-11: **Weekly Reimbursement Rates for Full-Time Infant Care**

County	Licensed Center-Based Care	Licensed Home-Based Care	Unlicensed Provider Care
Androscoggin	$155	$130.00	$91.00
Aroostook	$140	$95.00	$66.50
Cumberland	$225	$160.00	$112.00
Franklin	$145	$117.50	$82.25
Hancock	$180	$125.00	$87.50
Kennebec	$160	$130.00	$91.00
Knox	$170	$135.00	$94.50
Lincoln	$170	$130.00	$91.00
Oxford	$145	$125.00	$87.50
Penobscot	$160	$125.00	$87.50
Piscataquis	$150	$125.00	$87.50
Sagadahoc	$175	$135.00	$94.50
Somerset	$130	$125.00	$87.50
Waldo	$187	$125.00	$87.50
Washington	$175	$125.00	$87.50
York	$195	$150.00	$105.00

Source: DHHS OCFS Policy Manual, October 1, 2013.
Full-time is defined as 30+ hours per week.

According to the National Women's Law Center Report in February 2012, child care intake in Maine was frozen for families who applied for child care assistance. In March 2012, a waiting list was formally established; families who had applied during the "freeze" period were placed on a waiting list in the order of their application date. As of July 2012, 568 children were on Maine's child care waiting list. However, the Maine DHHS currently reports that the wait list has been eliminated.

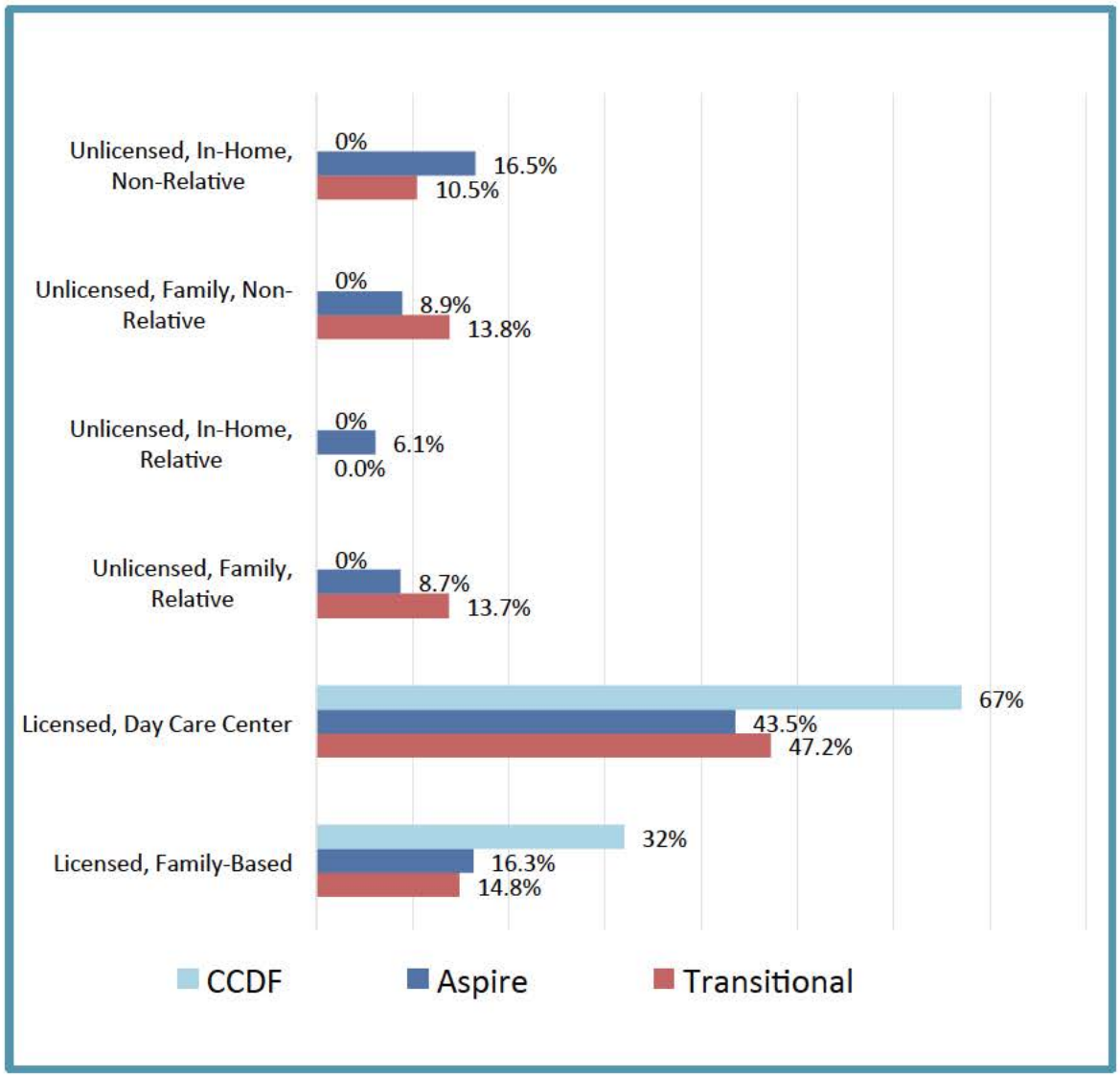
Chart 4-12: **ASPIRE and Transitional Child Care Costs**

Type of Care	Monthly Cost Per Case	Annual Cost Per Case
Licensed, Daycare Center	$672.07	$8,064.82
Licensed, Family-Based	$514.07	$6,168.82
Unlicensed, Family, Non-Relative	$398.27	$4,779.28
Unlicensed, Family, Relative	$397.89	$4,774.73
Unlicensed, In-Home, Non-Relative	$522.33	$6,268.00
Unlicensed, In-Home, Relative	$381.44	$4,577.23

Source: DHHS-OFI Data Reports, December 2013.

Chart 4-13 offers a perspective on the types of child care settings chosen by parents in ASPIRE, Transitional Child Care (post TANF), and CCDF child care subsidy program for low-income working parents (not on TANF). Formal care is defined as licensed centers and licensed family-based providers; informal care is defined as regulated but not licensed, or unregulated care (neighbor or relative care). As Chart 4-13 indicates, approximately 40.2% of ASPIRE families, and 38% of TCC families choose informal child care providers, and approximately 60% choose formal licensed child care providers. Interestingly, 99% of child care subsidy's low-income working families choose formal (licensed) providers.

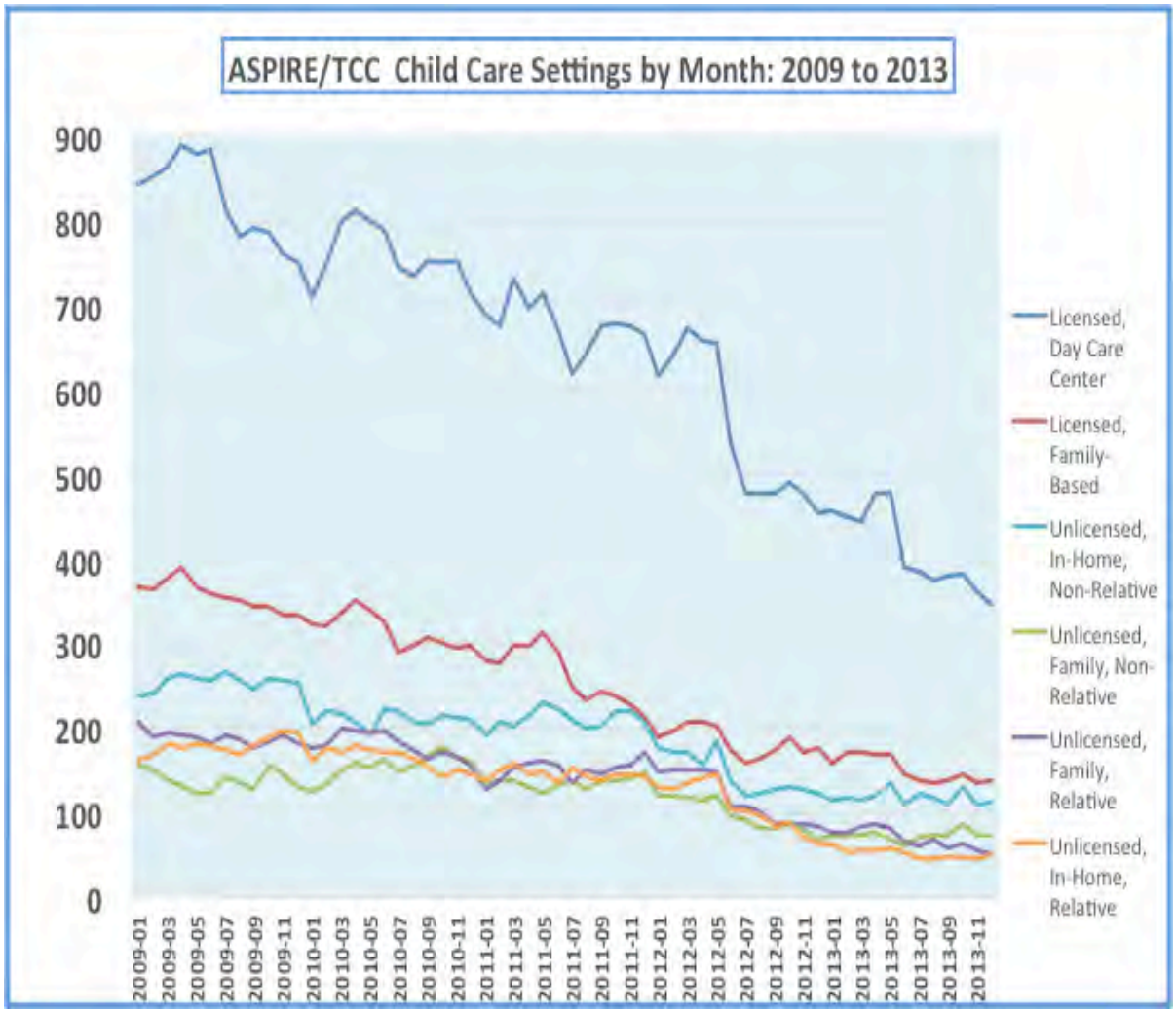
Chart 4-13: **Child Care Settings, 2013**



Sources: DHHS-OFI Data Reports, December 2013; ACF-801 CCDF data for FFY 2012, October 25, 2013.

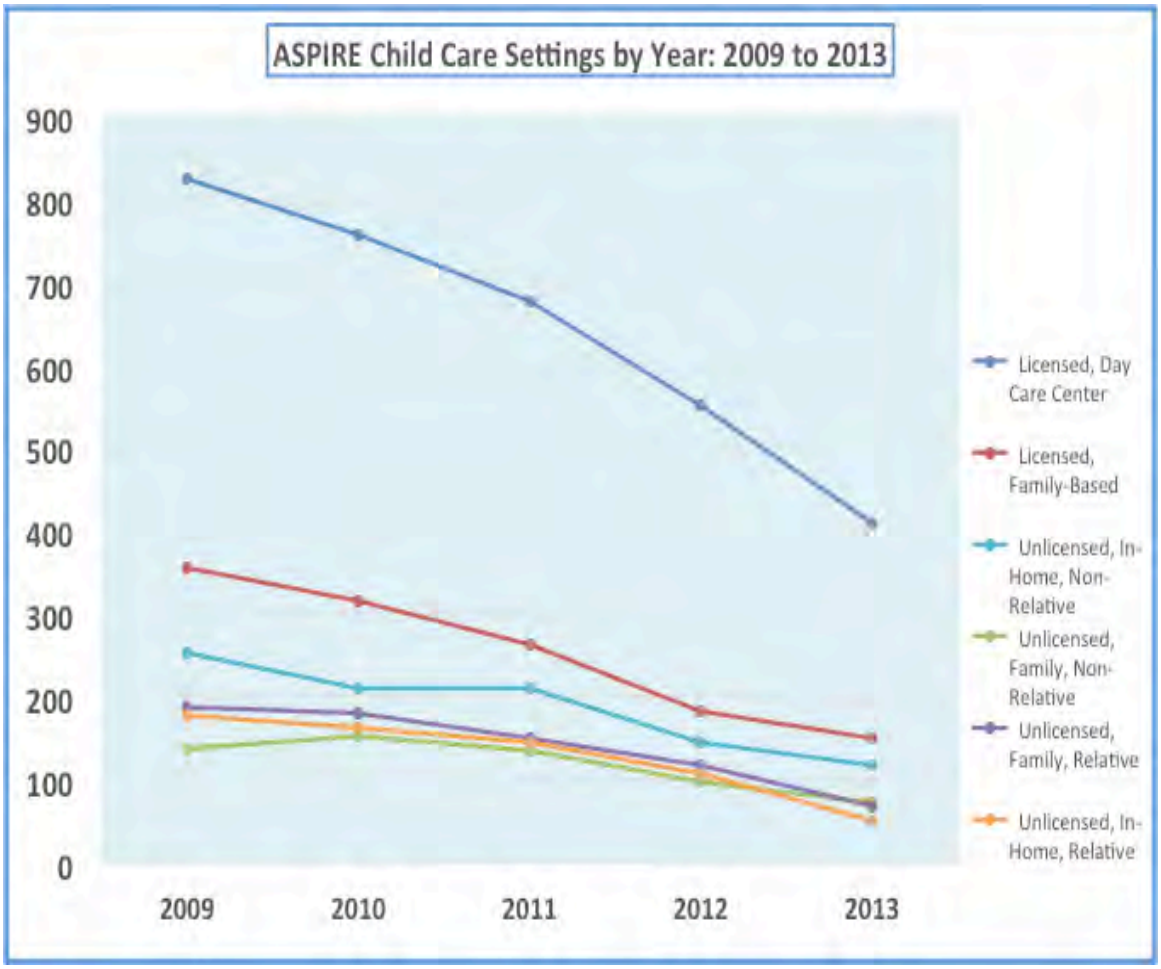
Consistent with economic declines in the country, as well as gradual caseload declines in the state's TANF program, Chart 4-14 provides a snapshot of the child care caseload decline by each month. The trend line in this chart, as well as the yearly pattern highlighted in Charts 4-15 on the following page, capturing the use of licensed family provider settings as well as informal provider settings, is less dramatic compared to licensed center-based settings, which follows a steeper decline. More analysis is needed to discern if the difference is statistically significant.

Chart 4-14: **ASPIRE/TCC Child Care Settings, 2009–13**



Source: DHHS-OFI Data Reports, December 2013.

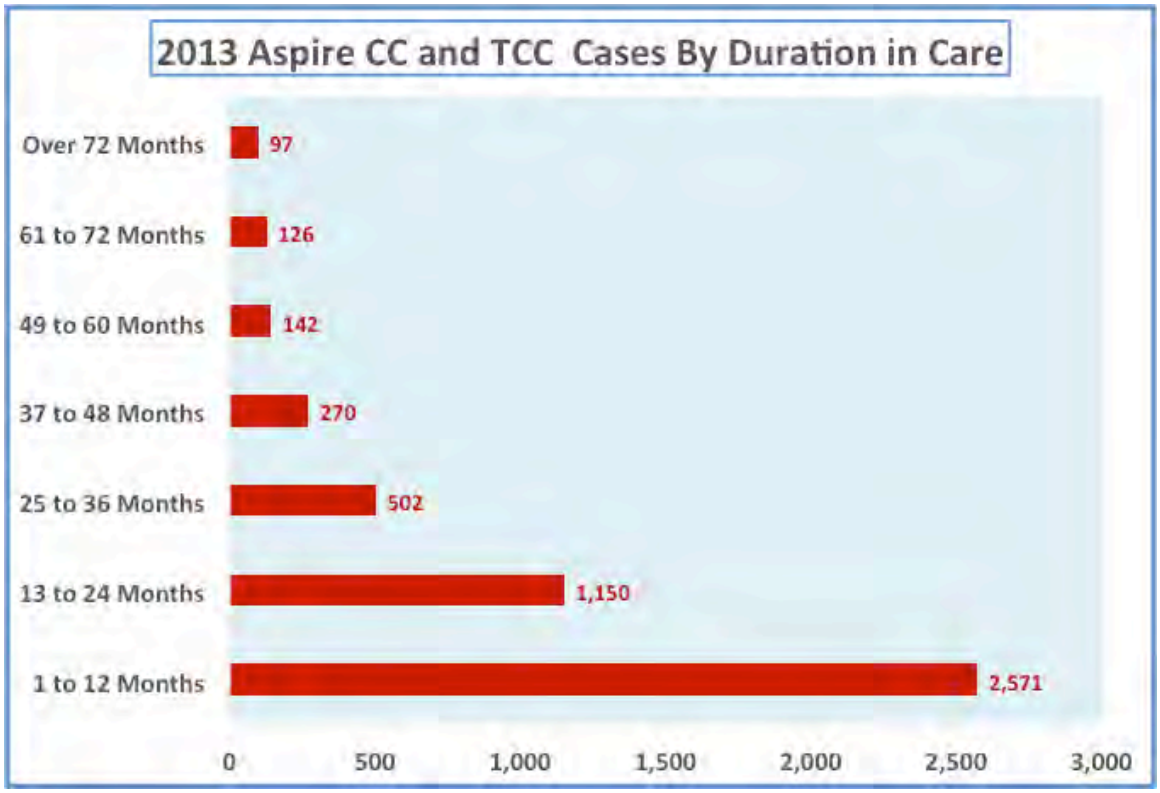
Chart 4-15: **ASPIRE Child Care Settings, 2009–13**



Source: DHHS-OFI Data Reports, December 2013.

Chart 4-16 highlights the length of time that families receive child care subsidies through OFI's ASPIRE and Transitional Child Care programs.

Chart 4-16: **ASPIRE & TCC Cases by Duration**

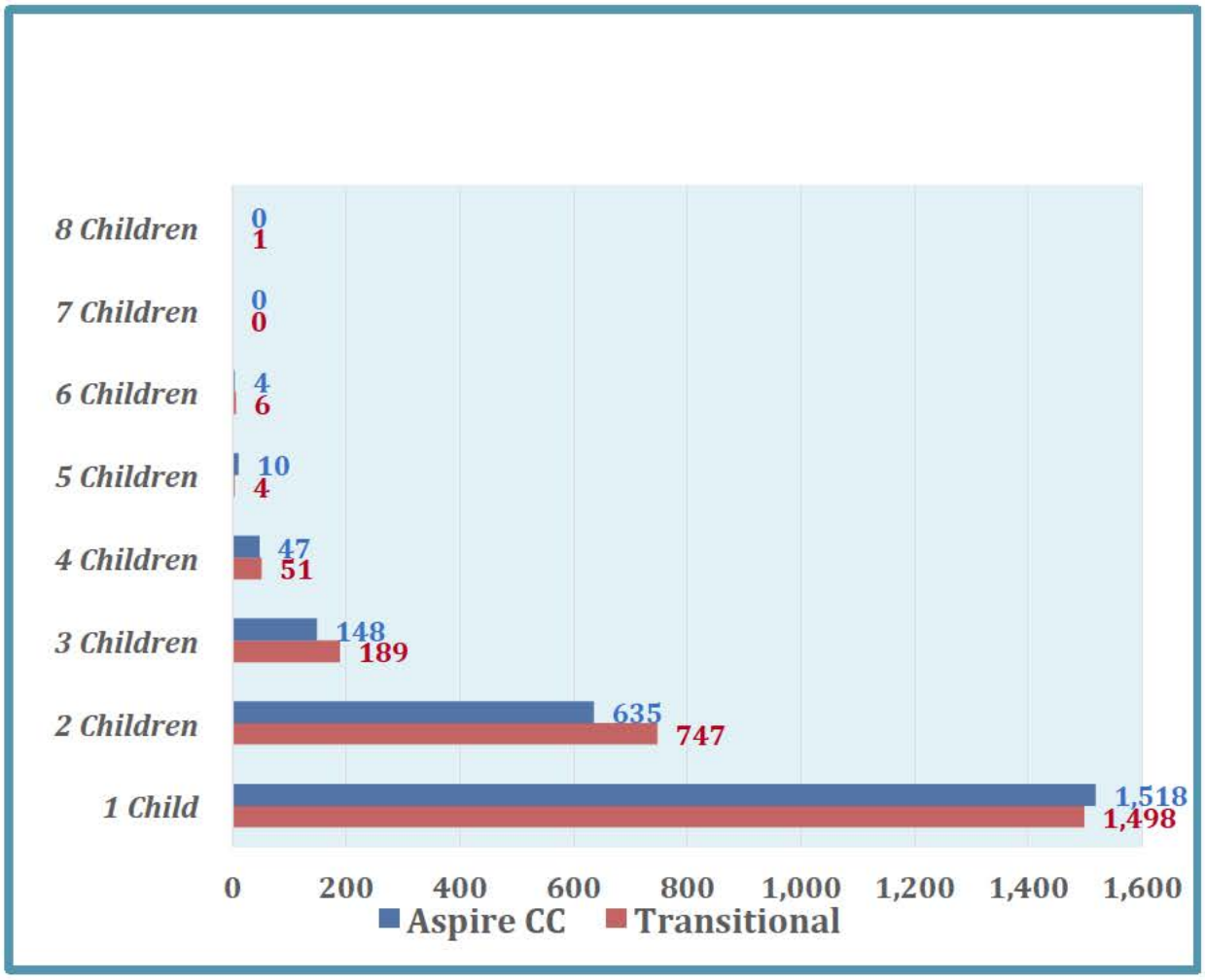


Source: DHHS-OFI Data Reports, December 2013.

According to outside studies of child care utilization and duration, some families have episodic, seasonal, or temporary employment. Consequently, at recertification time a parent or spouse may be unemployed, making the family ineligible for child care subsidy. It was not possible to discern how much of this occurs in the Maine child care caseload, however it is reasonable to speculate that Maine families experience similar circumstances that can interrupt care needs. Data was not available to verify the incidence and frequency of episodic use of care in the ASPIRE-TANF child care, TCC, or the CCDF Child Care Subsidy Program.

Chart 4-17 displays the number of families using ASPIRE and TCC by the number of their children (one or more) in subsidized care.

Chart 4-17: **Number of Families by Number of Children in Care, 2013**



Source: DHHS-OFI Data Reports, December 2013.

For budgetary purposes, it is useful to gauge the number of families needing child care for more than one child, however such data is not available through the CCDF CC subsidy program as it is not required for the federal ACF 801 report.

What we do know, according to the ACF 801 report, is that the CCDF Child Care Subsidy Program served approximately eighteen hundred families per month and twenty-seven hundred children per month throughout 2012. Based on percentages of family utilization in ASPIRE CC and Transitional CC, it is probable that approximately 60% of CCDF families have one child in care; approximately 28% to 30% have two children in care; and approximately 10% have three or more children in care.

Recommendations for Child Care Programs

Establish an integrated child care policy and program leadership role with responsibility across OCFS and OFI.

1. Strongly consider consolidation of child care administration and policy development into a single leadership role within the department. There is expertise on both sides of the existing structure, but there is a bifurcation in Maine's child care program that leads to redundancy in some areas, and inefficiencies in other areas. At the case level, it is difficult for families to understand how to straddle the two systems, but it is also challenging to administer the different policies, procedures, reporting, and budgeting which DHHS must deal with as part of their commitment to responsible government. This recommendation does not suggest changes to service delivery, but rather suggests building a more unified approach to policy and program development and to systems coordination, especially in the areas of federal and state tracking and reporting of expenditures. The department has tremendous strengths on all sides of the equation; this recommendation could better align policies and procedures into one efficient and cost-saving administrative structure that would in many ways offer simplification and streamlining in the service-delivery system. As importantly, there would be one individual with responsibility to manage data reporting for all facets of child care authorizations and this same person to represent the commissioner on all matters pertaining to child care.

Create a uniform child care data-reporting capability that captures data from OFI and OCFS.

2. Uniformity in child care data reporting is recommended by creating a new integrated child care report capability that would combine CCDF Child Care Subsidy Program data elements with ASPIRE-TANF and TCC data elements. Such a report produced either monthly, quarterly, or annually, would significantly assist the state to discern exactly who receives child care, the duration of care that is paid for by the respective programs, and could prompt better tracking of the care choices of parents, thus improving program planning and fiscal projections. The current structure has important information gaps on both sides of child care data reporting, i.e., authorizations, utilization and expenditures.

The OCFS system that administers CCDF is mandated to report annually under federal CCDF 801 reports. The CCDF 801 report captures critical data on family profiles, child care providers, levels of child care paid for, and a lengthy list of other types of data that are extremely useful to federal and state administration when dealing with tight budgets and program accountability.

The OFI system, which administers ASPIRE-TANF/PaS, reports supportive-service expenditures and case counts through monthly TANF report transmission. The ASPIRE-TANF/PaS program considers child care a support service like transportation. As such, the system captures general data on providers, monthly case counts tied to ASPIRE-TANF activities and/or Transitional Child Care, counts of licensed or unlicensed providers, and monthly expenditures in each category. It is not evident that the reports track actual CC start-and-end

dates by case level, changes in CC provider types, and whether CC is full time or part time. Nor is there an apparent system for collecting or checking records of child attendance, which is of particular concern given the fact that 40% of ASPIRE-TCC families use informal providers.

A number of states operate under different child care structures, depending on designated administrative agencies. However, with regard to reporting of data, it is not advantageous for a state the size of Maine, to report child care data and expenditures of two separate systems especially when the CCDF data is analyzed nationally and the ASPIRE-TANF/TCC data is omitted from that system. A solution could be to reprogram ACES to produce an ASPIRE-TANF/PaS child care data report that replicates the same elements required under the CCDF 801 report and submit a combined report annually to ACF Office of Child Care. However, it must be acknowledged that ACES has significant limitations and its adaptability to coordination of data production is unfortunately risky.

3. Uniformity in the child care payment policy would greatly improve payment controls and accountability. ASPIRE/PaS policy permits child care payments to be issued to parents on their EBT cards; the expectation is that the parent will then pay his/her provider for child care. Most parents manage well with this system of payment, and there are efficiencies for the OFI ASPIRE workers who review and approve child care payments using the EBT system. However, child care providers will frequently complain about never receiving payments from some of the parents. In Maine, as well as in other states where such a system had been followed, the parent can walk away from that provider and go to a new provider without ever looking back. It often leaves the child care providers "holding the bag" for unpaid services. Additionally, this method of processing payments via EBT, may lead parents toward more "informal" types of care; not always as safe or stable, as the more formal child care settings.

Pay child care providers directly as opposed to issuing payments through parents' EBT cards.

4. Explore partner support to help pay for the costly investments in the state's quality initiatives. The goal is to avoid the budgetary tension DHHS faces when savings are mandated and the only previous choice related to creating waiting lists versus cutting funds in Maine's CCDF quality initiatives budget. An alternative worth considering is to invite other agencies to contribute to the statewide quality investments for children.

Seek financial contributions from various stakeholders involved in Maine's quality care initiatives.

Additionally, reinforce the specified objectives of the state's QRIS by providing ongoing technical assistance (TA) for all QRIS providers to ensure that benchmarks are being met and that the four-step incentive plan is successfully delivering the highest standards in early care and education for children enrolled in these programs. Continuous oversight and TA will help fortify the achievement of strong and success-bound outcomes for children.

5. Paying for child care one week in advance of actual child attendance should be reconsidered, as prepayment carries a high potential for over-payments caused when clients experience "false starts" in programs they signed up for, and/or in job entries that often do not materialize. Such realities are not uncommon in welfare-to-work programs; paying in advance can result in care never used or, in fact, never needed. This problem is further compounded by the need to chase down payments already made and spent by either parent or provider.

Pay after performance, based on provider invoicing system; use technology to automate billing process.

The OCFS Child Care Subsidy Program pays two weeks after child care has been provided. While post-payment, too, has disadvantages, particularly in the startup phase, the long-term advantages of paying for services after they are received is much preferred from a program integrity and budgetary perspective. As with the eligibility review, the close scrutiny of bills, payments, and monitoring of child-attendance practices needs to be done whether it is a licensed or unlicensed provider setting.

Invest in automated support for attendance reporting.

6. Consider moving toward swipe-card technology for paying child care subsidies and build in safeguards for children in care by tracking attendance, arrival times, and pick-up times. Swipe-card technology has been found to be one of the most reliable ways to track attendance; proper protocols further contribute to safety measures for monitoring that children in care are exactly where the parent placed them. As of March 2011, nine states have implemented swipe-card technology: Alabama, Colorado, Indiana, North Carolina, Ohio, Oklahoma, Texas, Virginia, and Wyoming. Additional states have moved toward use of a swipe card but are not yet counted in the federal report.[30] While this technology would necessitate an upfront investment, it is consistent with the department's modernization efforts and would tighten controls on expenditures of state and federal dollars throughout the system of child care.

7. Increase/expand on-site monitoring visits of all child care providers with the goal of better assuring quality care for children while at the same time improving payment accuracy based on periodic checks on child-attendance information. This recommendation assumes policy coordination between OFI and OCFS whereby any provider receiving federal and/or state payments is held to a minimum set of standards, especially those that safeguard the wellbeing of children.

Increase on-site monitoring of child care settings throughout the system.

30. ACF, Office of Child Care, "Child Care Administrator's Improper Payments Information Technology Guide, Part 1: Inventory of State Child Care Information Systems," March 2, 2011.

5. Child-Support Enforcement via DSER

Background

On January 4, 1975, President Gerald Ford signed the Social Services Amendments of 1974, which created part D to Title IV of the Social Security Act. Commonly referred to as "Title IV-D," the amendment created a national child-support enforcement (CSE) and paternity-establishment program, and authorized federal matching funds to the states for enforcing child-support obligations by locating nonresident parents, establishing paternity, child-support orders, and collecting payments. Part D represents one of the four welfare provisions of Title IV: Part A for the TANF program; Part B representing child and family services; and Part E; foster-care and adoption services. (There is no Part C, as this section was repealed).

Although the purpose of the 1975 legislation was to secure reimbursement from absentee parents for the cost of welfare paid to custodial parents, the services provided by the child-support enforcement system are open to all parents irrespective of whether they receive any type of public assistance or not. While parents in Medicaid, TANF, or the federal foster-care program automatically receive child-support services — and at no-cost — single parents outside the welfare system can apply for child-support services for a modest fee.

When Congress overhauled the nation's cash-welfare program in 1996 and replaced AFDC with TANF, it introduced major enhancements to the CSE system as well, making TANF funds contingent on states ensuring that their child-support enforcement systems meet federal standards, and started to base funding on performance. The 1996 legislation also required states to increase the percentage of noncustodial parents identified and to use more rigorous enforcement techniques, including technology, to locate absentee fathers.

Integration of Child-Support Enforcement with Other DHHS Programs

Chart 5-1 provides a delineation of major public-assistance programs provided by DHHS-OFI and the cross-connecting policies related to child-support enforcement. As appropriate, rules requiring cooperation with child-support enforcement have been applied and responsible policies and procedures are currently in place throughout the various benefit programs administered by OFI. In the initial eligibility for assistance as well as the continuing eligibility process, families are counseled on their child-support obligations and there is an evident

culture throughout the system that is a critical part of a family's stream of support, irrespective of the benefits they may be receiving through the department.

Chart 5-1: **Coordinating Child Support across Multiple Programs**

Program	Policies & Procedures
TANF Cash Assistance (or) Parents-As-Scholars (PaS) Cash Assistance Program	• As a condition of receiving TANF or PaS cash assistance, applicant must provide known information on non-custodial parent; must cooperate with DSER in its efforts to collect CS unless "good cause" is established; and must assign all support rights to the state. • Whenever DSER collects CS payments in the month it is due, TANF or PaS custodial parent is entitled to the first $50 pass-through. • In addition to TANF or PaS cash and pass-through payments, custodial parent may be entitled to another payment called "gap." Gap payments come from the prior month's total child-support collections, less the pass-through. • All collections from tax refunds are considered "past-due," thus the custodial parent would not receive a pass-through payment from these funds. • After custodial parent stops receiving TANF or PaS cash assistance, DSER automatically continues to collect child-support in behalf of the child, unless the custodial parent informs DSER in writing to stop collections for their children. • "Good cause" is granted through Office of Family Independence (OFI).
Child Care Subsidy Program for non-TANF working families and families in education and training	• At time of application, must document any child support received for all children of absent parent(s), unless good cause can be shown (or) • Must show proof of attempt to collect child support through DSER or the legal system. • If no CS arrangements are in place at application, custodial parent must show proof that support has been pursued or have begun collecting child support within six months of award or assistance will be terminated.
Supplemental Nutrition Assistance Program (SNAP)	• Child-support expenses are excluded from household income calculation in determining eligibility for SNAP benefits. • No disqualification if parent fails to cooperate with DSER, and/or is in arrears with child-support payments. • States have the option to treat legally obligated child-support payments made to non-household members as income

	exclusion rather than a deduction. This option is intended to help encourage payment of CS. • Maine is one of 16 states opting for CS expense exclusion. • CS-related disqualification from SNAP is a state option. Only five states disqualify applicants for failing to cooperate with DSER and only one state disqualifies applicant if they have CS arrearages.
MaineCare	• Application for MaineCare requires information on children in household as well as absent-parent name(s) and last known address, as appropriate. This provision does not apply to pregnant women or individuals being covered under transitional Medicaid. • Any child support received should be listed as unearned Income for the child for whom the payments are intended. • For family-related categories, the first $50 per month of current child-support payments received by the assistance unit whether received through DSER or directly is excluded. For TANF recipients, child support paid by the division that is in excess of the monthly obligation is excluded. • Child-support "paid out" is the monthly amount paid to comply with court or child-support order, and it is used as a deduction when figuring MaineCare eligibility.
LIHEAP	Not Applicable
General Assistance	Not Applicable
SSI Program	Not applicable

Source: analysis of DHHS-OFI Policy Manual and informational materials (application forms, informational handouts, as well as interviews with DHHS-OFI program administrators.

Child-Support Enforcement Activities, 2012–13

During SFY 2012–13, Maine reported a total number of 63,455 child-support cases (or families, meaning a custodial parent and an absentee parent). Of this total, 57,347 have the benefit of support orders, although 6,852 of these orders are "medical only," leaving 50,459 other cases. Of these other cases, Maine reported that 35,359 actually received support in the same fiscal year, leaving 15,100 cases (or about 30%) without support.

Also, the total number (63,455) of child-support cases in 2012–13 can be broken down according to three categories specified by the DSER:

- Cases that are current public assistance: 7,212
- Cases that were formerly on public assistance: 35,319
- Cases that were never on public assistance: 20,924

Moreover, of the 7,212 cases on current public assistance (TANF), 3,179 (or 44%) received child-support payments in 2012–13.

Also during 2012–13, Maine's DSER established 6,506 child-support orders and located 34,028 absentee parents.

Total number of parents referred to DSER in 2012–13:

- Total new cases were 8,905; TANF cases were 2,504 (28% of total new cases).
- Total number of established and enforced medical-support obligations, including medical-only cases: 37,544.

Maine's Child-Support Collections in 2012–13:

- Total dollars collected on behalf of custodial parents: **$100,267,284**
- Total dollars collected and sent to federal government: **$11,221,906**
- Total dollars collected and sent back to state general fund: **$5,780,98**

Maine's DSER System Rankings

A review of the FY 2012 child-support program performance indicators revealed very positive data for Maine's program compared to all states. Rankings are indicated both on the national level and within the New England states.

Chart 5-2: **Maine's DSER System Rankings**

DSER Performance Indicator	Maine's National Ranking	Maine's Ranking in New England States
Paternity-establishment percentage (PEP)	9th	1st
Percentage of cases with support orders	7th	1st
Percentage of cases with collections current	37th	6th
Percentage of cases with collections in arrearages	24th	4th
Cost effectiveness (measured by total collections per dollar of program spending)	43rd	5th

Maine's ranking relative to the other states throughout the country is high on IV-D paternity-establishment percentage (ranks ninth in the country, and ranks first in New England). With regard to the percentage of cases with support orders, again Maine ranks high (seventh in the country, and first among New England states). These rankings have remained fairly steady

for the state and, as in previous years, Maine has earned federal performance incentive dollars averaging $2.2 million annually.

Chart 5-3: **Maine's DSER Performance Measures**

2012 Performance Measures	**Maine**	Conn.	Mass.	New Hampshire	Rhode Island	Vermont
IV-D paternity-establishment percentage (PEP)	**106.71**	95.43	90.80	107.28	92.54	105.57
Percent of cases with orders	**89.17**	75.19	83.55	86.39	67.08	88.67
Percent of cases current	**59.10**	57.80	69.01	62.86	59.63	69.12
Percent of cases in arrearages	**57.23**	59.49	59.82	64.92	56.73	69.88
Collections per dollar of program spending	**$3.71**	$3.77	$5.90	$4.63	$4.94	$3.50

6. General Assistance Program

Overview

The General Assistance Program is governed by Maine General Law, Title 22, Health and Welfare, Part 5: Chapter 1161, Municipal General Assistance; and Chapter 1251, Municipal General Assistance program. The law in Maine may require each municipality to operate a General Assistance (GA) program which provides immediate aid in the form of vouchers, for persons who are unable to provide the basic necessities essential to maintain themselves and their families. Eligibility criteria are based on financial need and assets, and access to these benefits is provided by the various municipalities throughout the state. GA is funded through a combination of state and municipal contributions. Chart 6-1 provides a three-year perspective on total state dollars expended through DHHS in General Assistance.

Chart 6-1: **General Assistance Expenditures**

State Fiscal Year	2011	2012	2013
GA Expenditures by year	$10,903,561	$13,521,293	$12,061,930
Approximate Number of Individuals Served*	11,287	12,900	12,486
Estimated Average Cost Per-Case Per Year	$966.03	$966.03	$966.03

Source: DHHS-OFI 2013 financial reports, December 2013.

*Program Data, DHHS-OFI estimates for 2013 based on counts reported from three major municipalities (Portland, Lewiston, and Bangor), plus actual counts reported by statewide shelters.

Program Operations

Applications are handled through each municipal GA office, where eligibility determination is carried out by the overseer of the municipality. Various forms of documentation of need are requested, but rules and requirements may differ from one municipal program to another. For example, some municipalities require GA recipients to participate in a workfare program.

The General Assistance law requires that able-bodied individuals participate in a

municipal work program as a condition of receiving financial assistance. This program offers realistic work opportunities in various city departments. The goal is to encourage employment and self-sufficiency.

Income eligibility standards are generally established using a formula based on 90% of 110% of the U.S. Department of Housing and Urban Development fair-market value standards established by area. In accord with language in law, each municipality has an “overseer” who works directly with the GA clientele.

Once a payment/voucher is approved for an eligible recipient, the overseer may make a payment (such as a utility bill) to a vendor on behalf of the eligible recipient. Payments directly to a recipient are not a feature of this program. Monthly General Assistance Reimbursement Reports are filled out by the municipal administrator or overseer and submitted to DHHS General Assistance Office located in Augusta. The types of assistance payments may include: housing, heating, utilities, food, prescriptions, medical services, dental, burials/cremations, diapers/baby supplies, household and personal supplies. GA payments may also be used for GA recipients who perform workfare for a municipality.

Municipalities submit reimbursement requests to DHHS-OFI General Assistance program, on a monthly basis and the state, through DHHS reimburses the respective municipalities at a rate of 50% of those GA expenditures. However a unique feature of the law states that once a municipality reaches its respective threshold amount in a year — which is based upon 0.0003 of the property valuation of that municipality — the state reimbursement rate increases to 90% of those expenditures without limit.

Chart 6-2: **General Assistance Billing & Payment Process, Portland**

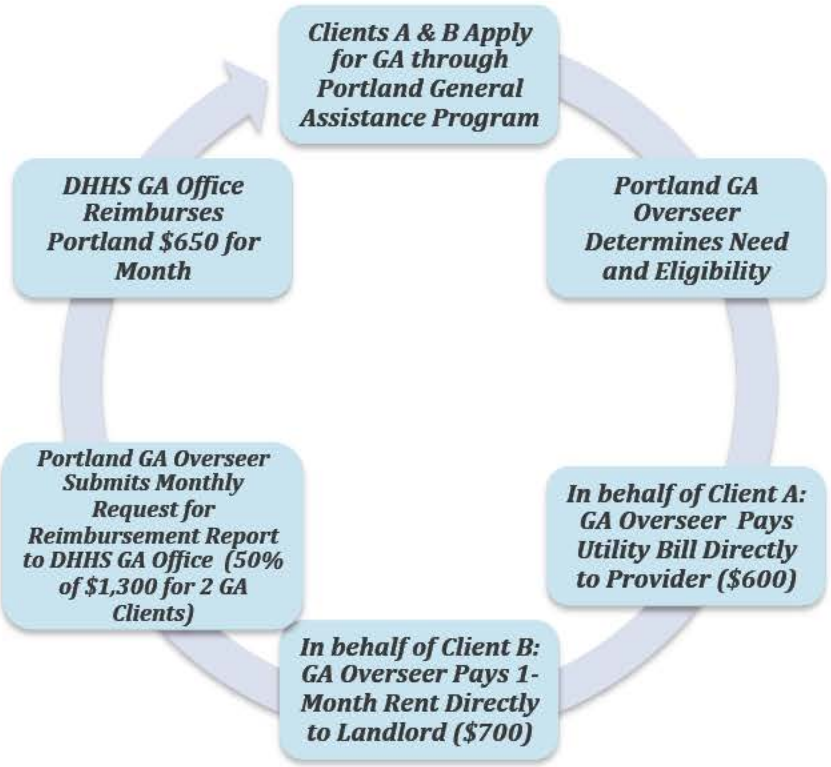


Chart 6-3: **General Assistance Spending, Top Five Counties**

County	SFY 2012 Cost	Participating Municipalities Count	Population (2010)	Per-Capita Cost	Municipalities & Unorganized Territory Count	Population (2010)	Revised Per-Capita Cost
Cumberland	**9,501,947**	**26**	**281,439**	**33.76**	**28**	**281,674**	**33.73**
Penobscot	3,145,681	49	149,261	21.08	66	153,313	20.52
Androscoggin	1,229,715	14	107,702	11.42	14	107,702	11.42
York	1,029,511	29	197,131	5.22	29	197,131	5.22
Kennebec	556,330	27	117,210	4.75	30	122,151	4.55

The per-capita cost in Cumberland is almost 7.5 times higher than in Kennebec ($33.72 versus $4.55) and 25.7 times higher than the lowest county in the state, Franklin ($33.72 versus $1.31 per-capita cost). In terms of expenditures by municipality, Portland's 2013 Annual Report indicates GA expenditures of $8,284,043 in FY 2012, and $9,678,567 in FY 2013, the highest level of annual municipal expenditures in the state. In fact, Portland's GA expenditures have shown dramatic growth each year since 2006, when expenditures were $3,027,687, to 2013 when expenditures grew to $9,678,567, an increase of approximately 69.7%.

Chart 6-4: **General Assistance Per-Capita Costs by County**

County	SFY 2012 Cost	Participating Municipalities Count	Population (2010)	Per-Capita Cost	Municipalities & Unorganized Territory Count	Population (2010)	Revised Per-Capita Cost
Androscoggin	1,229,715	14	107,702	11.42	14	107,702	11.42
Aroostook	289,919	50	65,811	4.41	73	72,480	4.00
Cumberland	9,501,947	26	281,439	33.76	28	281,674	33.73
Franklin	40,196	15	26,557	1.51	26	30,768	1.31
Hancock	122,914	27	48,506	2.53	41	54,418	2.26
Kennebec	556,330	27	117,210	4.75	30	122,151	4.55
Knox	153,481	14	34,377	4.46	20	39,736	3.86
Lincoln	147,393	15	32,515	4.53	21	34,457	4.28
Oxford	328,233	28	52,961	6.20	39	57,833	5.68
Penobscot	3,145,681	49	149,261	21.08	66	153,313	20.52
Piscataquis	86,392	14	16,083	5.37	23	17,535	4.93
Sagadahoc	176,070	9	34,866	5.05	11	35,293	4.99
Somerset	164,003	24	49,380	3.32	37	52,228	3.14
Waldo	112,812	21	34,497	3.27	26	38,786	2.91
Washington	333,937	30	27,273	12.24	48	32,856	10.16
York	1,029,511	29	197,131	5.22	29	197,131	5.22
Totals	**17,418,534**	**392**	**1,275,569**	**13.66**	**532**	**1,328,361**	**13.11**

Maine's GA Program Relative to Other States

Comparing Maine to other states that operate general-assistance programs, the majority (twenty-six) uses both a financial-need criteria as well as health-and-medical needs criteria to determine eligibility. Specifically, most states consider: physical and/or mental incapacity preventing employment; special populations such as elderly, blind, or disabled; adults awaiting SSI determination, and the long-term unemployed. As referenced above, GA is funded with a combination of municipal funds and general state funds, which are utilized to address specific short-term crisis situations such as to prevent imminent homelessness. While GA can be renewed, this benefit is not intended to meet recurring or ongoing needs and is not intended to extend beyond a four-month period for the eligible population.

A 2011 report conducted by the Center for Budget Policies and Priorities reported how nationally, GA programs have been weakened considerably over the years. The study looked at actions in 2011 state legislative sessions, including the state of Maine, and provided an overview of 2011 program policies across the thirty states:

- Thirty states have GA programs, which generally serve very poor individuals who do not have minor children, are not disabled enough to qualify for the Supplemental Security Income program (SSI), and are not elderly.
- Only twelve of the thirty states provide any benefits to childless adults who do not have some disability; the others require recipients to be unemployable, generally due to a physical or mental condition.
- Twenty-nine of the thirty states with GA programs, the maximum benefit is set below half of the poverty line for an individual. In fact, in most of these states, the maximum benefit falls below one-quarter of the poverty line.

There is no federally supported cash safety-net program for poor childless adults who do not receive SSI. These state or local GA programs are generally the only cash assistance for which such individuals can qualify. Some of these are uniform statewide programs; others have state guidelines with options for county variability, ranging from minimal cost-of-living adjustments to significant differences in eligibility standards.

A number of states have eliminated their GA programs altogether, while others have cut funding, restricted eligibility, imposed time limits, and/or cut benefits. Most states that eliminated GA programs for people who are not disabled did so between the late 1980s and late 1990s. Between 1998 and 2010, five additional states terminated their GA programs, and at least ten other states cut their programs back.

In 2011, as states struggled to close large budget shortfalls, ten states considered proposals to further shrink or eliminate general assistance, and seven states adopted such measures. Illinois and Kansas eliminated their programs, Minnesota restricted eligibility, Michigan reduced benefit levels for all recipients, Washington restricted eligibility and reduced benefit levels for all recipients who still qualify, and Rhode Island has cut benefits for some recipients. The District of Columbia reduced funding for its program by two-thirds and plans to limit the size of its caseload accordingly.

In Maine, several initiatives to contain GA expenditures were enacted by rule:

- **Fugitive from justice ineligible for GA.** A fugitive from justice is not eligible for GA.

- **Calculation of pro-rata share.** When an applicant shares a dwelling unit with one or more individuals, eligible applicants may receive assistance for no more than their pro-rata share of the actual costs of the shared basic needs of that household. The pro-rata share is calculated by dividing the maximum level of assistance available to the entire household by the total number of household members. Income of household members not legally liable for supporting the household is considered available to the applicant only when there is a pooling of resources.

- **Lump-sum calculator.** All income received by the household between the receipt of the lump-sum payment and the application for assistance is added to the remainder of the

lump sum and the total is then prorated. The period of proration is then determined by dividing this total by the verified actual prospective thirty-day budget for all of the household's basic necessities.

- **Unemployment benefits as available income in cases of fraud**. Consistent with 22 M.R.S. § 4317, an individual who is found to be ineligible for unemployment compensation benefits because of a finding of fraud by the Maine Department of Labor pursuant to 26 M.R.S.A. §1051(1) shall be ineligible to receive general assistance to replace the forfeited unemployment compensation benefits for the duration of the forfeiture as established by the Maine Department of Labor.

- **Maximum level of assistance for fiscal years 2013–14 and 2014–15.** Establishes the aggregate maximum level of general assistance for July 1, 2013, to June 30, 2014, as the amount that is greater than 90% of 1100% of the HUD fair-market rent for FFY 2013, or the amount achieved by increasing the maximum level of assistance for fiscal year 2012–13 by 90% of the increase in the federal poverty level for 2013 over the federal poverty level for 2012. The same formula is used for July 1, 2014, to June 30, 2015.

- **Indian tribe reimbursement.** Establishes the GA reimbursement formula for tribes as 10% of the reimbursement amount, up to 0.0003 of tribe's most recent state valuation added to 100% of the amount in excess of 0.0003 of tribe's most recent state valuation.

- **Circuit Breaker program benefits as income.** Counts the Circuit Breaker program benefits as income when determining eligibility for general assistance unless the benefits are used to provide basic necessities.

- **Municipal property tax assistance.** Counts the property tax fairness credit as income when determining eligibility for general assistance.

Recommendations/Options for General Assistance

Two proposals to curb GA expenditures have not been adopted but remain viable options to realize important savings in state dollars:

- A GA block grant was proposed that would have provided a specified amount of money to each municipality, based on the average expenditure of a municipality in the last three years. Under this proposal, municipalities would have been able to design their own eligibility criteria, but once funding was exhausted, there would not be any additional dollars received from the state.

- Another proposed initiative would have limited all reimbursements to 50% of expenditures; thus eliminating the 90% yearly threshold amount.

In addition, the following options — if adopted — would also result in savings for the state:

Option 1: Maine DHHS could assume total administration of the GA program and uniformly apply standards of eligibility and benefits issued on a statewide basis. A number of efficiencies can be expected by operating GA through the sixteen regional centers, where the provision of services would be done by experienced eligibility workers who have access to automated eligibility, payments/vouchers, and reporting systems. Most noteworthy is the elimination of duplication of benefits issued through two separate program operations.

Option 2: Contingent upon funding constraints**,** DHHS could work with lawmakers to follow the pattern of other states and eliminate the GA program altogether.

Option 3: Maine DHHS could consider capping GA program dollars per municipality; setting a maximum amount available for each year, based on availability of state funding. While this is similar to the already considered fixed block-grant proposal, this option would be based on available state dollars each year, which would be subject to annual allocations that may fluctuate up or down.

Option 4: Discontinue cash benefits to employable adults without children; continue MA if they are income eligible under Medicaid and have a verified need for medical services and/or prescription drugs.

Option 5: Deny GA emergency cash assistance to those who are on TANF — they already receive monthly cash benefits, SNAP, and MA through DHHS and may also qualify for emergency assistance under certain DHHS rules. Duplication of assistance is a significant possibility within the current GA benefit structure.

Option 6: Discontinue limitless renewals for General Assistance benefits. Other states limit assistance to no more than one time per year, or no more than three times per individual or family per lifetime, or one time per lifetime. Maine has no limitation on the number of times a recipient can be approved for benefits.

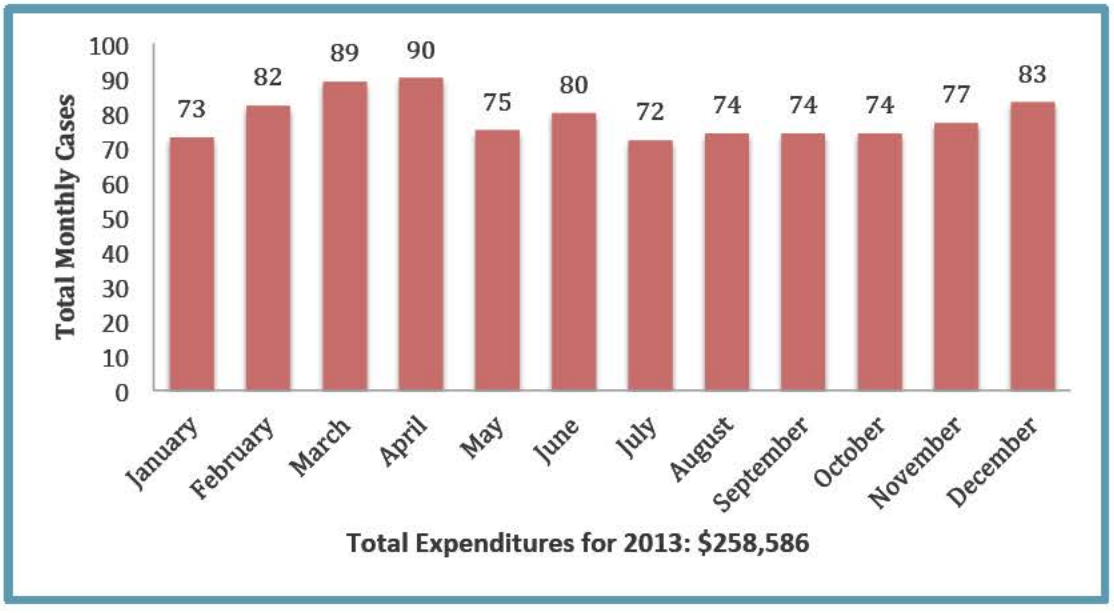
Option 7: Cap enrollments, effective SFY 2015. GA caseloads will decline overtime due to attrition, and savings can be realized through this limit on receipt of benefits.

7. Refugee Cash Assistance

Overview

This program includes TANF-eligible families who are refugees and asylums and receiving social services through the Refugee Cash Assistance (RCA) program. The services provided include cash assistance, case management, and employment and training services provided by local refugee agencies during the first eight months after their arrival in the United States. The Office of Refugee Resettlement (ORR) provides social services funding for employment services to refugees. The TANF-eligible families are better served through this extensive service-delivery system; TANF federal funds are used to pay for the services provided these families. Costs are charged to TANF federal funds, but TANF state MOE may also be expended on these services. The financial eligibility for these services is the same eligibility used for TANF cash assistance. The following number of RCA cases received cash assistance:

Chart 6-5: **Refugee Cash-Assistance Caseload, 2013**



Source: DHHS-OFI Geographic Distribution of Programs and Benefits for 2013.

The RCA caseload for 2013 averaged seventy-nine cases per month. Looking back at previous years, the RCA Program has not grown substantially, however the 2013 numbers are showing a gradual increase compared to previous years.

Chart 6-6: **Refugee Cash-Assistance Caseload, 2006–13**			
2006	48	**2010**	49
2007	34	**2011**	62
2008	38	**2012**	75
2009	80	**2013**	83

All refugees have access to MaineCare for up to eight months from their U.S. arrival date. Their MaineCare is paid for out of refugee medical-assistance money granted by the federal government. Following the initial eight months of MaineCare, only those who are 65 and older, and those on TANF, are eligible to remain on MaineCare. As of September 2013, 75 refugees were eligible for MaineCare refugee assistance.

Recommendations for RCA

- RCA agencies are intensely grounded in helping recipients to access employment opportunities. The OFI should work closely with RCA providers to bring appropriate resources to those agencies who work with RCA families.
- Accommodate RCA job seekers in those opportunities now available through the DHHS-OFI/DOL job-readiness program.

8. Welfare-to-Work Coordination

Current Initiatives

Throughout 2013, the DHHS Office of Family Independence (OFI) — in collaboration with the Maine Department of Labor (MDOL), Bureau of Employment Services (BES) and the Maine Adult Education program — pursued a promising initiative to assist low-income parents of the ASPIRE-TANF program as well as recipients of the SNAP Food Supplement Employment and Training (FSET) program who need assistance to enter the workforce. Both ASPIRE and FSET participants — referred to as Able Bodied Adults without Dependents (ABAWDs) — are required by federal mandates to actively engage in work activities that lead to long-term employment and, to the greatest extent possible, independence from public assistance.

A great deal of planning amongst the DHHS-OFI, the Maine Adult Education program, and MDOL's administrative and supervisory staff resulted in a model which meets the needs of the two special populations, ASPIRE-TANF parents and ABAWDS. Relying on information and data provided by the Labor Department's chief economist on Maine's Workforce Challenges and Opportunities,[31] both departments collaborated on developing strategies for linking participants to jobs in a streamlined, coordinated process. All referred participants will receive job-readiness assessments, basic job-preparation skills, and an overview of expectations in today's job market, including how to search for a job. In addition, the agreement calls for two components available through this employment-service reform:

- For **ASPIRE-TANF parents**, work-experience placements will be strategically created in areas, which are focused on an individual's vocational interests and occupational skill development. Worksite placements will include structured learning along with actual work experience, typically for twenty-six weeks. Customized placements will require one to forty hours per week, and participants will be placed in paid or unpaid worksite activities. These placements may be developed in the private for-profit sector, nonprofit sector, and/or in the public sector. Parents will receive a range of ASPIRE-TANF support services such as transportation, child care, and supportive-service payments to assist participants with work attire, tools for the job, etc. The likelihood of finding permanent paid employment is promising because this model utilizes recent worksite learning and builds credible detail for a participant's resume, which may be used to qualify him or her for a better job, even with a different employer.

31. See "Maine's Workforce Conditions & Outlook, the Recession and Recovery," January 9, 2014.

- For **SNAP-FSET ABAWDs**, a pilot program will provide short-term employability support for up to 1,000 recipients, primarily from Kennebec and Washington counties, who will be served through Augusta and Machias Career Centers. The goal is to accelerate success of employment and independence from Maine's public-welfare services. As a voluntary program, refusal to participate will not affect SNAP benefits. Participants will be served for a maximum of three months. They will begin with an orientation session, followed by complete assessments, workshops, and job searches as determined by BES. Participants may receive $50 per month to help with transportation expenses.

Funding for this collaborative effort comes from both ASPIRE-TANF funds and from SNAP-FSET funds, which are 100% federal dollars. Thirteen full-time staffers have been dedicated to carrying out the two program models. According to a MDOL press release dated April 1, 2014, Commissioner Mary Mayhew stated:

> With nearly seven thousand job listings already on the Maine Job Bank, 2014 looks to be a strong year for hiring and creating thousands of opportunities for welfare recipients to transition to employment. Some of our participants are ready to return to work almost immediately; others will take some time to learn the behaviors and expectations involved in working,'' said Mayhew. "We encourage both participants and worksites to celebrate the small victories along the way and to recognize that not everyone will be successful on the first try."

The value of the multi-departmental partnership cannot be overstated. DHHS has low-income households attached to virtually every program it administers; at one time or another, adults in these households will need services that are available through the MDOL. In fact, a significant number of crossover populations (unemployed and under-employed) are known to both systems. When the unemployment rate rises, the SNAP caseload will also rise, but the latter trajectory usually lags changes in the unemployment rate by approximately six to twelve months. Until the LaPage administration initiated this collaborative partnership, little coordination existed between the DHHS-OFI and MDOL. This administration therefore deserves credit for creating strong collaboration between departments to help ASPIRE-TANF participants and FSET participants move into the job market.

For the DHHS OFI, the advantages are immediate: This arrangement connects the welfare system to the Maine Workforce Investment Boards and the Chambers of Commerce, which can help expand opportunities for participants who need employment. Together, new and effective programs can be developed; however, knowing which designs are effective depends on identifying effective goals and approaches that have demonstrated the most positive results in the past. For many years, researchers have analyzed welfare-to-work approaches with different goals in mind. Whether the program is judged as a success — in terms of its benefits to participants versus government-cost savings — depends on the purposes policymakers have set for each program. Several considerations are offered, based on

research reported by the Manpower Development and Research Corporation (MDRC) in February 2009, "Welfare-to-Work Program Benefits and Costs, A Synthesis of Research."[32] The following are excerpts from that report and can be used to consider future directions for the new collaboration:

- If a chief goal is to increase participants' income, then programs that provide individuals with financial incentives or earnings supplements intended to encourage work appear to best achieve this goal. While beneficial for participants, earnings-supplement programs tended to result in a net cost for the government. Participants, however, often gained more than a dollar for every dollar the government spent, making this type of program an efficient mechanism for transferring income to poor families.

- If a chief goal is to reduce government expenditures, then programs that require individuals to look for jobs immediately, and that assign other activities if work is not found, are relevant strategies. Researchers found that these programs tended to be beneficial for the government budget (and to be less expensive than the type of program described next), but they result either in small benefits or in net costs for participants.

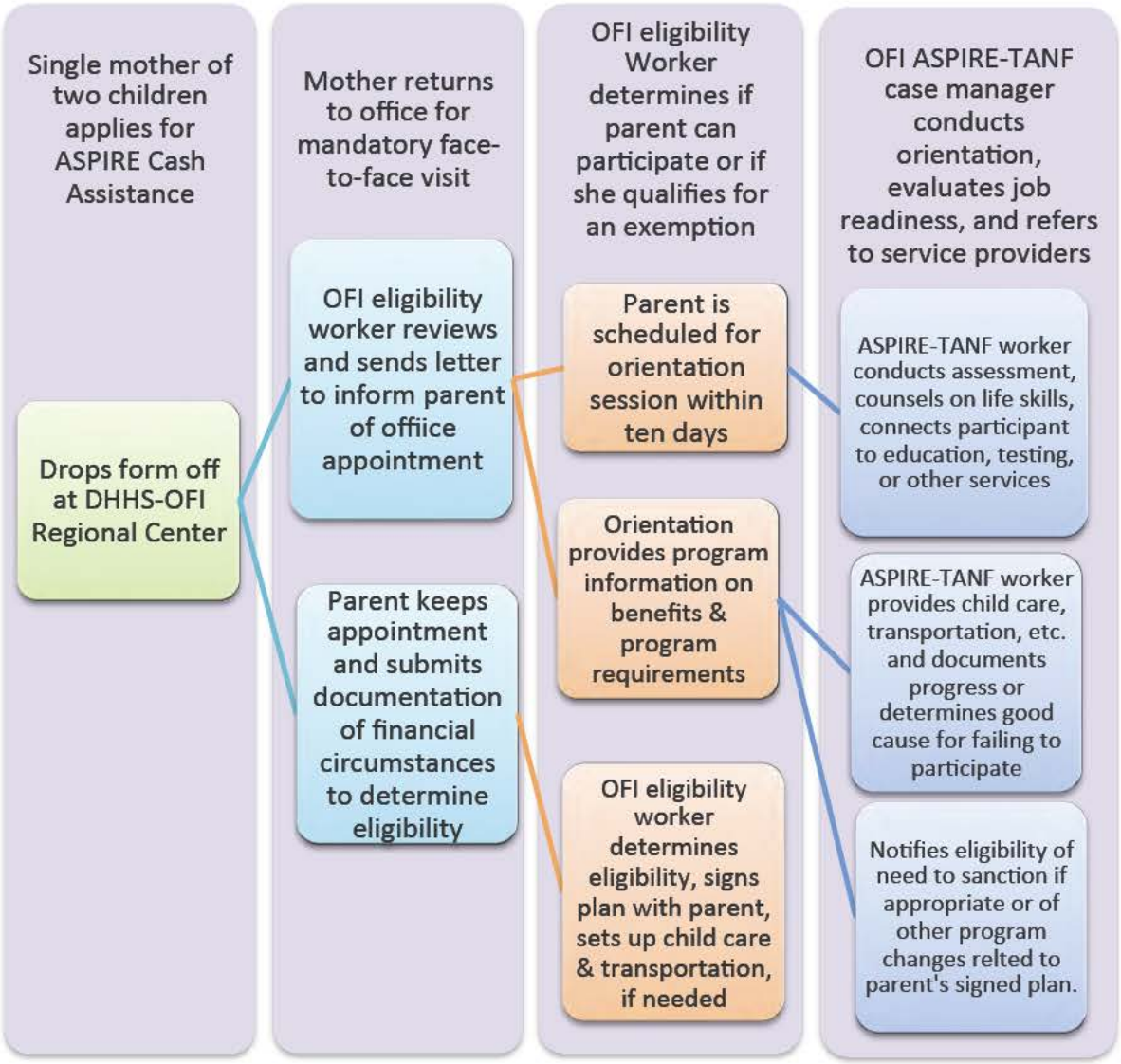
- If a chief goal is to balance reducing welfare expenditures with increasing participants' income, then programs that require individuals to participate initially either in a short-term education or training activity or in a job search activity can meet this goal. This type of program, when targeted to both short-term and long-term welfare recipients, was beneficial for both participants and the government's budget.

In FY 2012, OFI made certain major changes to its ASPIRE-TANF program policies. OFI implemented the sixty-month time limit on cash assistance and also modified its sanction policies to impose full family sanctions if parents failed to comply within ninety days of the initial sanction. Implementing the sixty-month time limit on cash assistance is consistent with the federal TANF requirements and, in effect, reduced the ASPIRE-TANF caseload by approximately eighteen hundred cases as of June 2012. Since that time, the program has seen between seventy-five to eighty-five cases close monthly due to time limits. The effect of the full family sanction policy has also resulted in closing of cases, but in a less significant way.

Maine's welfare-to-work initiatives include recommendations that alter the application and acceptance policies for ASPIRE-TANF cash assistance. Chart 8-1 illustrates the current application process:

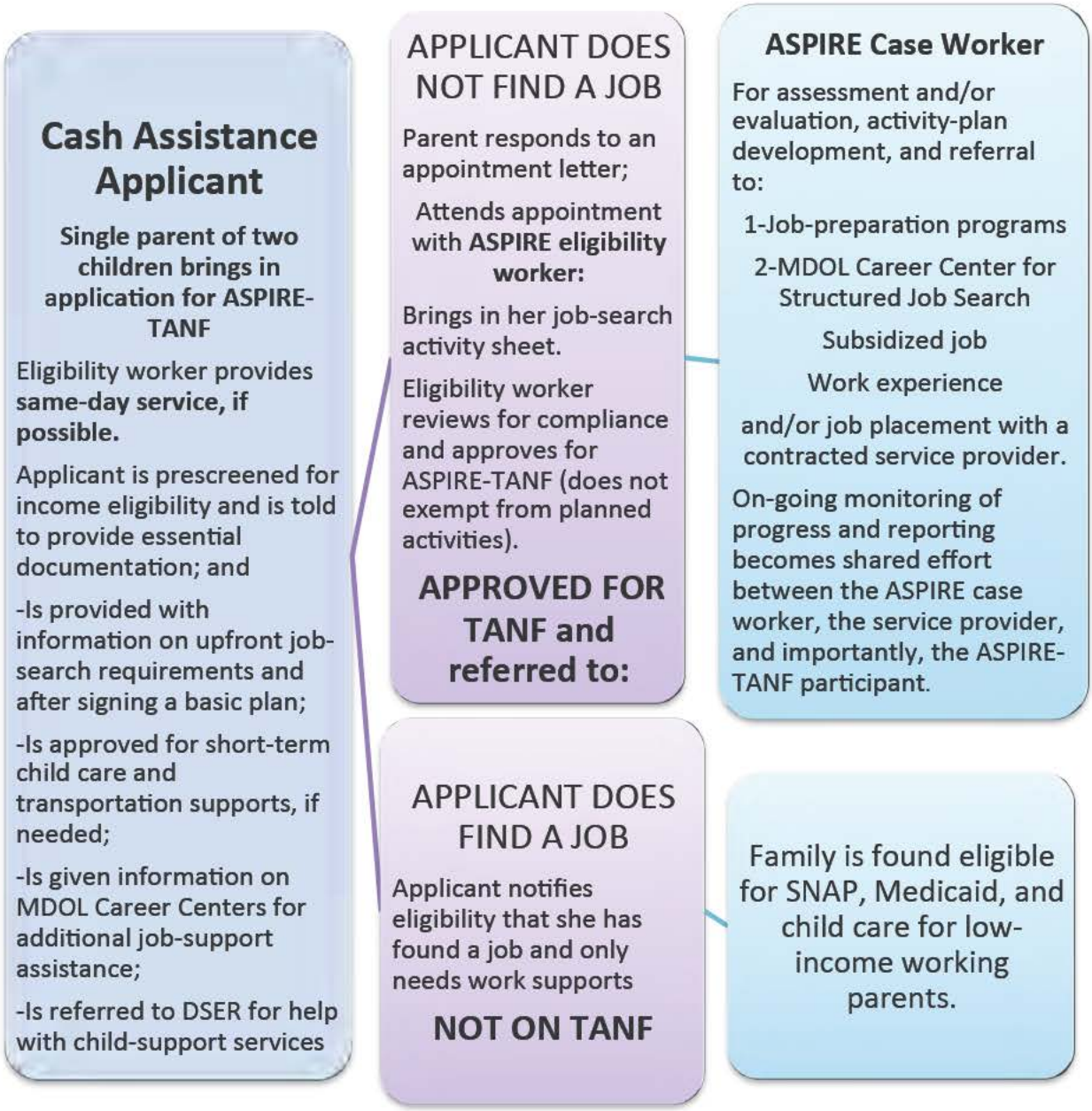
32. David H. Greenberg, Victoria Deitch, and Gayle Hamilton, "Welfare-to-Work Program Benefits and Costs, A Synthesis of Research," MDRC, February 1, 2009.

Chart 8-1: **Current Applicant Process for ASPIRE-TANF Program**



If DHHS adopts a universal engagement/upfront job-search model, the application process would change accordingly. Chart 8-2 illustrates what that new model might look like:

Chart 8-2: **New Application Process for ASPIRE-TANF Program**



Note: For applicants who, after formal assessment and evaluation, are found to have indications of learning disabilities, a special service provider is needed who has the expertise to know how strong the potential is for placing individuals with LD, and to focus on linking this job seeker to a job where basic accommodations will help them to perform well (i.e., audible stethoscopes for CNAs and special software and/or monitors for desktop computers). The majority of LD individuals have a strong desire to work as opposed to pursuing education, which, for them, has often been a negative experience. Identifying their many strengths can lead to placements with employers who are willing to give them a chance to demonstrate their potential as highly creative, hard-working, and dedicated employees.

Expanding Reforms of the ASPIRE-TANF Program

The following are reforms to the current ASPIRE-TANF program that are aimed to increase program participation, meet work participation rates, and improve outcomes for all families that rely on the system.

Universal Engagement. With universal engagement, the principle of exemption from participation goes away and is replaced with the expectation that all recipients can and must participate to their maximum level of ability. Every recipient should have a signed plan which delineates action steps with time lines, and every plan needs to be tracked by the agency to assure that participant is carrying out their requirements. Experience has shown that engaging all recipients in planned activities increases work participation rates. Even parents who face barriers to immediate employment can begin with specific steps to barrier resolution, which over time prepares recipients to take part in countable work activities in the future, and at the level of participation that will eventually count toward the state's work participation rate.

Job Search as a Condition of Eligibility. Requiring activities of applicants such as attending orientation, signing a plan, and carrying out job-search activities is a common practice in many states, particularly because it advances important purposes. It not only reinforces the imperative of mandatory work participation requirements but also ensures that when recipients enter the rolls, they know in advance what is expected and how to comply with their employment plan; they also enter the rolls already engaged in a countable activity. Moreover, a number of applicants who have been guided into job search before coming onto the program actually find employment; they no longer need cash assistance or may be found eligible for a smaller grant based on the earnings-disregard formula. In these cases, determining if other work supports are available is an essential part of ensuring that the family receives the level of work supports it is entitled to by the agency.

Subsidized Jobs Program. Even in a less than robust economy, an evidence-based strategy for moving disadvantaged populations into the job market includes a well-designed and flexible subsidized jobs program. While unsubsidized full-time work should remain the top priority, subsidized employment can be used as a supplement to jump start a recipient's work experience and reinforce a work ethic. During 2009 and 2010, when the economy dipped into a recession, no less than thirty states created subsidized jobs programs, which in a relatively short term proved to be cost effective. They also produced impressive results for placing large groups of unemployed individuals into work rather quickly.

According to the Center for Budget Policies and Priorities, the following advantages were demonstrated by implementing simplified and flexible subsidized jobs programs:[33]

33. LaDonna Pavetti, Liz Schott, and Elizabeth Lower-Basch, "Creating Subsidized Employment Opportunities for Low-Income Parents: The Legacy of the TANF Emergency Fund," Center on Budget and Policy Priorities, February 16, 2011.

- It is possible (though challenging) to get large-scale job-creation programs up and running relatively quickly and to engage the private sector in creating job opportunities.
- Subsidized jobs targeted to disadvantaged individuals (low-income adults, ex-offenders, and youth) benefit not only participating workers and businesses but also entire communities by putting money into the hands of individuals most likely to spend it.
- Subsidized jobs programs can be implemented at reasonable costs.
- Flexibility makes success possible in many different environments.
- New targeted funding can provide the catalyst for innovation and increased collaboration.
- Provide direct and timely support to help businesses, nonprofits, and local governments weather the recession.
- Provide opportunities for low- income parents and youth to maintain a connection to the labor force and build new skills.
- Create new partnerships between TANF agencies, workforce agencies, businesses, foundations, advocates, and local nonprofit service providers.
- Help states sustain work-focused TANF programs.

Lessons Learned from Other States

Most recently (from 2009 to present), subsidized jobs programs have largely been associated with two groups: welfare recipients and ex-offenders. As a part of efforts to shift the focus of their public-assistance programs to work, some state and county welfare agencies have used their regular TANF funds to create subsidized employment programs for individuals who have not been successful at finding unsubsidized employment; others have created work-study programs to help students enrolled in post-secondary institutions meet work requirements while pursuing their education. The federal government has also provided funding to help states launch initiatives for ex- offenders through the Serious and Violent Offender Reentry Initiative, the Prisoner Reentry Initiative, and, most recently, the Second Chance Act of 2008.

The majority of states that operated programs did so as a part of a broader, multi-pronged strategy to serve needy families during the recession. The most common strategies used to help create job opportunities in difficult economic environments included:

Creating new temporary jobs in the private and public sectors. The largest subsidized employment programs worked with private-sector businesses and government agencies to create new temporary jobs that otherwise would not have existed. These jobs usually were targeted to job-ready individuals who were sometimes eligible for child care assistance but did not receive any other special support. Employers were not required to hire individuals at the end of the subsidy period but were encouraged to consider their subsidized employees for any permanent positions that became available during their tenure.

In the two largest programs of this type, operated in Illinois and Los Angeles, all

individuals were paid the same wage: $10 per hour for up to forty hours per week. In both programs, the majority of jobs created were in the private sector. Individuals were on the payroll of an intermediary, a nonprofit organization, or a Workforce Investment Board. In other smaller programs, employers put workers directly on their payrolls and were then reimbursed for some or all of their wage-related costs.

Giving businesses incentives to hire individuals with the least favorable employment prospects and the most to lose from extended unemployment is effective. Some programs use subsidies to influence employers' hiring decisions. Because the programs were targeted to low-income families and youth, many of whom have lower levels of education and more limited job histories, the subsidies provided an incentive for businesses to hire individuals they might not otherwise hire. For example, South Carolina targeted its subsidized employment program to job-ready TANF applicants. By subsidizing part of individuals' wages, the state encouraged chain grocery and department stores to hire TANF applicants, which the state had been unable to accomplish in the past.

Creating transitional job opportunities for individuals who face personal and family challenges that limit their employment prospects even when the economy is stronger. A non-trivial portion of the TANF caseload faces significant challenges that limit its ability to work full time in regular, unsubsidized employment. Often, these individuals need intensive personal support and a supportive work environment to succeed in the workplace. For example, Washington, Oregon, and San Francisco used funds to expand long-standing programs that serve individuals with employment barriers. Nonprofit organizations that are able to create job opportunities for individuals with employment barriers (often with other nonprofits) and provide support to individual participants throughout the program played an important role in the implementation of these programs.

Creating career-ladder initiatives that include a subsidized jobs component is also valuable. A few states create or expand programs that help low-income individuals with limited skills combine work and training to move into higher-paying jobs. For example, New York created training and employment opportunities for green jobs and health careers, while Maryland created a career-advancement program that uses wage subsidies to encourage employers to hire low-income individuals as trainees in entry-level jobs that have higher starting wages (usually between $10 and $12 per hour) and the potential for career growth.

The following matrix offers three structures used by other states that have administered subsidized jobs programs. The matrix provides examples of options and decision points in designing such a program. They are interchangeable based on state resources and other considerations related to business and the economy.

Chart 8-3: **Subsidized Jobs Program**

Maximum wage eligible for reimbursement	Amount of wage to be subsidized	Coverage of payroll costs: FICA, unemployment tax (UT), and workers compensation (WC)	Hours per week eligible for reimbursement	Primary service-delivery structure	Employer of record
No maximum hourly wage level	100% x 2 mos.; 80% x 2 mos.; 50% x 2 mos.	Employer covers most payroll costs; programs cover WC	Up to 40 hours	TANF agency	Employer or temporary employment agency
$12 per hour	80%	Employee portion of FICA	No weekly maximum hours, but no more than 1,040 hours per participant	County workforce agencies	Third-party staffing agency
State minimum wage: $7.50 per hour	100%	FICA, UT, and WC	25 to 40 hours per week	Collaboration partners (TANF, Adult Ed., MDOL Bureau of Employment Service)	Employer

Building an Effective Subsidized Jobs Program

- Collaboration between Maine DHHS, Adult Education, and MDOL is critical to current and future program development.
- Stakeholder input is vital.
- Maine Division of Tax Revenue may be a valuable asset to helping the state structure its program. The division has a unique relationship with private-sector employers who are part of taxation's data system — some simplifications and efficiencies may be possible.
- Identify funding and target groups to be engaged and geographical areas that will benefit most by a subsidized job model.
- Whenever purchasing services is an option, develop joint-contracting methods with performance-based payments as the rule rather than the exception.
- Plan in advance and consider key decisions for structuring the program.
- Determine who will develop placements.
- Determine who will match potential participants with subsidized jobs.
- Determine the paperwork requirements.
- Determine how time and attendance will be tracked, monitored, and billed.

Performance-Based Contracting

Although Maine DHHS has decided to utilize state agencies as collaborators to increase work participation, it may also consider other partners. The contracting-out of social services to nonprofit and faith-based organizations has been done since the turn of the twentieth century. But contracting-out welfare (TANF) services, especially welfare-to-work services, became an important practice after the enactment of PRWORA in 1996. A small number of states, like Wisconsin, whose program was the best known, contracted-out both case management and eligibility determination to the private sector. The majority of states however, kept most services in-house and focused on contracting-out the jobs search and placement to private entities. Maine could consider a hybrid approach and let state agencies compete against private agencies — and measure performance between them. If Maine followed this approach, regulations and state accounting systems would not be able to facilitate the withholding of funds to a state agency based on performance like they can to a private vendor. Nonetheless, performance metrics and benchmarks could still be developed with state agencies to actually see who performs more efficiently.

Performance-based contracting might enable Maine to expand capacity and restructure its service-delivery system quickly with greater flexibility and more efficiency and truly move toward "full engagement." Full engagement drives performance for all participants — including those with barriers that limit their ability to fully participate in employment programs. With full engagement, those with barriers are engaged through alternative activities. Contracts could be divided in two categories:

- Employment services for applicants of welfare, including skill assessment and job placement, and
- Employment services for recipients who are considered "employable" or able to work.

The contractors (also referred to as vendors) may vary in size. Contractors/vendors work with recipients/participants on meeting both placement and job-retention goals. The state should expect the contractors/vendors to balance these objectives and achieve high performance for both. The contractors/vendors might include large national for-profit companies and nonprofit organizations or local for-profit and nonprofit agencies and community colleges. A number of contractors might also use community- or faith-based organizations as subcontractors.

Contracts should be performance-based and awarded on a negotiated basis to each contractor with the unit price negotiated between the contractor and the state. This can vary among the contractors. The same contractor would be responsible for both applicants and recipients — or for the contract categories 1 and 2 below. The state should create milestones and negotiate these payments or the unit price with each contractor during this process.

The design of the contract payment milestones is critical for success. In an era where the public sector is focused more intensely than ever on performance, the best leverage points for achieving high performance are embedded in the details of how milestone payments are constructed. The contracts should be crafted with an eye on incentivizing payments and how milestone payments are weighted — all toward driving performance for vendors around effectiveness and efficiency. The payments drive contracted vendors to achieve the desired outcomes, since their revenue is tied to their ability to achieve specific outcomes. The contractors assume the financial risk or reward attached to their performance. Although contractors can build financial models and budgets of their own, state administrators should work closely with them.

Contract Category 1. Performance-payment contracts can be contingent upon meeting the performance milestones tied to a recipient's assessment, engagement, job placement, and retention in employment. Unit price per contract can be distributed in the following milestones:

- Assessment: 8%,
- Engagement: 22%,
- Placement: 30%,
- Ninety-day retention: 40%
- A bonus milestone for a case closure due to earnings at ninetieth day.[34]

This focus will aim at assessing individual needs and interest, providing job-readiness skills, and attempt to attach applicants to jobs as quickly as possible *before* the application for welfare is approved. On average, a potential recipient can work with the contracted vendor for four to six weeks. If the individual is placed in a job, the case might be rejected or closed, and the vendor should be expected to track and assist the individual to retain employment.

Contract Category 2. The average unit price for contracts for recipients who are considered "employable" or able to work should have milestone payments focused on the recipient's employment placement and retentions. The unit price might be structured as follows:

- Job placement: 30%,
- 90-day retention: 40%,
- 180-day retention: 30%
- A bonus milestone for a job with high wage at 90 days and a case closure due to earnings at 180 days.

34. The state needs the opportunity to restructure the amount paid for each milestone after renewing the efficacy of the contracts. For example, the state could increase the value paid for ninety days of job retention while decreasing the amount paid for placements. Bonus payments can also be offered. The state can use this type of incentive to encourage full-time employment over part-time, to focus on jobs that pay above minimum wage, to promote job advancement, and to encourage placements for a targeted population. However, expectations need to be communicated at all times.

Recipients that do not secure a job during the application phase, and those who are already receiving assistance, could be randomly assigned to receive services for a few days a week as a part of a "full-engagement model." During the other days of the week, the recipients could be required to participate in a work-experience program (or subsidized jobs program). In Category 2 contracts, recipients might receive a more intensive mix of services compared to Category 1. These might include all of the following: job search, job-placement assistance, and short-term training such as computer training and other trainings (for example, working as a certified nursing assistant).

Those recipients who do not get a job in the first six months could be reassigned to another vendor. Higher contract payments might be reserved for Category 2 contracts because they will be serving those that need more intensive services. Also, the higher proportion of unit price would be allocated to job placement to move recipients into employment more expeditiously. The contracts could also include additional bonus milestones for a) job placement for sanctioned, 2) job placement for time-limited participants, 3) wage gain at 180 days, and 4) case closure at ninety days. These types of payments could be a small fixed- dollar amount. If contracts give more weights to a specific milestone — that is what a contracted vendor will focus on. These milestone weights might vary, depending on the philosophy of those operating the program. But a focus on full engagement, emphasizing placement and successful implementation of employment contracts would help Maine continue its decline in the caseload.

The use of performance-based contracting can be a valuable tool in driving full employment engagement into the public-welfare system and helping recipients find and retain employment. A well designed and managed performance-based contract can provide incentives for contractors and the state to ensure that focus is put on the recipient and his or her movement up the economic ladder. While performance-based contracting shifts the public sector into the role of a contract manager as opposed to a service provider, other tools are needed to assist the state in its quest to move recipients into employment; for example, the need for a technology and management infrastructure that works across a whole portfolio of contractors to ensure accurate exchange of data, financial claims, and performance information and a clear set of performance metrics to not only hold contractors accountable — but recipients and state administrators as well.

As demonstrated in Wisconsin, New York City, and Philadelphia, performance-based contracting to increase employment can have positive effects on the recipients, state infrastructure, and program goals. Maine could consider a hybrid approach which utilizes its new current system and initiates outside vendor contracts to enhance and supplement current operations. Either way, performance-based contracting might just be what Maine needs to continue its momentum to decrease caseloads, improve accountability across the enterprise, and increase economic opportunity.

Needs of TANF Recipients with Disabilities

For some TANF recipients, the pathway to work is encumbered with undiagnosed and untreated disabilities that interfere with steady program participation and work. Mental health conditions, learning disabilities, and physical health problems are among the most prevalent disabilities documented, accounting for a substantial portion of the TANF caseload. While the majority of these recipients eventually may be able to find and sustain employment, they may need specialized assistance and take more time to do so, as a 2008 Mathematic Policy Research report explains.[35]

This report strongly urges universal engagement, meaning that all recipients are expected to participate in activities that will prepare them for work, for the following reasons: 1) with time limits on cash assistance, recipients cannot expect to rely on TANF in the long run; 2) paid employment is the surest path to achieving self-sufficiency for all, including recipients living with a disability; 3) the TANF system has an employment infrastructure in place that can be expanded and adapted to meet the needs of recipients who need more intensive services and employment accommodations; and 4) TANF agencies, like all public agencies, are required by the Americans with Disabilities Act to provide opportunities for recipients living with a disability to benefit from all the programs, services, and activities they offer.

The key to properly identifying issues of learning disabilities rests in the use of specialized assessment tools, including Disability Screening Tools, Psychosocial Assessments, Clinical and Psychological Assessments, Functional Needs Assessments, and Vocational Assessments.

Numerous studies have been conducted that have attempted to quantify the portion of TANF recipients with LD, and while the findings are not consistent across these studies, they all suggest that a substantial portion of the TANF caseload is living with a disability.

Maine recently built into the TANF assessment process a comprehensive vocational assessment through a local medical provider to identify LD and other conditions that may limit participant engagement with employment. Recognizing the issues is the first step and accommodating particular needs through specialized service providers can assist this population to succeed in a job.

Integrating Individuals with Disabilities into Private-Sector Workforce

When he signed the Americans with Disabilities Act in 1990, President George H. W. Bush promised the legislation would “mainstream” Americans with disabilities, allowing them

35. See Jacqueline Kauff, “Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment,” Mathematica Policy Research, February 2008.

to achieve employment and live as independently as possible. Yet, the real-world effects of that landmark legislation have actually worked to keep many of these Americans out of the workforce. With costly incentives embedded into the Medicaid-delivery system, the law has not rewarded citizens who seek independence from the public-welfare system.

The good news is that states, localities, and a coalition of businesses are spearheading a more promising alternative: private-sector employment. When disabled workers are connected with private companies, employers acquire the hardworking, skilled employees they need while people with disabilities achieve the financial independence they need. Additionally, these solutions reduce the demands placed upon the overburdened welfare system while increasing the number of disabled Americans earning a paycheck.

Many employers still exclude persons with disabilities — intellectual and physical — from the workplace because of persistent but unfounded myths, fears, and stereotypes. Some employers believe that workers with disabilities will have a higher absentee rate than employees without disabilities. Studies show that this is not true; workers with intellectual and physical disabilities are absent no more than other workers. Another popular misperception is that employing people with disabilities will cause insurance costs to skyrocket. Studies show, however, that employing workers with disabilities will not lead to higher insurance rates or more workers' compensation claims.[36] In fact, studies show that those with disabilities have high productivity and output, sometimes even better than their non-disabled counterparts.

A growing number of employers, however, have established initiatives to increase the participation of employees with disabilities within their companies as a component of their workforce planning and diversity strategies. These employers typically establish partnerships with state agencies or workforce and disability-service organizations to source for talent. Coordinated by a single agency (or small number of agencies), employers are provided assistance and support services for recruitment, training, and job retention of employees with disabilities. Maine has already begun this effort — although much more needs to be accomplished in order to truly integrate those with disabilities into the workforce.

The success of this solution is obvious at Lowe's regional distribution center in Luzerne County, Pennsylvania. Lowe's, with the help of the Arc of Luzerne County, implemented a model, originally formulated by Walgreens, for offering a new employment track, complete with special training for citizens with physical and intellectual disabilities. The National Technical Assistance and Research Center has acknowledged the Walgreens-Lowe's model as one of the most effective in the nation. Because this business-centered strategy generates better economic outcomes, other major employers around the nation are stepping up to replicate similar programs. As of 2012, Walgreens had more than a thousand individuals working at its seventeen distribution centers in the United States.

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36. Peter David Blanck, *The Americans with Disabilities Act and the Emerging Workforce: Employment of People with Mental Retardation* (American Association on Mental Retardation, 1998), p. 17.

Following the Walgreens-Lowe's model, Proctor & Gamble has created opportunities for people with disabilities through its "Diversity of Abilities" initiative at its new packaging facility in Auburn, Maine. In partnership with the state's Rehabilitation Services and DHHS, this facility is offering employment opportunities for people with physical and/or intellectual disabilities.[37]

Maine is likewise stepping up to the plate to reach out to this vital population. In 2010, the state was awarded a $1.5 million federal grant under the Federal Disability Employment Initiative. That grant was used to increase access to employment opportunities for adults with disabilities through Maine's workforce development system, including the expansion of the Social Security Ticket to Work program through Maine's Career Center network.

That focus, however, as its challenges. According to the National Council on Disability:

> Many people with disabilities receive public disability income in the form of Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). Such income is typically accompanied by health care through Medicare or Medicaid. People with disabilities are often reluctant to become employed for fear of jeopardizing these benefits, and research clearly shows that these benefits affect both labor market exits and return to work.[38]

Further, many individuals with disabilities are encouraged not to work full time by government agencies for fear of losing benefits. Moreover, some disabilities require extra time for self-care, therapy, and medical appointments, and transportation problems can introduce an added level of uncertainty in daily schedules. For these reasons, some people with disabilities are not able to accept traditional full-time jobs, and those who want to be employed may be drawn to part-time and flexible work arrangements. However, many adults with disabilities can and do overcome these obstacles. In fact, they strongly prefer private-sector pay and benefits to public-welfare dependency.

Steps to Achieving a Balanced Integration: The Employment First Maine Act of 2013

Enacted on June 16, 2013, this law creates customized employment and integrated community-based employment opportunities in the general workforce for individuals with disabilities. The law requires DHHS and the Departments of Labor and Education — across all programs — to offer, as the first and preferred, employment as a service. The law also charges the Employment First Maine coalition with proposing and promoting such employment

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37. Shaun Heasley, "Inclusive Employment Model Gaining Steam," Disability Scoop," August 4, 2011, http://www.disabilityscoop.com/2011/08/04/inclusive-employment/13678/.

38. "Empowerment for Americans with Disabilities: Breaking Barriers to Careers and Full Employment," Report to the President George W. Bush, National Council on Disability, October 2007.

opportunities. The following steps are recommended to help the state achieve the spirit of the law and more fully align its efforts with the needs of this vital population:

1. The state should adopt the motto that individuals with disabilities want to work full time and live independently.

2. An annual multi-day statewide disability employment summit to bring together government agencies, policymakers, families, stakeholders, and businesses to discuss how to improve the disability-work climate and opportunities. This conference would discuss the challenges, opportunities, models or case studies of programs of excellence, advancements in adaptive technology, supports, and suggestions for system improvements. This should be spearheaded by DHHS and MDOL with the assistance of advocacy organizations like the Arc.

3. The state should designate a small staff to work exclusively across state agencies to breakdown silos and territorial ownership so that it focuses on the people served, not the bureaucracy. The state should convene quarterly meetings of state and federal department senior administrators (including the Governor's Committee on Employment of People with Disabilities) that have a role in this effort to create greater cohesion among leaders and more targeted efforts to help the disabled achieve their goals.

4. The state should serve as an intermediary and service broker between local service providers, consumers, and businesses, thereby helping companies effectively recruit, hire, retain, and support workers with disabilities. With dual expertise in human-capital management, human-resource expertise, recruiting, policy and program expertise, and vocational rehabilitation (e.g., job coaching and employment networks), the state is naturally suited to serve as this neutral convener.

5. Acknowledge that each employment opportunity may operate differently based on the job seeker's needs and abilities as well as the needs of the employer. The state's centralized unit (as the lead) would identify local service providers that can work with consumers and business to ensure that orientation and training —to the first day of work and beyond — are accomplished smoothly. In other words, one size does not fit all. Strategies to usher individuals with disabilities into employment are as diversified as the employers seeking the labor pool. Moreover, performance should be measured, and each case detailed, so that the public and private sectors can learn how to continuously improve.

6. Maine maintains a Flexible Employment Fund, which provides one-time, short-term financial assistance to people with disabilities who are experiencing barriers to maintaining or obtaining competitive employment. The fund is operated by the Disability Employment Initiative project through Maine Local Workforce Investment Boards Regions 1 and 2. Financial support from the fund, however, is only available to individuals in a limited number of counties. By streamlining programs for abled-bodied

individuals, the state might be able to increase the size of the fund to help additional individuals achieve their dream of economic independence.

7. Government finances should be used to train individuals and orient them to work in this new employment opportunity. Once the individual is trained and integrated into the workforce, the private employer should assume the responsibility for benefits.

8. The goal of the state should be to create a person-centered system that has as its goal the full integration of participants in the life of the business. This means that the new employee might be totally independent of government assistance and fully integrated into his/her employment.

As John R. Vaughn, chairman of the National Council on Disability, wrote to President George W. Bush on October 1, 2007:

> There is a direct benefit to expanding employment opportunities for people with disabilities. For employers who are projected to face labor shortages as the baby-boom generation retires, non-employed people with disabilities represent a valuable tool of human resources to help fill those needs. For people with disabilities, employment has not just economic value, but important social and psychological value as well. For government, increased employment of people with disabilities helps increase tax receipts and decrease social expenditures. Finally, as recognized in the passage of the Americans with Disabilities Act, there are societal benefits from greater inclusiveness in mainstream society as the barriers facing people with disabilities are dismantled.[39]

A 1990 DuPont study of 811 employees with disabilities found that 90% of these workers rated an average or better in job performance, relative to 95% or employees without disabilities. A 2007 DePaul University Economic Impact Study of twenty-five businesses from the health-care, retail, and hospitality sectors — and 314 employees — concluded that workers with disabilities had fewer scheduled absences than employees without disabilities and nearly identical job performance ratings. Further, workers with disabilities tend to remain with their employer for longer tenures, reducing turnover.[40]

Policy solutions that focus on moving disabled recipients into the workforce make good economic sense. Most importantly, they remain the choice for all Americans (and Mainers) with disabilities and their families, rather than the antiquated, top-down disability policies offered by the federal government. By offering progress on the path to independence — free from labels — they can deliver what all citizens want: a chance to achieve the American dream.

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39. John R. Vaughn to George W. Bush, October 1, 2007, http://www.ncd.gov/publications/2007/Oct2007.

40. 2007 DePaul University Economic Impact Study.

Achieving TANF Work Participation Rates

Achieving the federally mandated work participation rates in TANF, perhaps the most practical measure of success, remains challenging for most states. Indeed, failing to achieve these rates imposes severe risks of fiscal penalties, a consequence that drives almost all TANF program designs and strategies throughout the country. The ideas offered herein for Maine are no different, but they take into consideration the interests of all parties, most of all the low-income families who need help to become self-sufficient.

To improve the state's success, DHHS has solicited help to restructure, refine, and revamp services and policies. Developing partners to achieve the desired outcomes is no small factor but by sharing responsibilities, the department can overcome the challenges. Moreover, acknowledging the role of all stakeholders is one of the most valuable strategies of all.

Chart 8-4: **TANF Work Participation Stakeholders**

Measuring success is another tool that has emerged from the research presented in this report. A fault of TANF is it focuses on participation and ignores family outcomes. DHHS and its collaborative partners can and should expect much more in terms of outcomes. Chart 8-5 identifies basic measures that are likely to provide the information needed to evaluate program costs and effectiveness as well as the well-being of the TANF caseload.

Chart 8-5: **TANF Goals and Measures Each Program Year**

Performance Goals	Performance Measures
Increase number of participants who meet work participation rates	Rate at which participants are actively engaged in approved work activities for required number of hours per week
Increase the number of participants who overcome educational and skill barriers to become employable	Rate at which participants complete education/training programs in their approved employment plans
Increase number of participants who secure full-time, high-wage jobs	Wage Rates and Weekly Work Hours of those who were approved for post secondary education or job placement service providers
Increase number of participants who gain employment	Job Placement rate for all participants both those who were assigned to providers of employment related services and those who find and enter employment through individual job search activities
Increase number of participants who close due to employment	Rate of hourly wages above eligibility maximum for family size
Measure number of families who close to cash assistance with Transitional Child Care and health care	Rate of participants who are helped with work supports and the length of time the work supports are needed

A job is critical, but other initiatives may be needed to help escape poverty. The following concepts are offered by Robert I. Lerman of the Urban Institute in his paper entitled, "The Two Worlds of Personal Finance: Implications for Promoting the Economic Well-Being of Low- and Moderate-Income Families." Including any one or combination of these strategies will enhance the financial literacy levels of individuals who attend ASPIRE-funded programs and will also improve the overall success of welfare-to-work programs.

Five Strategies to Improve the Economic Well-Being of Low- and Moderate-Income Working Families

1. **Individual Development Accounts (IDAs)** are models, which combine a financial literacy program with matched savings. To low-income qualified individuals, IDAs provide incentives to open a savings account, which can be matched by the program to the participant's savings. Assuming the purpose of the savings is in line with the goals of the IDA program, such as placing a down payment on a home, paying tuition, or starting a business, these strategies can be life changing. Example of IDAs: participant saves $1,000 in her/his IDA account, which is then matched at a 3:1 ratio; that participant will actually have $4,000 to put toward a house, tuition, or a new business startup. Note: TANF funds may be used for IDAs.

2. **Educating lower-income workers** about the importance of Social Security income. Many parents, who have been tied to welfare over one or two generations, do not realize that their long-term trajectory out of poverty is based on paying into Social Security while they are young and having this basic support built up for the time they may no longer be able to work and earn.

3. **Sharing information** about the detrimental effects of high-cost financial service products (credit cards, high-level educational loans, auto loans, to name a few). "Signing on the bottom line" can lead to bankruptcy down the road and in a perverse way, can lock a family into the very low-income/no-income situation they hoped to have escaped.

4. **Structured discussions with knowledgeable experts can help guide non-custodial parents through child-support issues and obligations.** For low-income men in particular, the buildup of arrearages in child support, often at high-interest rates, is another issue that tends to be ignored when discussing financial matters.

5. **Living within a budget**, in some circles referred to as behavioral economics, is an important life skill to teach families to help them gain ground on financial security. This may not be clearly understood by some low- and moderate-income households, but without such skills, stability of finances and security for the future are unlikely.

Coordination and Collaboration at the Service-Delivery Level

Finally, a lesson learned over years of running TANF, SNAP food stamps, and other public-welfare programs is facilitating recipient compliance with program requirements.

Indeed, attention to program requirements will reinforce the efforts of welfare recipients not only to prepare for and find a job but also to attach themselves to the labor market as opposed to continuing an attachment to the welfare system. Components of such an approach include:

- Referrals to the labor system need to be done as simply as possible;

- Recertifications and renewals for SNAP, child care, MA, and other benefits should occur through integrated technology and communication; requiring office appointments with OFI should be minimized as opposed to having recipients travel back and forth between the two major program offices;

- Expanding the role of MDOL employment services staff who work with DHHS populations to allow ease of approval of changes, reporting of recipient engagement, and tracking recipient activities;

- Establishing a unique role of a work participation specialist to function across agency staff. This specialist would track and monitor the work participation level by office and report monthly on how well the new programs are working.

The Maine DHHS-OFI has already implemented some policy reforms that are helping the ASPIRE-TANF program to better achieve programmatic goals; however a number of additional reforms that have greater emphasis on universal engagement and work activities for all will enhance the performance measures of the program and will improve the economic potential of all families who participate in ASPIRE-TANF welfare-to-work programs.

PART II: MAINE'S WELFARE ADMINISTRATIVE SYSTEMS

9. Eligibility and Service-Delivery System

Maine's DHHS-OFI computer system has integrated virtually all of the eligibility processing for public-assistance programs through a single Automated Client Eligibility System (ACES). With the exception of eligibility for long-term-care services, which is done through a centralized unit in Augusta, ACES has enabled OFI administration to rely on a universally trained eligibility staff to handle all major assistance programs offered to low-income individuals and families throughout the state of Maine. These major programs include SNAP, ASPIRE-TANF/PaS, Alternative Aid Assistance, DSER, Transitional Child Care, Transitional Transportation and other supportive services for families who close to TANF or PaS due to increased earnings, Child Care Development Fund for non-cash working families, Disability Determination Services, SSI State Supplement, Emergency Assistance, MaineCare, Medical Assistance, General Assistance, Refugee Cash Assistance, and State Food Supplemental Benefits for legal non-citizens, and several smaller programs available to eligible families. The Long-Term Care Program has the only unique eligibility determination function that operates separately from the OFI eligibility specialists located in specific field offices.

Access to these services is available through sixteen regional offices located within the following counties: Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York.

ACES is designed to operate a fully integrated eligibility determination process, one in which OFI eligibility specialists function as the gateway to virtually all programs offered at the regional centers. All states have systems to handle multiple programs; however often the staffing structure divides up into program-specific entry points; the universal eligibility-specialist role has been challenging for many states to implement and sustain. One example relates to child care access, which is often completely disjoined from TANF, SNAP, and/or medical assistance eligibility. Even if the system can handle all programs, the process may get divided by worker roles, often creating confusion and breakdown in communication among and between program specialists. Other states have not attempted to merge eligibility for SSI and General Assistance through one worker/one system. Because the OFI eligibility specialist is the single point of entry onto all forms of public assistance, Maine's system is able to coordinate recertification dates for more than one program. This provides efficiencies for families and for the system; avoiding unnecessary interruptions of benefits and services because there is a

consistency of information gathered and recorded within the recipients' electronic records by one worker as opposed to several workers.

Some studies of public-assistance programs are "recommending coordination of recertification dates for child care and MA, or child care and SNAP as innovative for beneficiaries and bureaucracies alike." Maine deserves credit for building a system and a staffing structure that truly serves an entire range of needs through a single access point.

Chart 9-1: **Office of Family Assistance Staffing Levels, 2013**

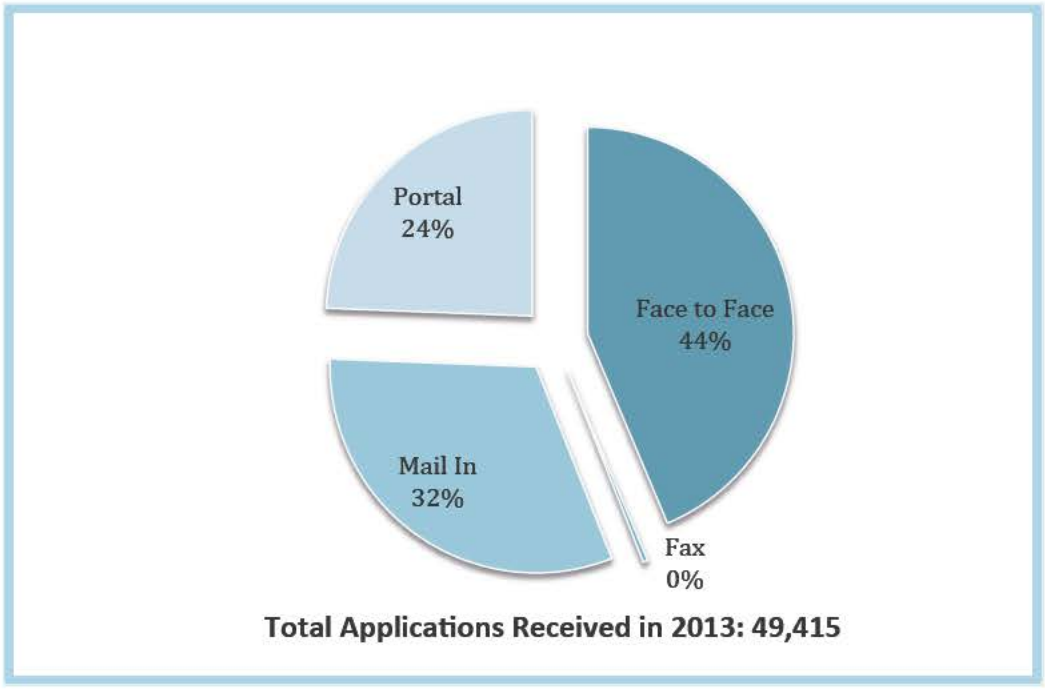
Location	Total Positions Allocated	Total Number Filled	Total Number Vacancies	Vacancy Rate
Portland*	87	77	10	11.4%
Biddiford & Sanford	58	53	5	9.0%
Lewiston & South Paris	84	75	9	10.7%
Augusta & Rockland	88	81	7	7.9%
Skowhegan, Farmington & Augusta*	81	71	10	12.0%
Houlton, Caribou & Fort Kent*	47	41	6	12.7%
Bangor	79	73	6	7.5%
Ellsworth, Machias & Calais	46	38	8	17.3%
Administration (Central Office)	102	94	8	7.8%

Source: DHHS-OFI Staffing Charts, October 2013.

*Long-term care (LTC) staff located in these offices — either LTC supervisor and/or eligibility specialists.

In October 2013, the average vacancy rate in field operations was approximately 11.06%. A majority of vacancies were in the eligibility specialist category. Discussions with DHHS-OFI administration revealed that by and large, vacancies are only a problem because there is a lack of the appropriate skill set among job seekers. Finding a job-ready pool of knowledgeable applicants who can adapt and perform the multi-faceted tasks required of an eligibility specialist is challenging. There is general agreement among administrative staff that if the appropriate candidates can be found, refilling vacant positions is typically efficient and well supported by the state's Office of Human Resources. Training is another challenge that must be considered.

Chart 9-2: **Source of Applications for All Programs**



Source: DHHS-OFI ACES data counts for CY 2013.

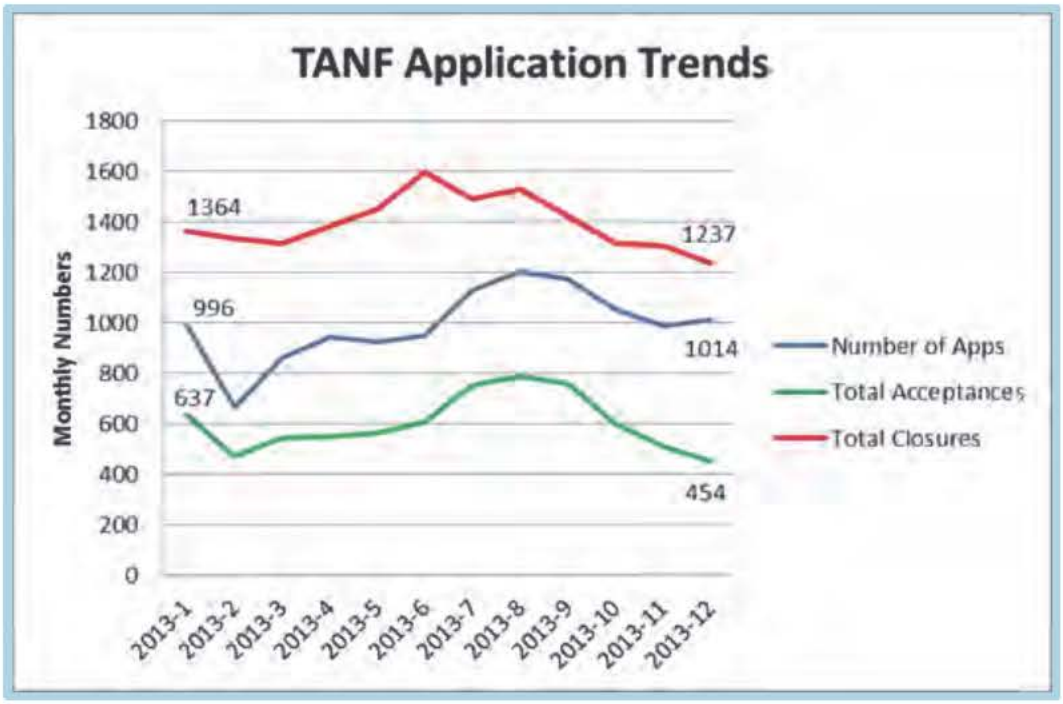
The majority of program applicants continue to prefer the face-to-face option to either the mail-in or on-line application options. Making certain that the technology and the paper application forms are as user-friendly as possible is an enduring goal of all state welfare administrations; Maine is no different.

TANF Application Trends

Between January 1 and December 31, 2013, the number of TANF applications was 11,899, with 7,239 acceptances and 16,759 closures. Closures more than doubled the acceptances in 2013, of which no single month of applications or acceptances exceeded closures. This represents a decrease in the statewide TANF caseload. The average monthly applications were 992, with 603 acceptances and 1,375 closures; this trend created a gap at the early part of the year, although the gap closed by approximately 9% at the end of the year.

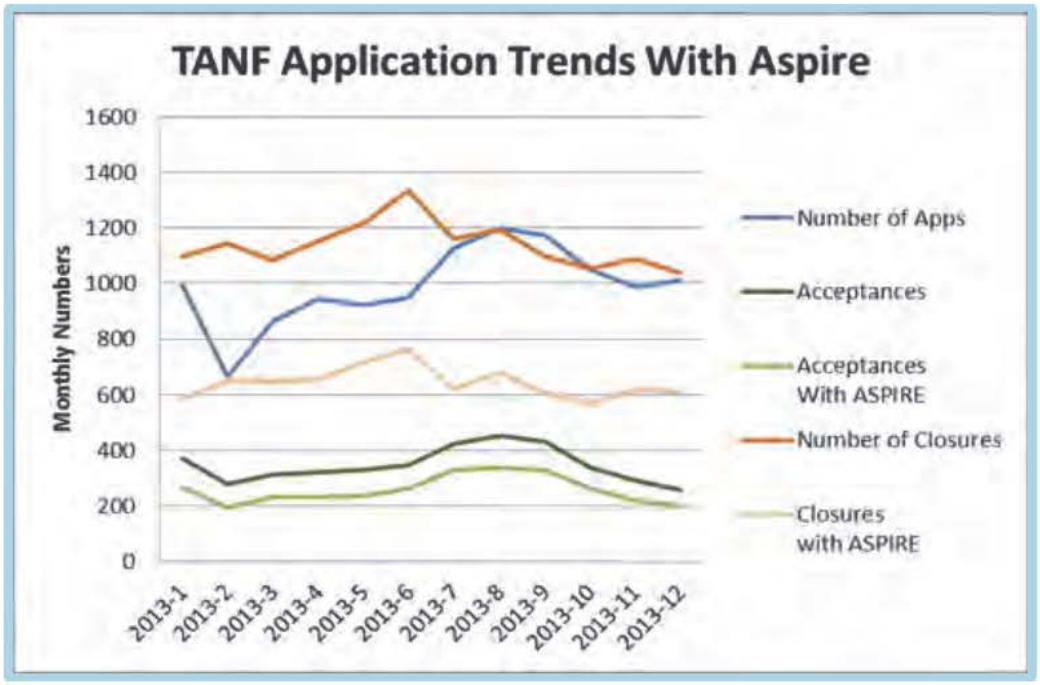
During that same calendar year, both ASPIRE and non-ASPIRE acceptances were similar and followed the same pattern. The closure trend was consistent, although the ASPIRE closures averaged nearly five hundred less throughout the year. This would be attributable to the dramatic number of time-limited case closures that occurred at the beginning of implementation of the sixty-month time-limit.

Chart 9-3: **TANF Application Trends**



Source: DHHS OFI, December 2013.

Chart 9-4: **ASPIRE-TANF Application Trends**



Source: DHHS OFI, December 2013.

Portland and Farmington Offices

By far one of the highest volume service centers in the state, Portland provides initial eligibility, ongoing eligibility, and support for all public assistance available for needy individuals and families. Staffers are friendly, knowledgeable, and dedicated to helping all applicants and recipients of DHHS services. This office enables recipients to obtain status information on their cases, and handles reporting of changes, and program recertifications. For ASPIRE-TANF/PaS families, the office provides supportive case management from program specialists who are involved in assisting parents to develop and carry out case plans. Because this office is shared by other Maine human-service agencies, mental-health services, and disability determination specialists, Maine's Department of Administration has assigned a receptionist to the center who supports the overall operation.

The Farmington office has a virtually ideal physical space, which provides applicants and recipients a welcoming, well organized, service friendly place. Waiting area equipped with television monitors providing informational videos that are pertinent to issues and interests of people needing services. As with the Portland office, eligibility and program-specific staffers were very knowledgeable, responsive, and very dedicated to doing their job with competence and efficiency. Documents and informational handouts were available and shared with recipients and benefits and program requirements were routinely explained to recipients.

Farmington office management and staff have been preparing to assume responsibility for a statewide Document Imaging Center to scan paper documents into individual electronic records of all recipients throughout the state. The center will accept mailings from all parts of the state and process documents submitted through the mail-in system. The expectation is that more than three thousand documents can be processed per day.

Recent Changes and Ongoing Improvements

- Installation of multiple client-centered kiosks in Portland that help applicants and recipients to enter their own data into the system, as appropriate
- New statewide telephone system enabling a new call-center capability (office-based and/or statewide)
- New statewide Document Imaging Center in the Farmington office
- Centralized the mail center in the Farmington office (implementation underway)
- Reorganized work flow and work assignments resulting from new technology
- Colocation with MDOL which will benefit those seeking employment

Enhancing Program-Integrity Initiatives

The AG has made baseline observations of two field sites as illustrative of the eligibility system. Accuracy and program integrity are clearly important to staff. However, without detailed data that can only be obtained through sampling of case records, areas of agency vulnerability cannot be identified. In the near future, AG will review sample records (twenty-five to thirty) of certain public-assistance programs. Gathering of information based on policy and procedures will help the agency to verify accuracy of payments made in behalf of eligible households; and will produce useful evidence to determine how the types of program supports affect the range of participant outcomes over time.

For ASPIRE/PaS and the SNAP employment-and-training participants, a review of employment outcomes will be recorded; if employed, that review would track how long participants retained their job(s) and, if available, wage information, full- or part-time status, and position titles. This information will help to determine if these parents/participants demonstrate a capacity to work and remained employed over measurable time periods. Additionally, indications of family stability could be assessed.

10. Maine's Public-Welfare Data Systems

Maine operates nine public-welfare data systems either directly or through a series of contracts. The systems each operate within their own environment and are physically housed throughout various offices in the Augusta area. Those systems include the Maine Child Welfare information System (MACWIS), Maine Adult Protective Services Information System (MAPSIS), MaineCare, Maine's Integrated Health Management Solution (MIHMS), Maine Point of Purchase System (MEPOPS), Automated Client Eligibility System (ACES), Enterprise Information System (EIS), and the DataHub.

When a Maine citizen applies for welfare services, ACES is the first stop in terms of the information exchanges. This system was developed in conjunction with Keane Inc. to support the operational needs of the Office for Family Independence (OFI) and was deployed in 2002. The web-based system is used statewide to support sixteen district offices and a central office. The system was built to support the numerous business requirements of OFI, which include the administration of numerous state and federal welfare programs. Thus the system maintains and provides recipient information, determination of eligibility for multiple programs, and benefit information for several programs. ACES currently interfaces with several state and federal agencies to collect information that is used for verification and determination of benefits where applicable. The program also supports other functions such as fraud investigation and recovery, medical review team, quality assurance, and the child care subsidy program.

MACWIS houses child-welfare information. The system collects eligibility data and case management records. The system was developed in-house; its front-end or user access was built using Sybase PowerBuilder in conjunction with an Oracle database. Maintained by the state, this system primarily serves the Office of Child and Family Services (OCFS). That office uses this system primarily as the case management system for casework staff, Title IV-E eligibility determination for children in DHHS care, as well as licensing functions for foster-care placement services, placement-services payment processes for children in DHHS' care, miscellaneous bills processing, and intake and assessment processes for child abuse-and-neglect reporting and mandatory federal reporting. The system also contains all the office's licensing, Title IV-E eligibility determinations, miscellaneous bills and child-welfare payments, resource management, child-welfare contracts, central intake work, and the processing of authorizations for medical services or services provided by non-Medicaid providers. MACWIS also supports the administration of the Early Childhood Division's Child Care Subsidy Program, which administers funding to eighteen hundred families receiving support under the federal CCDF. MACWIS provides support for the eligibility determination, case management, financial reporting, and provider payment. MACWIS is also used by the Division of Licensing and

Regulatory Services to manage the licensing of children's residential facilities and child care resources across the state. The MACWIS finance module interfaces with Maine's statewide financial system software (Advantage) for the processing of DHHS payments to service providers; child-welfare payroll; recipient-specific invoices; the Miscellaneous Bills Payroll; and payments to agencies with contracts/agreements with DHHS. The system serves more than eight hundred users in the OCFS, Bureau of Children's Behavioral Health Services, the Attorney General's office, ASPIRE and regional operations, and financial services staff.

MAPSIS is a browser-based case-management system. It supports the mission, strategic plan, and initiatives of the Office of Aging and Developmental Services by providing case-management functionality that enables staff to perform and record all recipient support interactions in an efficient manner. The system allows for tracking recipients data from initial referral through to the completion of case-management activity, and enables users to manage data on all relevant aspects of recipient care. The data system interfaces with several other systems in the deliverance and payment of services.

EIS is a treatment data-collection system that allows for the gathering of recipient- and provider-specific information on behavioral health/adult mental health services, adult developmental services, and child mental-health services. The system also contains the department's agreement management functions to track provider contracts. The system serves users not just in DHHS behavioral health but also in OCFS and the state psychiatric hospitals. EIS is operational twenty-four hours a day, seven days a week. EIS supports these business areas with planning, management, incident reporting, and quality improvement for behavioral and developmental services in Maine. It is a generic, configurable system that can be customized as program, system, and policy needs change, helping to minimize external resources required.

The DataHub consolidates/integrates eligibility and demographic information from multiple source systems and provide that information mainly to support claims processing.

MIHMS is used for paying Medicaid claims. It is a complete suite implemented and maintained by Molina (state fiscal agency) and its subcontractor Truven. The system loads financial eligibility information from the DataHub, medical/classification (coverage-code) eligibility information mainly through manual user entry, prior authorizations through electronic-file submission and manual entry, and TPL information mainly through electronic feed. Benefit packages (services that are covered) are associated with the loaded information. MIHMS processes medical/dental claims submitted by providers mainly through an electronic-data process using all of the above information. Pharmacy claims are adjudicated by MEPOPS using similar techniques, but are submitted to and through MIHMS for financial/accounting purposes. Payments to providers are made through electronic feed from MIHMS to Advantage.

MEPOPS processes Medicaid prescription-drug claims by assessing a number of factors including eligibility. The system is maintained by Goold Health Systems, the state pharmacy benefits manager.

PART III: MAINECARE

11. MaineCare Overview

Medicaid is the single largest line item in most state budgets, representing 24.4% of total state spending in fiscal 2013. In Maine, MaineCare spending in SFY 2013 represented 24.8% of total general-fund spending, or $767 million (MaineCare OMS Analytics, November 2013). This excludes administrative costs of $20.9 million, representing salary and benefits for MaineCare personnel as well as outsourced services. When Medicaid tax revenue is included, total non-federal spending as a percent of total non-federal revenue rises to 30.6%. According to analysis by the National Association of State Budget Officers (NASBO), in SFY 2013, Maine ranked highest in New England for Medicaid state spending as a percent of total state expenditures and the fifth highest among all states.[41]

Chart 11-1: **Medicaid Expenditures**

Medicaid Expenditures as a Percent of Total Expenditures (NASBO 2013)	
State	**Percent**
Maine	32.2
Vermont	28.0
New Hampshire	25.6
Rhode Island	24.4
Connecticut	22.0
Massachusetts	21.3

Maine "All Funds" Medicaid expenditures grew at an average rate of 5.5% from FY 2000 to FY 2012, or double the FY 2000 level. In comparison, state revenue growth is projected to increase by 3.2% per year (Maine Office of Revenue Services). As a result, MaineCare general-fund spending by itself will account for more than 40 cents of each additional tax dollar (per the historical trend that is lower than CMS actuarial projections of 6.3%). As growth rates in MaineCare spending outpace revenue growth, all other legislative priorities will likely face diminished resources. Without a planned restructuring of current Medicaid costs, there will likely be increasing pressure to implement arbitrary across-the-board cuts in all programs, as reflected by comments from the National Governors Association (NGA): "With the growth of Medicaid expenditures, spending priorities will again face competition for state budget dollars this fiscal year," said NGA Executive Director Dan

41. National Association of State Budget Officers, "State Expenditures Report: Examining Fiscal 2011–2013 State Spending," 2013.

Crippen. "States have undertaken numerous actions to contain Medicaid costs, including reducing provider payments, cutting prescription drug benefits, limiting benefits, reforming delivery systems, expanding managed care and enhancing program integrity efforts. These efforts alone, however, cannot stop the growth of Medicaid."[42]

Chart 11-2: **MaineCare Spending by Service Categories, 2008–13**

Expenditure Category	SFY 2008	SFY 2013	Percentage of SFY Total	Percent Change
Hospital	$517,370,632	$617,957,232	24.11	19.4
Residential Total	549,398,932	530,699,685	20.71	–3.4
HCBS Waivers Total	304,581,856	319,031,573	12.45	4.7
SSA Health Insurance	127,065,715	165,217,888	6.45	30.0
Pharmacy Total	159,645,382	133,175,055	5.20	–16.6
Deduct. & Co-Ins for Duals	539	124,397,590	4.85	23098943.6
Medical Professionals	88,944,843	143,202,229	5.59	61.0
Behavioral Health Clinician	78,389,464	128,165,814	5.00	63.5
Clinic Total	61,307,637	125,243,609	4.89	104.3
Rehab Services Total	50,514,814	68,458,529	2.67	35.5
Transportation	43,038,669	44,424,676	1.73	3.2
Case Management	64,160,916	42,876,277	1.67	–33.2
Dentistry	25,500,565	32,416,358	1.26	27.1
Laboratory Services	9,284,431	10,851,527	0.42	16.9
Home Health	11,417,870	10,361,997	0.40	–9.2
Insurance	555,099	1,868,652	0.07	236.6
Other	37,819,053	26,280,288	1.03	–30.5
School-Based Services	57,064,215	38,316,562	1.50	–32.9
Grand Total	**$2,186,060,631**	**$2,562,944,328**	**100.00**	**17.2**

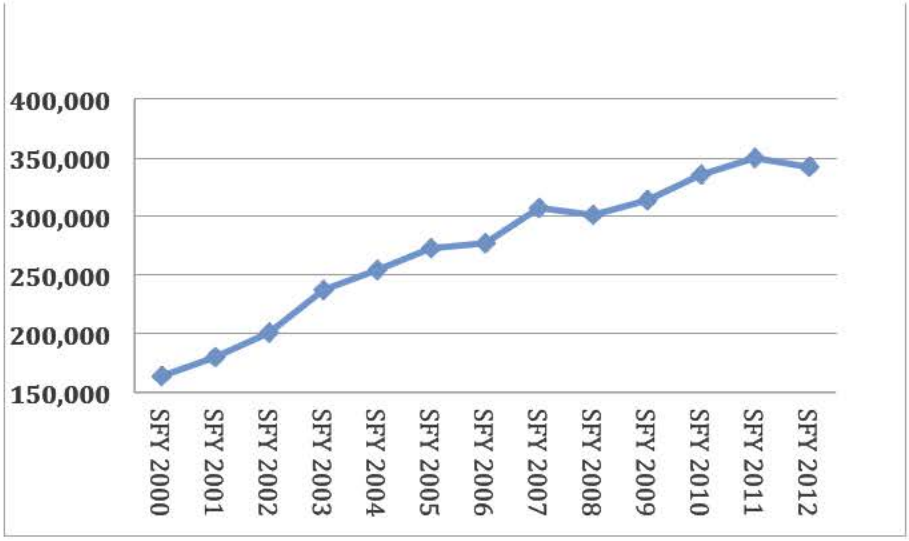
Source: DHHS Office of MaineCare Services, November 2013.

42. National Governor's Association and National Association of State Budget Officers, "Fiscal Survey of States, 2013."

The Doubling of the MaineCare Caseload

MaineCare caseloads more than doubled from June 2000 to June 2012 (DHHS Analytics). Based on data from the Medicaid Statistical Information System for FFY 2010, and population estimates for states from the U.S. Census Bureau for 2010, Maine Medicaid enrollment as percent of total population was 31% (based on unique users) exceeding every state except California and the District of Columbia (Kaiser Family Foundation, State Health Facts 2010).

Chart 11-3: **MaineCare Caseload Growth**



Source: DHHS-OMS Analytics

Maine has elected to cover more persons and services under MaineCare than required by federal regulation through either a state plan amendment or CMS-approved waivers. MaineCare enrollees include mandatory and optional populations covered through expansions that extend coverage to children under the State Children's Health Insurance Program (SCHIP), commonly known in Maine as CubCare, parents and legal guardians of minor children, as well as waiver programs for persons with developmental disabilities receiving home- and community-based care, persons with HIV/AIDS, women with breast and cervical cancer, and persons with disabilities receiving care at home under the consumer-directed home-care program.

Chart 11-4: **Medicaid and SCHIP Eligibility Levels in New England**

As Percentage of Federal Poverty Level, July 1, 2012

State	Infants	Children, 1–5	Children, 6–19	Pregnant Women	Parents of Medicaid-Eligible Children	Childless Adults
Federal Minimum level	133	133	100	133	N/A	N/A
Connecticut	185 M 300 C	185 M 300 C	185 M 300 C	250	191	State only funding
Maine	200 M	150 M 200 C	150 M 200 C	200	133	100 (closed)
Massachusetts	200 M 300 C	150 M 300 C	150 M 300 C	200	133	*
New Hampshire	300 M	185 M 300 C	185 M 300 C	185	47	
Rhode Island	250 M+	250 M+	250 M+	250	175	
Vermont	225 M 300 C	225 M 300 C	225 M 300 C	191	185 limited program	150 limited program

Source: Kaiser State Health Facts, Accessed December 18, 2013.

M Medicaid offers coverage to children up to this percentage of the federal poverty guidelines.
M+ state's Medicaid program has a SCHIP expansion.
C state has a separate SCHIP program that offers coverage to children up to this percent of the federal poverty level.

*In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth basic or essential plans. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.

Chart 11-5: **MaineCare Eligibility Groups**

Mandatory	**Optional**
Children under age 6, below 133% FPL	Low-income children above 100% FPL, not mandatory by age
Low-income parents with income at or below 1996 AFDC level	Parents below 133% FPL (reduced to 100% FPL as of January 2014)
Pregnant women at or below 133% FPL	Pregnant women up to 200% FPL
Elderly and disabled SSI beneficiaries at or below 77% FPL	Elderly and disabled above SSI level but below 100% FPL
Certain working disabled adults	Certain working disabled
Medicare buy-in groups (QMB, SLMB, QI) at or below 135% FPL	Buy-in groups up to 175% FPL
	Medically needy
	Nursing home residents above SSI levels but below 300% SSI
	Persons at risk of needing nursing home or ICF- MR care
	Non-categorical adults below 100% FPL (eliminated as of December 31, 2013).

Source: DHHS and Maine Equal Justice Partners, "MaineCare Eligibility Guide," July 16, 2013.

Chart 11-6 shows the MaineCare caseload and monthly costs by population for SFY 2012 and SFY 2013. Note that the chart does not include enrollees eligible for a limited set of benefits. These elderly and disabled enrollees qualify only for assistance with their Medicare premiums and coinsurance. In FY 2013, MaineCare served 44,290 of these individuals at a total cost of $84.9 million and a PMPM cost of $160 (DHHS Office MaineCare Services). Maine currently covers individuals in this category up to 175% FPL, higher than all other states.

Chart 11-6: **MaineCare Caseload and PMPM Breakdown**

MaineCare Enrollment and Per Member Per Month (PMPM) Costs				
Category	**SFY 2011-12**		**SFY 2012-13**	
	Members	**PMPM**	**Members**	**PMPM**
Traditional MaineCare				
Aged	22,932	$1,472	22,778	$1,527
Blind or Disabled	51,806	$1,579	52,015	$1,553
Children <100% FPL	110,732	$312	107,312	$321
Parents <100% FPL	50,494	$392	48,848	$392
Pregnancy	1,895	$887	1,922	$912
State Only	1,689	$2,226	767	$1,786
Other Traditional	10,889	$267	12,754	$254
Total Traditional MaineCare	**250,438**	**$711**	**246,397**	**$712**
Other Groups				
Childless Adult Waiver	16,086	$458	10,689	$514
Children > 100% FPL	16,363	$214	14,178	$222
Parents (100%-150% FPL)	22,157	$280	19,702	$271
Total Other	**54,607**	**$312**	**44,569**	**$314**
Grand Totals	**305,045**	**$639**	**290,965**	**$651**

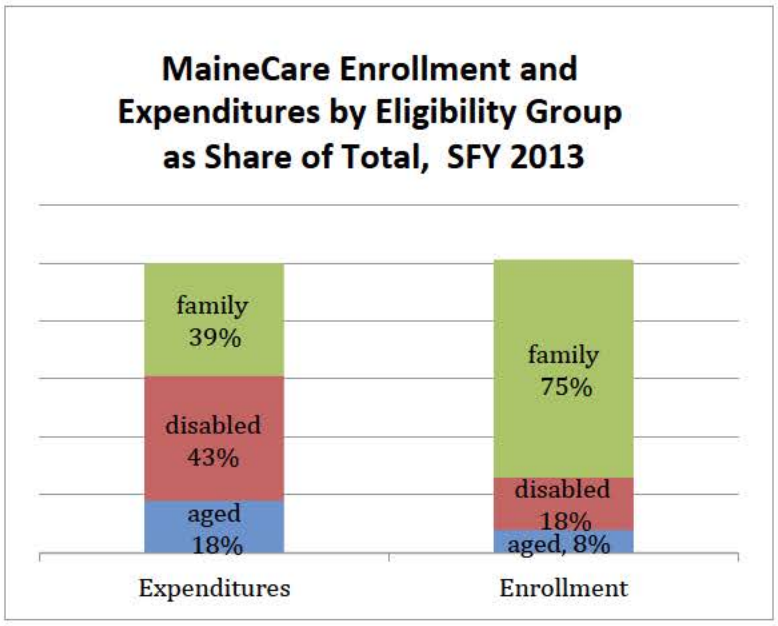
MaineCare spending, by category of member served, has generally followed national trends. In SFY 2013, children and families comprised 74.2% of the MaineCare population but accounted for just 38.6% of the spending; elderly adults comprised 7.9% of the population and accounted for 18.5% of spending; and persons with disabilities comprised 18% of the population and accounted for 43% of all expenditures. While seemingly disproportional, the high cost of serving the elderly and persons with disabilities reflects the higher expenses of long-term care, especially in residential settings. Medicaid pays the majority of costs for enrolled families, while many aged or disabled members are also enrolled in Medicare, the primary payer.

This is critical for Maine, where services for individuals with intellectual disabilities rely heavily on residential settings. As a result, Maine spends an average of $90,178 annually on services for adults with developmental disabilities, ranking the state Number 3 in spending per member. A comparison to the average spending by population for all state Medicaid programs is shown in Chart 11-7 on the next page. Spending on children and families constituted 75% of enrollment in both Maine and the United States. However, MaineCare spends more on families than the U.S. average, as shown by their higher share of total expenditures. In SFY 2003, MaineCare families represented 72% of members and 34% of expenditures.[43] Recent MaineCare taskforces have concentrated on high-cost use among the disabled categories.

43. The Kaiser Commission on Medicaid and the Uninsured, “MaineCare and Its Role in Maine’s Healthcare System,” 2005.

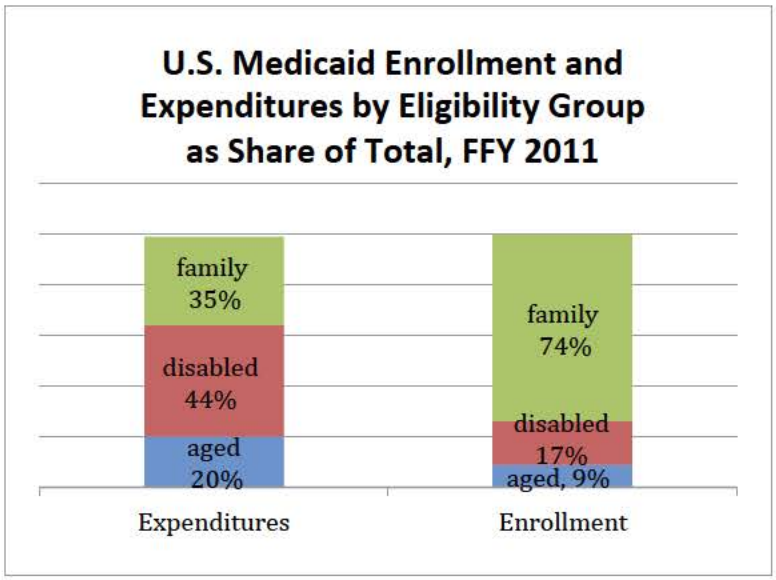
Given the high relative share of costs driven by children and family members, there may also be opportunity to steer these expenses closer to national averages.

Chart 11-7: **MaineCare Enrollment & Expenditures by Eligibility Group**



Source: 2011 CMS Actuarial Report on the Financial Outlook for Medicaid

Chart 11-8: **U.S. Medicaid Enrollment & Expenditures by Eligibility Group**



Source: DHHS-OMS Analytics, 2013.

The family group in both charts includes parents, children, and childless adults.

Federal Medical Assistance Percentage (FMAP)

Sometimes an increase in federal funds can help offset the budgetary demand for public-welfare spending, but recent history shows otherwise. Maine has been facing declining FMAP, i.e., the share of the Medicaid program paid for by the federal government. Since 2000, the rate has fallen from 66.12 to the current 61.55. Each percentage-point drop in FMAP shifts approximately $25 million in federal Medicaid expenses to the general fund. Without a comprehensive reform of the MaineCare program, it will continue to be a financial burden on the state. When considering the fiscal problems of the federal government, the sustainability of current MaineCare funding sources are even more tenuous.

Maine's declining FMAP results from a formula that compares per-capita income for each state relative to other states. Although the statutory formula has not changed, the highest FMAP has declined, and the average FMAP has declined over four decades while the lowest FMAP has remained unchanged, shrinking the distance between the highest and lowest FMAPs. A report by the Kaiser Commission on Medicaid summarizes the major contributing factors:

> Per capita personal income in states that were relatively wealthy in 1969–1970 (and therefore had the lowest FMAPs) grew more slowly over the four decades than per capita personal income in states that were relatively poor. The relatively slow per capita income growth in these states meant slow growth in the national average per capita income. Because a state's FMAP is calculated by comparing its per capita income to the national average, the faster income growth of the poorer states relative to the national average per capita income has reduced their FMAPs over time.[44]

44. Kaiser Commission, "An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid," July 2011.

12. MaineCare Programs and Waivers

MaineCare for Able-Bodied Adults of Working Age

Since 1998, Maine has adopted a number of policies to reduce the number of people without health insurance and curb uncompensated care costs. In 2002, Maine applied for and received a Section-1115(a) demonstration waiver that allows childless adults with income at or below 100% of FPL to receive a comprehensive benefit package.[45] CMS allowed the state to tap unused disproportionate-share-hospital (DSH) allotments to make up the federal share of the state's waiver. Previously, a portion of the DSH allocation had been divided up among psychiatric hospitals and community hospitals, neither of which traditionally met their DSH limit. The DSH allocation, currently at $85 million (state and federal) became the upper limit for the program. In the waiver proposal, the state estimated that eleven thousand new members would enroll in the first year. However, by October 2003, fourteen months after implementation, 16,854 newly eligible childless adults had enrolled in MaineCare.

Chart 12-1: **Maine's Uninsured Population**

Maine Insurance Coverage for Individuals under 65 Years Old Percent Uninsured								
2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
12	10	12	11	10	12	12	11	11

US Census Bureau

Due to the subsequent state budget shortfalls and the risk of exceeding the waiver cost-neutrality terms, Maine requested to amend the waiver by reducing the current demonstration benefit package and eliminating retroactive coverage for demonstration populations. These amendments were approved on September 6, 2005, shortly after enrollment was temporarily capped. Subsequently, enrollment caps were used to control spending and, by 2013, the cap reduced the program's spending to approximately $40 million in combined annual federal and state spending. As of September 2013, there were less than eighty-five hundred enrolled childless adults. The waiver to cover these individuals expired on December 31, 2013.

While these policies did result in small and temporary decreases in the number of

45. CMS, Waiver Information, http://www.medicaid.gov/Medicaid-CHIP-Program- Information/By-Topics/Waivers/1115/downloads/me/me-childless-adults-fs.pdf.

uninsured citizens, it proved not to be a long-term solution in reducing the number of uninsured citizens. That number has remained fairly constant on an annual basis as a percentage of all individuals under 65 years of age, as seen in Chart 12-1. Over the same time, from SFY 1999–2000 to SFY 2012–13, the total MaineCare budget, including both state and federal funds, rose from $1.2 billion to almost $2.5 billion, an increase of 109%. In terms of state funds, the increase was even greater. It grew from $403 million to $992 million, an increase of 146%.

Maine's experience in expanding eligibility for MaineCare did not result in a noticeable reduction in uncompensated care. Latest estimates by the Maine Hospital Association place charity care at approximately $200 million. Just like enrollment and the MaineCare budget, hospital charity care also exceeded budget targets, as it grew by more than 200% from 2000 to 2013. As these numbers indicate, despite efforts to expand health coverage in order to reduce the number of uninsured citizens and curb uncompensated care, both issues remain unsolved.

This lack of evidence linking Medicaid eligibility expansions with reductions in uncompensated care costs may be explained by the results of several studies, including one by Jonathan Gruber and Simon Kosali that found:

> Continued interest in public insurance expansions as a means of covering the uninsured highlights the importance of estimates of "crowd-out," or the extent to which such expansions reduce private insurance coverage. Our results clearly show that crowd-out is significant; the central tendency in our results is a crowd-out rate of about 60%.[46]

Recent evidence from employer-sponsored insurance (ESI) support that research. From 2000 to 2011, ESI coverage in Maine for the under-65 population fell from 69.6% to 61.3%.

Maine Private Health Insurance Premium Program (PHIP)

States have pursued a number of strategies to leverage funding and stretch their health-care dollars in order to avoid cutting eligibility. Authorized under Section 1906 of the Social Security Act, Health Insurance Premium Payment (HIPP) programs subsidize enrollment in employer-sponsored health insurance for Medicaid-eligible individuals — and their families — who have access to such coverage and for whom it is cost-effective. When an adult is identified as having other private insurance coverage, the member's commercial insurance or ESI becomes primary and Medicaid fee-for-service is secondary.

46. Jonathan Gruber and Simon Kosali, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance," National Bureau of Economic Research Working Paper, January 2007.

The Maine PHIP program was set up in 1993. Enrollment in PHIP is voluntary in Maine. To identify MaineCare members who are working and who may have access to ESI, PHIP program administrators send letters to MaineCare enrollees that are employed for thirty-two hours or more per week (approximately thirteen thousand households) and distributed brochures at regional intake offices and other locations. However, unlike the Rhode Island, Iowa, and Pennsylvania programs, the Maine PHIP program has shown low enrollment and minimal cost-savings. Currently, 400 MaineCare households and 1,345 individuals representing less than 1% of total MaineCare working-age families participate in PHIP.

Rhode Island began with low enrollment under a voluntary program but was able to reach more than 6% of cases when enrollment in PHIP was mandated. MaineCare requires members to contact the PHIP administrator in order to be enrolled. Rhode Island also passed legislation to require Medicaid providers to submit information on employer-sponsored health insurance (ESI) as a condition for enrollment. In addition, all other employers were required to submit timely filings on ESI (RIGL 40-6-9.1).

Long-Term Care Systems Support

MaineCare covers a range of long-term care (LTC) in home- and facility-based settings that include skilled nursing, home health, assistance with home chores and personal care, adult day- center services, and residential care. These services are driven by Maine's "oldest in the nation status," as the state's population has a median age of 43.5 years (2012 Current Population Survey, U.S. Census Bureau) while 17% of the state's population is over age 65, the seventh highest percentage in the country. As the over-age-65 population grows faster than all other Maine age groups (2012 Maine State Profile, Woods and Poole) over the next few decades, a smaller percentage of working-age Mainers will be financing a larger percentage of low-income elderly MaineCare enrollees. This is important as traditional long-term care expenses for elderly and physically disabled individuals represented 34% of total MaineCare services in SFY 2013.

> Maine has the third-most aged population in the country, and as of 2012, 17% of Maine's population was age 65 or older.

Maine has received approval of the Balancing Incentive Program (BIP) (awarded effective July 1, 2012) to further develop Maine's systems of community-based long-term services and supports (LTSS). The BIP application shows Maine spending 49.1% of its LTSS spending on community LTSS. As part of its participation in this initiative, Maine commits to meeting the 50% spending benchmark for community LTSS as required by the BIP no later than September 30, 2015. However, the benchmark includes spending on individuals with developmental disabilities. Excluding these services the share of institutional spending (excluding private non-medical institutions, or PNMI) rises to approximately two-thirds. The

share of LTSS for all residential costs including PNMI personal-care services exceeds 87% (DHHS Analytics).

Maine initiated several reforms to target nursing facility admissions to those most in need by establishing stricter medical-eligibility criteria and requiring that anyone seeking admission to a nursing facility, regardless of payment source, be assessed for medical eligibility and provided an advisory community plan of care. As a result, the state has one of the highest acuity levels for nursing-home residents.

Maine has also been transitioning children needing nursing facility level-of-care to home- and community-based services through the Katie Beckett eligibility option. As a result of these reforms, Maine has reduced its utilization of large institutional services for many individuals needing LTSS.

Home- and Community-Based Services (HCBS) Waivers

In addition to mandatory and optional Medicaid state-plan services, there are currently six approved home- and community-based waivers that serve elders, adults with physical and intellectual disabilities, and children as described in Chart 12-2.

Chart 12-2: **Selected Section 1915-Waiver Populations**

Waiver	Target Population and Basic Description
Aged and disabled	Individuals (age 18 or older) who meet nursing facility level-of-care requirements but choose to remain at home. Services include: care coordination, personal support services, home-health services, adult day health services, transportation, emergency-response system, environmental modifications, and respite services. The program rules are in Section 19 of the MaineCare Benefits Manual (10-144 CMR Chapter 101). As of February 2013, 1,331 members were being served.
Community support benefits for members with developmental disabilities	Provides support services to members who most commonly live on their own or with families; there are occasionally individuals living in group homes who are also eligible. The major services are community support and work support. This waiver does not provide any residential services. The program rules are in the MaineCare Benefits Manual, Section 29. The enrollment limit is 1,450 persons.
Home and community benefits for the physically disabled (self-directed)	Individuals with physical disabilities, age 18 or older. Individuals in this program choose to manage and direct their own personal-care attendant. Some services provided are: supports brokerage functions, personal-care attendant services, and the emergency-response system. The program rules are in the MaineCare Benefits Manual, Section 22. Serves 126 members.

Home and community benefits for members with intellectual disabilities or autistic disorder waiver	Offers a comprehensive mix of services to members, age 18 or older. The major services offered are: home support — including support to live alone or in settings with others (i.e. group homes), community support, and work support. The program rules are in the MaineCare Benefits Manual, Section 21. These individuals are residing in the community and have been classified as needing nursing facility level-of-care requirements or meeting the ICF-MR level of care. This waiver was serving 2,855 members as of February 25, 2013.
Children with intellectual disabilities and/or pervasive developmental disorders	This waiver provides an alternative to institutional care to children, ages 5 through 20, with intellectual disabilities and/or pervasive developmental disorders who would otherwise require services in an ICF/MR or psychiatric hospital. The services offered and program rules are specified in the MaineCare Benefits Manual, Section 32. Implemented November 2013. The waiver will serve up to 80 children.
Other related conditions	Serves adults, ages 21 or older, who meet institutional level of care and choose to live in the community. This waiver is designed to maximize opportunities for members with several conditions including cerebral palsy and epilepsy. It became effective July 1, 2013, and will serve up to 70 individuals.

Chart includes only the waivers and does not include amendments to the Medicaid state plan.

Medicaid Estate-Recovery Program

The Medicaid Estate-Recovery Program is a federal-state program designed to recover Medicaid-funded medical costs from the estates of Medicaid recipients, including nursing-home residents whose costs of care were covered by Medicaid. A claim may not be filed where the recipient is under the age of 55, or where there is a surviving spouse, minor child, or blind/disabled child. The current law allows MaineCare to file a claim in probate court, file liens on property of the probate estate, and recover up to the amount of Medicaid expenditures paid on behalf of a deceased recipient. In addition, certain transfers of assets prior to or after becoming eligible are prohibited.

Several factors make maximizing nursing-home recoveries important for Maine. Maine ranks eighth highest among states for elders 85 years or older, the age cohort most likely to require long-term care. Maine also has the highest proportion of nursing-home residents with dementia of any state (55%) and the second lowest percentage of residents with low-care needs (2%).[47]

47. Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, *Across the States: Profiles of Long-Term Services and Supports*, Ninth Edition, 2012.

MaineCare reimbursement to private nursing homes currently exceeds $250 million (DHHS Office of MaineCare Services). Although Maine has ranked about average of states, collecting 1% to 2.5% (states range from 0% to 10.4%) of nursing-home spending or an annual amount of approximately $2.7 million (DHHS Dashboard SFY 2010, accessed on 12/20/13) to $6 million over the past few years, there remains opportunity to increase recoveries by utilizing best practices among states with a higher percentage of collections.[48] The scope of policy options for estate recovery should be enhanced to include eliminating the value of assets exempt from recovery, pursuing spousal recoveries, imposing additional liens on eligible properties, and hiring professional staff to pursue the increase in the inventory of probated property.

48. Department of Health & Human Services Medicaid Eligibility for Long-Term Care Benefits Office of Assistant Secretary for Policy & Evaluation Policy Brief #6, contract #HHS-100-03-0022.

13. Care Management/Value-Based Purchasing Initiatives

Although MaineCare services have been delivered primarily through fee-for-service provider reimbursements, since 2003, MaineCare has undertaken a number of care-management initiatives through pilot programs and state plans under the ACA.

Primary-Care Case Management (PCCM)

Maine implemented a primary-care case-management (PCCM) program in 2004 when approximately 163,000 MaineCare members were enrolled in PCCM with the hope of increasing access to primary care, promoting preventive care, reducing episodic care, controlling chronic conditions, and reducing health-care costs. Approximately 180,000 persons, or 73% of the eligible MaineCare caseload, are currently participating. MaineCare members on Medicare and home- and community-based waivers, and children with special health-care needs, are not eligible for PCCM services. That feature is unlike most state Medicaid programs in which some or all elderly and disabled Medicaid recipients are enrolled in a traditional manage-care organization (MCO) or a care-management program similar to Maine's PCCM.

Under the PCCM program, the MaineCare enrollee has a primary-care physician (PCP) who provides a "medical home" and manages and coordinates care for the member. MaineCare pays participating PCPs a per-member per-month fee of $3.50 for their case-management responsibilities. The PCCM program also includes a pay-for-performance component, the Primary Care Physician Incentive Program (PCPIP). Under PCPIP, participating PCPs are tracked for quality indicators and receive regular performance reports, and MaineCare pays an incentive payment to those PCPs ranked above the twentieth percentile on specified performance measures within their primary-care specialty. Examples of performance criteria include emergency-room utilization rates, admission rates for avoidable hospitalizations, lead-screening rates, and mammogram rates.

Patient-Centered Medical Homes (PCMH)

In 2010, Maine introduced the PCMH model in primary care for all major payers including MaineCare. The pilot program was a three-year effort implementing a set of ten "Core Expectations." Physician practices receive a per-member payment for coordination with community-care teams (CCT) that also receive payment from the major health-care payers.

State Innovation Model (SIM)

Maine has been selected by the Center for Medicare and Medicaid Innovation as one of six states to receive a state innovation model (SIM) award. This federal award is designed to test a set of bold changes to align improvement efforts in the state and transform health-care delivery and payment systems. The $33 million, three-year award was made to the governor's office and is led by DHHS and MaineCare, in partnership with providers, recipients, and several other organizations encompassing a multi-payer network.

The overarching goal of the Maine SIM initiative is to achieve the "triple aim" of improvement: improve health-care quality and population health; improve patient experience of care; and reduce health-care costs. Through its SIM-funded efforts, the state is working to bring together private-public partnerships and align improvement efforts across payers and provider groups, with a strong focus on expanding new payment models such as the patient-centered medical home (PCMH) and accountable-care organization (ACO) models.

Health Homes

MaineCare is now using the time-limited enhanced ninety-ten match rate included in Section 2703 of the ACA to deliver coordination and preventive services for persons requiring chronic disease management and long-term care system supports. The first stage began in January 2013, with MaineCare payments to practices qualifying as health homes and CCTs. Both children and adult practices are included. Stage B will begin in Spring 2014, as qualified community mental-health centers partner with primary-care providers. Coordinated care will be provided to individuals with serious mental illness or serious emotional disturbance. Reimbursement to practices is $12 PMPM; reimbursement for CCTs is $129.50 PMPM. As of November 2013, DHHS did not have a monthly tracking of cases and costs; an initial query of the Truven database identified seventy-five thousand persons classified as health-home eligible. DHHS estimates that 65% of PCCM members would qualify for health homes (Michelle Provost, November 2012). Physician practices not qualifying as a health home will receive payment as a PCCM. It is not clear how DHHS plans on financing the current costs or the higher state share once the demonstration period ends.

The next step in the value-based purchasing initiative is development of ACOs sharing the risk and savings defined by quality benchmarks. ACOs will deliver primary-care services and commit to integrating behavioral-health services. ACOs will be allowed to share in savings only or enhanced savings with acceptance of risk corridors.

14. MaineCare Cost Drivers

Value-based purchasing initiatives have the goal of delivering care through a more coordinated and cost-effective approach. In order to determine if these initiatives will address those opportunities, it is necessary to look at both the drivers of expenditures, as well as the categories where growth is an outlier to the annual 5.5% growth in MaineCare over the past ten years and 3.2% growth over the past five years.[49] Expenditures for hospitals, residential, and waiver categories comprise 60% of the MaineCare claims paid in SFY 2013. Of those categories, only hospital claims had an average five-year growth rate exceeding MaineCare's 3.2% growth. However, the large share of MaineCare claims and higher cost per case for residential and waiver services warrant review for possible payment reform.

Hospitals

The expansion of eligibility for adults and parents in the early 2000s increased hospital spending beyond the available monthly prospective payments described below. The practice of the Government Accounting Standard Board generally would require this incurred, but not-paid amount, to be recorded as a year-end liability. However, the state ignored this liability and closed the ensuing fiscal years with a growing debt to Maine's thirty-nine community hospitals. Finally settling the years after 2008, MaineCare made $490.2 million in payments to hospitals as authorized under Public Law 2013, chapter 269. The $183.5 million state share of these payments was funded using the bond proceeds from the sale of liquor-operation revenue bonds. These funds were matched by $306.7 million in federal funds.

Total MaineCare inpatient and outpatient payments to hospitals in SFY 2013 amounted to $618 million, or a 24.1% share of MaineCare costs, the largest provider group. For inpatient services, hospitals received an episode-based payment based on a DRG (Diagnostic Related Groups) system in place since July 2011. Previously inpatient and outpatient claims were paid primarily with prospective interim payments (PIP) with a cost-based, year-end settlement. From SFY 2008–13, the total of inpatient, outpatient, and PIP payments, including settlements and DSH payments, increased from $517.4 million to $618 million, an annual growth rate of 3.5% (not adjusted for the $490.2 settlement debt). On July 1, 2012, Maine began paying outpatient claims based on APC (ambulatory payment classification) fee schedules.

49. Calculated as compounded annual growth rate over SFY 2008–13.

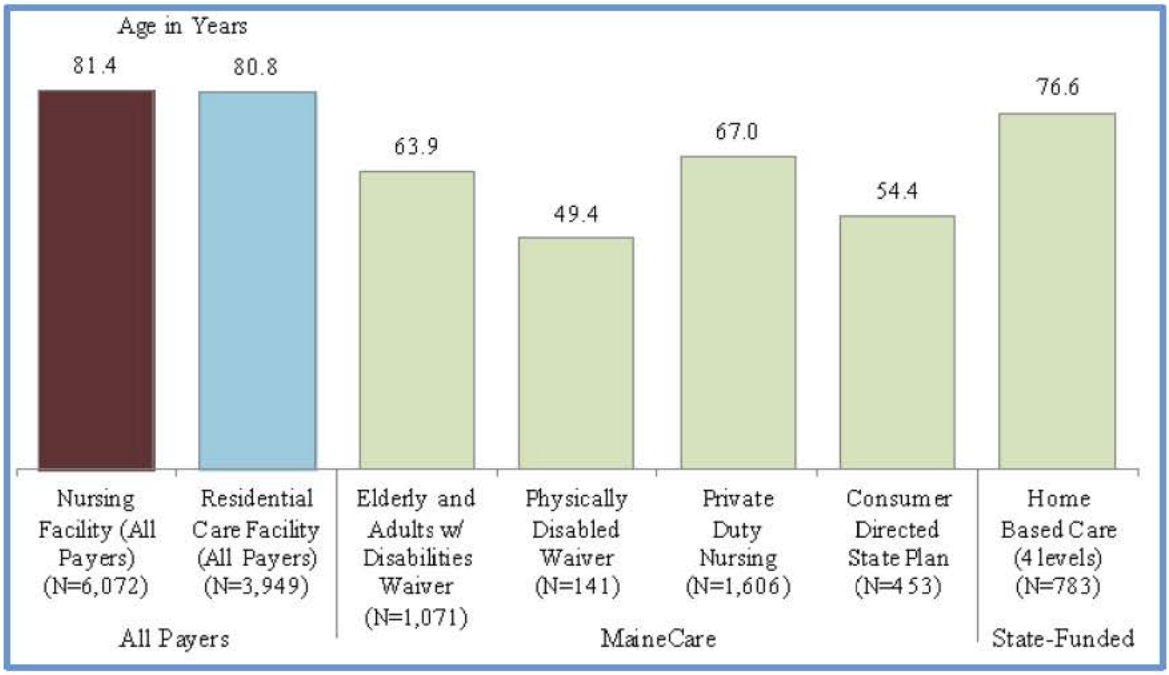
Long-Term Care for Elderly and Adults with Physical Disabilities

The second most expensive part of the MaineCare budget is long-term care system supports. When coupled with acute hospital services, the two categories combined represented 58% of MaineCare spending in SFY 2013 (see Chart 11-2: hospital, residential, and HCBS-waiver expenditure categories).

Nursing homes, residential care in PNMIs and adult family homes, waivers for elders and adults, personal care, home health, and private-duty nursing totaled $544.2 million in SFY 2013 (DHHS Analytics). Although the majority of these members have third-party insurance, Medicare (dual eligible) and private health insurance cover little of their long-term care needs. Nursing homes received $242 million, the second largest provider of service in MaineCare after the developmental-disability waivers. Nursing-home Medicaid days have been declining since SFY 2008, contributing to an average annual decrease in expenditures of 1.95%.

Since SFY 2000, residential-service costs have been falling while home-based service expenses continue to represent a greater share of LTSS. However, this trend has stalled since SFY 2008 as residential services for elders and individuals with disabilities remains about 87% of all LTSS. Moreover, LTSS services contribute to a significant number of high-cost cases.[50]

Chart 14-1: **Estimates of Average Age of LTC Users by Setting, SFY 2010**



Source: Muskie School of Public Service.

50. DHHS, "Older Adults and Adults with Disabilities: Population and Service Use Trends in Maine," 2012.

Nursing-facility rates are based on a provider's allowable costs compared to the most efficient operators. MaineCare daily rates are approximately 69% of the average private rate of $275 per day. This has resulted in a loss of approximately $21 per Medicaid bed day.[51] The two HCBS waiver programs for elders and adults with physical disabilities provide help with housekeeping, chores, meals, and other services to recipients who would need nursing-home care but for these services. The ratio of the state's LTC expenditures for institutional and residential care versus home- and-community-based services has decreased since SFY 2008, but the ratio remains at 87% to 13% institutional-residential to community- based services, excluding services for individuals with intellectual disabilities.

This comparison is at odds with those reported in the state's Balance Incentive Program (BIP). The BIP includes a ratio of 51 to 49 but includes services for individuals with developmental disabilities and may classify residential services as community based. More importantly, the use of either residential or institutional settings remains high, contributing to the high cost of members using LTSS. In SFY 2010, 71% of high-cost members (meaning the top 5% of the highest cost MaineCare enrollees) used long-term care supports that represented 53% of the high-cost members' claim payments (DHHS High Cost Member Fact Sheet, 2010).

Individuals with Developmental Disabilities

The third largest group of services includes persons with autism and developmental disabilities, making up more than $330 million of the Medicaid budget. In contrast to the LTSS services for the elderly, the state's continuum of care for the developmentally disabled is weighted much more toward the community-based waiver services. The share of spending on community providers compared to large institutional providers is just the reverse of the elderly long-term care category; however, services are still weighted toward group residential care, although in smaller settings.

The predominant means for providing services to individuals with developmental disabilities is the HCBS waiver program, which pays for an array of supports to help individuals remain in the community as opposed to an institution. In 2013, MaineCare providers served more than four thousand individuals in the intellectual/developmental disability (I/DD) waiver programs, including 2,855 in the Section-21 comprehensive residential program, as compared to approximately two hundred individuals in the larger private residential settings known as intermediate-care facilities (ICF) for individuals with developmental disabilities. MaineCare I/DD-waiver services are constrained by person limits of 2,935 and 1,450 for Section 21 and 29, respectively. Although the expenditures in the I/DD waiver increased by only 1.4 % per year — and ICF programs decreased an average 1.3% — between 2008 and 2013, the average expenditure per recipient was $77,736 in SFY 2010, far greater than the cost in other New

51. "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," ELJAY, LLC for the American Health Care Association, December 2011.

England states.[52] Only Rhode Island spent more on I/DD-waiver services per citizen. These costs do not include the other medical services that are provided through the MaineCare fee-for-service program.

Chart 14-2: **I/DD Waiver Spending per Citizen, 2011**

State	Spending
Top Five	
Rhode Island	$236
Maine	$222
New York	$222
Minnesota	$207
Vermont	$196
Bottom Five	
Illinois	$36
Georgia	$34
Texas	$29
Nevada	$25
Mississippi	$13

Source: http://stateofthestate.com.

It is not clear if the state is seeking I/DD providers (in coordination with primary-care physicians) as health homes to coordinate all the care for individuals with developmental disabilities. There are other alternative funding models that may provide more appropriate and cost-effective services for this population that are discussed in the last chapter of this report. However, AG has not yet reviewed the data necessary to provide a formal recommendation. These wavier services have been overwhelmed by continuing waiting lists currently totaling 1,401 individuals. It is hoped that use of the recommended alternative delivery systems will alleviate the backlog for most of these underserved persons.

52. DHHS, "Older Adults and Adults with Disabilities: Population and Service Use Trends in Maine," 2012 Edition.

Chart 14-3: **Waitlists for State-Funded and MaineCare Programs**

	Waitlist (As of 2/1/14)	Average PP Annual Cost (State Funds only)	Annual State Cost to Fund	Annual State & Federal Cost to Fund
State-Funded Programs:				
Consumer-directed Home Based Care	20	$18,900	$378,000	
Home Based Care	94	$8,856	$832,464	
Home Based Care Assessment Waitlist	246	$8,856	$2,178,576	
Homemaker (Independent Support Services)	1377	$1,428	$1,966,356	
Annual State-Funded Program Needs Totals	**1,737**		$5,355,396	$5,355,396
MaineCare Programs:				
Section 21, Home and Community Based Services Comprehensive Waiver	889	$101,000	$34,523,870	$89,789,000
Section 29, Home and Community Based Waiver Support Waiver	467	$22,000	$3,950,353	$10,274,000
Physically Disabled Waiver	74	$27,719	$788,688	$2,051,206
Brain Injury Residential Services	21	$95,695	$772,689	$2,009,595
Annual Maine Care Totals (State Funds only)	**1,451**		$40,035,600	
Total State Funding Needed			**$45,390,996**	
Total State & Federal				**$109,479,197**

Chart 14-3 displays the waitlist count — and average operating costs — of state-only home-based services as well as federal waiver services for individuals with intellectual disabilities, physical disabilities, and brain injuries. The total number of persons waiting for services for all programs is slightly less than thirty-two hundred. This number is larger than the actual waitlist due to the allowance for enrollment in more than one program. State funding alone would not eliminate this waitlist since wavier limits would prevent filling all requests. Chapter 16 outlines a budgeting initiative that eliminates both individual program funding and enrollment limits while allowing the use of least-restrictive care settings. All programs listed offer a range of services that include personal assistance in the home with activities for daily living such as bathing, dressing, meal preparation, and housekeeping. Additional services include inpatient costs at nursing facilities and other residential-care services.

Mental Health

Mental-health services for 6% of the adult MaineCare population account for 19% of adult MaineCare expenditures.[53] Residential-care and behavioral-health costs represent the

53. Presentation to the APS-DHHS Quarterly Data Forum, DHHS Office of Continuous Quality Improvement and Muskie School of Public Service, May 30, 2013.

highest cost categories for people with mental illness. Behavioral-health costs include community integration, substance abuse, day treatment, home-based mental health, rehab services, social worker, and clinical counselors. Mental-health related hospital inpatient-and-outpatient costs are also major cost drivers but are included with PNMI mental-health residences in the broader hospital and residential/long-term care categories. Excluding hospital and residential costs, MaineCare spent $196 million, a 7.5% share, for community mental-health services in SFY 2013.

MaineCare mental-health community spending has grown by more than 116% since SFY 2008, or an average annual growth rate of 17%. This increase would be less of a concern had total state spending by Maine's Office of Mental Health and Substance Abuse realized offsetting savings. Most state mental-health funding goes to centers and clinics operated by private firms. A much smaller portion funds state hospitals. *Governing Magazine* examines total state mental-health per-capita spending in all settings, including prisons. By this measure, the District of Columbia and Maine reported the highest per-capita rates in FY 2010. Maine is confident that the recently enhanced care management under the ACA home-health option will aid in bending these steep cost curves; however, the health-home initiative — while currently treating individuals with substance abuse — has yet to integrate recipients with diagnoses such as serious and persistent mental illness, a contributor to this above-average growth.

In the substance-abuse field, confidentiality is governed by federal law (42 U.S.C. § 290dd-2) and regulations (42 CFR Part 2), which outline under what limited circumstances information about the patient's treatment may be disclosed with and without the patient's consent. Determining when 42 CFR Part 2 is applicable and how to legally access information about substance-abuse treatment requires practitioners to work through a multitude of questions. As a result, it is often necessary for states to phase-in behavioral-health services to devote the necessary resources to properly protect patient information.

Chart 14-4: **Mental-Health Spending in New England**

SFY 2010

State	Total Expenditures	Expenditure Per-Capita	Per-Capita Rank	Poverty Per-Capita Expenditure	Poverty Per-Capita Rank
Maine (1)	**$459,680,997**	**$346.92**	**2**	**$1,972.88**	**1**
Vermont	$150,000,000	$239.84	6	$1,485.15	5
Connecticut (2)	$675,500,000	$189.34	9	$1,659.71	3
New Hampshire	$192,590,991	$146.40	17	$1,356.27	7
Massachusetts (3)	$714,300,000	$109.07	24	$665.70	20
Rhode Island (4)	$94,919,34	$90.51	30	$494.37	30

Source: National Association of State Mental Health Program Directors Research Institute, *Governing Magazine*, 2010.

(1) Totals include funds for mental health services in jails and prisons.
(2) Medicaid revenues for community programs and children's mental health not included.
(3) Medicaid revenues for community programs not included.
(4) Children's mental health expenditures are not included.

15. Pharmacy System

The MaineCare system not only provides recipients affordable access to medications but also manages cost and quality. The MaineCare pharmacy programs serve a population predominantly comprised of younger adults and children. While Maine's 65-and-above age group is projected to grow at a rate that exceeds other New England states and the nation, since 2006, individuals who are also eligible for Medicare receive pharmacy benefits through Medicare Part D drug plans. This includes a majority of elders receiving long-term nursing-home care. An estimated 25% of MaineCare recipients are Medicare-eligible elderly or adults with disabilities that receive their pharmacy benefits through Medicare, rather than through the MaineCare pharmacy program.

A brief review of the MaineCare pharmacy program was conducted in January 2014. Information sources reviewed included program descriptions provided via publicly available reports and websites, posted policies and meeting minutes of the MaineCare Drug Utilization Review Board, and interviews of MaineCare pharmacy program administrators. Findings are presented below, categorized in four sections: Payment and Pricing; Drug Coverage Policy; Drugs of Abuse; and Population Health and Pharmacy Services.

Payment and Pricing

Drug Reimbursement. MaineCare prescription-drug reimbursement rates are within the range established across most states. For brand name products, reimbursement is set at the lesser of the average wholesale price (AWP) –16%, or the wholesale acquisition cost (WAC) +0.8%. The dispensing fee paid to pharmacies is $3.35 (per prescription). Reimbursement for brand drugs is generally comparable to neighboring states: the New Hampshire brand-drug reimbursement rate is the lesser of AWP –16% or WAC +0.8%, with a dispensing fee of $1.75; while the brand-drug reimbursement rate in Vermont is AWP –14.2%, with an in-state dispensing fee of $4.75.

MaineCare reimbursement for generic products is set at the lower of AWP –13% or WAC +4.4%, with the same dispensing fee ($3.35). As many generic products are available from multiple manufacturers, reimbursement is also capped at the lesser of the CMS federal upper limit for reimbursement, or the maximum allowable cost set by Maine. Additionally, a supplemental dispensing fee of up to 65 cents is provided to rural pharmacy providers.

Medications distributed through specialty pharmacy providers are reimbursed at a slightly lower rate (lesser of AWP –17% or WAC –0.4%, plus a $3.35 dispensing fee).

Efficiencies of mail-order distribution are leveraged by MaineCare, which reimburses these providers the lesser of AWP –60% or WAC –52%. The dispensing fee paid to mail-order pharmacies is $2.50.

Most state Medicaid programs have added a WAC-based scheme in response to publishers planning to cease reporting this benchmark, and also as a means to closer align reimbursement with actual cost. The WAC reflects the listing price for a drug product as sold by the manufacturer, and more closely represents the pharmacy's actual purchase price as compared with AWP, which was widely recognized as an inflated "sticker" price. However, WAC does not reflect all discounts received (e.g., for timely payment or bulk purchasing), and cannot be audited practically. States including Alabama, Colorado, and Oregon have implemented an actual-acquisition cost (AAC) reimbursement scheme that aligns reimbursement more closely with actual pharmacy purchase price, as verified through periodic reporting required of the pharmacy. As the AAC benchmark is likely to result in decreased reimbursement, states shifting to this method have increased the pharmacy-dispensing fee (for example, from $5.40 to $10.60 in Alabama). Further analysis and modeling may reveal cost savings yielded from this approach. However, decision-makers must ensure that any change in reimbursement policy does not threaten access to pharmacy providers, particularly those serving individuals in rural areas.

Rebates. By federal mandate, drug manufacturers provide rebates to all state Medicaid pharmacy programs, as based upon volume of utilization. Since 1996, the rebate provided for innovator (brand) medications was set at the greater of 15.1% of the average manufacturer price (AMP) or the margin between AMP and the inflation-adjusted best-unit price. For generic drugs, the rebate has been set at 11% of the AMP. The Affordable Care Act increases the rebate amount to 23.1% of AMP for innovator drugs, and 13% of AMP for generic products; however the increase in this range will be directed federally and not shared with states. Additionally, Maine Medicaid is a member of the multi-state Sovereign States Drug Consortium, which provides a purchasing pool to maximize supplemental rebate opportunities.

As coupled with MaineCare's Preferred Drug List (PDL), the mandated and supplemental rebates can result in net drug costs that approximate generic drug costs or, in some instances, fall below the cost of generic alternatives. Broadly, managed care has yielded dramatic cost savings by driving increases in the use of generic products. The U.S. Generic Pharmaceutical Association reported that savings associated with the utilization of generic drugs in 2012 totaled an estimated $217 billion. Increases in generic medication utilization within Medicaid would realize savings measured in terms of reduced pharmacy reimbursements. However, decreases in rebates for branded products would be a tangible offset. Targeted, continual evaluation of brand/generic alternatives is necessary to identify which strategy yields the greatest cost savings (i.e. promoting generic use versus maximizing branded product rebate), particularly given the dynamic nature of drug pricing, therapeutic competition, and drug patent life. Accordingly, MaineCare publishes a "Brands Preferred Over Generic Version List."

Drug Coverage Policy

Preferred Drug List. The MaineCare pharmacy benefit is managed by Goold Health Systems (GHS), which implements the PDL and related activities, in concert with a robust management information system supported by Unisys Corporation. The PDL is well designed and updated regularly to reflect changes in drug evidence, pricing, and availability. Stepped therapy protocols ensure that higher-cost medications are utilized only when medically justified, and include essential clinical considerations.

The MaineCare Drug Utilization Review (DUR) Board, comprised of physicians, pharmacists, and other experts, conducts evaluations and assesses medication use within specific populations, considering particular areas of medication safety and quality. The MaineCare DUR Board also serves as the program's drug formulary committee, acting to add and remove drugs from the PDL. The MaineCare DUR Board, GHS, and the state pharmacy administrators work in concert to provide a high-quality pharmacy benefit that promotes access to necessary drug therapies with a focus on cost containment.

Like all state Medicaid programs, medications for mental-health diagnoses are a leading cost category. Restricting access to expensive therapies, such as atypical antipsychotic medications, has been applied as a strategy to mitigate cost. Currently, open access to atypical antipsychotics and antidepressants are provided for several preferred drugs, while the remaining drugs in these classes are designated as non-preferred, requiring prior authorization for coverage. Some evidence suggests that this policy has not resulted in untoward patient health outcomes,[54] while others have reported treatment disruptions.[55] Given that hospitalizations for mental-health conditions represent 10% to 12% of all heath-care utilization expense, careful and continual assessment of the impact of the PDL on access to antipsychotic and antidepressant medications is warranted.

Specialty Drugs. Like all pharmacy-benefit providers, the program is challenged to address the rising expenditure projected for high-cost specialty medications. These medications include long-acting formulations of atypical antipsychotics, products for autoimmune disorders, and various other injectable products spanning a range of conditions. In its Drug Trend™ report, the pharmacy-benefit organization Express Scripts documents a 16.7% yearly increase in overall Medicaid spending for specialty drugs, as compared with a minimal 1.5% increase in expenditures for conventional drugs. Volume-driven rebates and PDL placement will likely be insufficient as strategies to mitigate the projected increases in specialty drug costs over the next decade. In addition to the development of evidence-based prior authorization protocols, cost-mitigating tactics commonly considered include supply-channel management, outcomes-

54. Alyce S. Adams et al., "Prior Authorization for Antidepressants in Medicaid: Effects among Disabled Dual Enrollees," *Archives of Internal Medicine* 169.8 (April 27, 2009): 750–56.

55. S. B. Soumerai et al., "Use of Atypical Antipsychotic Drugs for Schizophrenia in Maine Medicaid Following a Policy Change," *Health Affairs* 27.3 (May–June 2008): w185–w195.

based reimbursement, augmented case management, and directing payment through the medical benefit.

MaineCare has developed a pharmacy-care management program designed to heighten the management of high-cost pharmaceuticals. Case management is a common approach, providing oversight and support for highest-cost cases. For patients utilizing specialty pharmaceuticals, key aspects of case management might include in-depth patient education regarding appropriate administration and self-management, close therapeutic monitoring by clinical providers, and the involvement of pharmacists to assure that medication is not stockpiled or wasted. Importantly, these techniques may reduce costs associated with unnecessary use or adverse events, yet with limited effect on total drug expenditures.

Abuse of Drugs

Overuse and abuse of narcotic pain medications is a national epidemic. In 2013, MaineCare implemented two policies addressing the utilization of medications for pain and opiate addiction. One policy pertains to the prescribing of oral opioid medications, which have been limited to up to a forty-five-days supply of medication over a twelve-month period. Additionally, chronic users of narcotic pain medications are required to try other non-drug options for pain relief. The second policy set a lifetime limit of twenty-four months for the use of buprenorphine/naloxone (Suboxone®) for the treatment of opioid addition. These policies are progressive, aiming to address this public-health concern. The Summer–Fall 2013 issue of the MaineCare's PDL newsletter notes that the policies are beginning to reduce the level of use of these medications. Yet formal evaluation of the success of these policies should include measuring unintended outcomes, such as increases in use of alternatives (buprenorphine and oxycodone) and the use of emergency services for opiate intoxication, as well as considering the potential social consequences such as crime and fatal overdoses.

Population Health and Pharmacy Services

The dissemination of the medical-home model presents significant opportunity for integrating pharmacy into care-delivery models. This can be considered from three perspectives: The role of medications in achieving aims for population health and preventive care; the role of clinical pharmacy services as delivered within an interdisciplinary ambulatory-care model; and leveraging the state's health-information exchange and other information technology to virtually connect pharmacists with prescribers and patients to prevent adverse drug events, promote medication adherence, and maximize drug efficacy.

Medications are fundamental towards achieving aims for population health and preventive care. For example, patients with mental-health conditions are at increased risk of developing cardiovascular disease and diabetes, partly as a result of the medications prescribed

for their illness. Medications for blood pressure and glycemic control are crucial aspects of preventing disease progression and complications. Additionally, the pharmacy program can deliver a range of health-promotion activities, including providing immunizations and offering smoking-cessation programs. Openness to new payment methods provides an opportunity for configuring these services within risk-based global payment models.

Similarly, prospective reimbursement aligned with the medical-home model of care affords flexibility in staffing the clinic with health-care providers that best meet the needs of patients. Pharmacists working in ambulatory-care settings manage medication regimens, provide guidance for drug selection and monitoring, educate patients, and reconcile medication lists among providers and across settings. Moreover, the pharmacist in the medical-home model is ideally situated to help patients and providers utilize specialty pharmaceutics effectively.

Lastly, information technologies can virtually connect pharmacists to prescribers and patients in a variety of ways that serve to promote safe medication use while reducing waste. IT-connected pharmacists can review drug-dispensing databases to assess patient adherence or check for abuse, while also checking recent laboratory results prior to dispensing a medication.

16. Medicaid Flexibility and Fiscal Certainty: The Promise of Global Reform

Medicaid's purpose is firmly rooted in law: "To furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care."[56] Despite this original charter, subsequent amendments of the law and many thousands of regulations promulgated by the federal CMS have burdened the Medicaid program with a default focus on institutional care, a bias toward reimbursement of high-cost settings and services, and an inefficient system of providers and care givers.

The institutional bias and inefficiencies remain even though most Medicaid long-term care recipients would prefer to stay at home and most quality-driven Medicaid providers would rather be delivering more lucrative post-acute care and rehabilitation services. Moreover, the bias remains entrenched even as policymakers have been trying for decades to "rebalance" Medicaid's long-term care system so that the frail elderly and people with disabilities have access to benefits no matter where they receive care. And it continues to shape the program even though the Supreme Court ruled fourteen years ago that persons with disabilities had the legal right to care in community settings whenever possible.[57] Indeed, more than half of Medicaid long-term care dollars nationwide continue to be spent on nursing-home services.

While many Medicaid administrators would like to see this institutional bias come to an end, federal policymakers have yet to make Medicaid assistance equally available regardless of where supports and services are needed — or who delivers them. The issue was debated when Congress was considering the ACA, but lawmakers blinked, suggesting only modest changes to the current institutionally based home-centric system. More recently, the congressional Long-Term Care Commission, which issued its final recommendations in September 2013, could not agree to make Medicaid equally accessible for people receiving help at home.[58]

Under current federal law, frail elders and persons with disabilities are entitled only to institutional care. They can receive related home care and ancillary services, but usually only if

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56. 42 U.S.C. § 1396 (2).

57. *Olmstead* v. *L. C.* (98-536) 527 U.S. 581 (1999) 138 F.3d 893.

58. Although broad agreement was not reached, the commission provided firm recommendations on state flexibility and ways in which efficiency could be achieved. See *Commission on Long Term Care*: *Report to Congress*, September 2013, Appendix A.

their state receives special permission from the federal government. This permission comes in the form of waivers for each of the Medicaid service populations. All states have been granted waivers to varying degrees, but their home- and community-based programs remain, in most cases, underfunded. Further, states have to apply for and manage multiple waivers across different populations. These waivers impose various eligibility limits, service definitions, quality standards (or lack thereof), dissimilar rules, and reporting requirements. States also utilize amendments to change administrative aspects of their Medicaid state plans. Examples of these efforts include changing provider-payment rates, adding or cutting optional services, adding managed care,[59] and changing benefit structures like prescription-drug limits or cost-sharing.

By "Balkanizing" the program, the federal-waiver system makes Medicaid difficult to manage at the state level. That's because in essence, each waiver functions as a separate program, often in conflict with others. Each waiver program requires multiple filings, reports, meetings, and public hearings — not to mention reams of paperwork and staff time — before a state can achieve even a modest amount of flexibility from federal rules and regulations.

The waiver system also negatively affects the most vulnerable populations that the program is designed to serve. Not only are community services limited but also potential recipients find themselves stuck on long lists waiting to be enrolled in a home-care program. There is something especially cruel about putting a frail 90-year-old on a two-year waiting list, especially when a state invites abled-bodied recipients to sign up and receive free Medicaid services immediately, an inequity exacerbated by the ACA, as the vast majority of eligible applicants use state health exchanges to enroll in Medicaid.

In addition to the institutional bias, Medicaid suffers from other arcane rules that stifle innovation — including those that allow "any willing provider," "freedom of choice," state-wideness, and limits on cost-sharing — factors that contribute to a less-than-optimum distribution of services, an inability to target services, and cost overruns. States can and do receive relief from these burdensome rules; however, such relief is usually granted only in piecemeal fashion over multiple waivers and service populations. And achieving such flexibility often takes many years and over many administrations.

The MaineCare Challenge

Like all states, Maine must function under the existing federal framework that rewards institutional placement and high-cost care settings over targeted low-cost alternatives that would actually improve care quality. Like other states where the Medicaid penetration rate is high, this institutional bias has shaped Maine's health-care services market (i.e., access and availability) and utilization trends far more than the preferences of recipients or the Supreme Court (i.e., the *Olmstead* decision, see footnote 57).

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59. Managed care can also be added via the waiver process.

In recent years, MaineCare has implemented changes that have improved service options available to recipients with chronic and/or disabling conditions. For the most part, these improvements have been limited to specific populations or programs. Moreover, these changes affect only recipients covered under the state plan as well as the various Section 1915I home- and community-based waivers. Indeed, the small population of Maine and its affected service populations make it difficult to integrate and/or target services to meet the changing needs of recipients across the life-cycle, let alone comply with Title XIX requirements — waiver and non-waiver — related to scope, freedom of choice, comparability, and state-wideness.

In chapter 12, Chart 12-2 identified Section-1915I waivers that Maine has secured to allow Medicaid recipients to obtain coverage while living in less-restrictive residential settings and to enjoy greater control over their care. These six waivers, however — each with different service definitions, rules, and requirements that may or may not comport — preclude the state from pursuing reforms that target services in the most appropriate settings or alleviate waiting lists. Nor do they allow the state to try service methods that improve care quality. If Maine wishes to add a service that is not authorized under a current waiver, the state has to submit a waiver amendment. This might be approved quickly — depending on who answers the petition at CMS — or it could take years. Further, per CMS rules, each of these waivers imposes its own administrative reporting requirements. With limited staff, the multiple waivers create administrative burdens that shift the state's focus to bureaucratic process rather than leverage the state's purchasing power to driver innovations in service design, delivery, and settings.

In addition to these six waivers, the state has pursued initiatives across service populations designed to: 1) reduce the reliance on institutionally-based long-term care (e.g., Real Choices Systems Transformation grants and Money Follows the Person grants among others); 2) divert or transition recipients from high-cost institutional and residential settings into less-restrictive settings (e.g., department programs developing the shared-living option for individuals with developmental disabilities, alternatives to hospitalization for adults with psychiatric conditions, and wraparound services for children with behavioral-health needs living in the community); and 3) expand the capacity of providers delivering home- and community-based services and supports (e.g., increase rates for adult day-service providers and expand assisted-living waiver slots).

Maine's efforts at reform are further hampered by federal law that allows Medicaid recipients to obtain services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services."[60] This provision is often referred to as the "any willing provider" or "freedom choice of provider" provision. States are not permitted to exclude providers from the program solely on the basis of the range of medical services they provide. Consequently, MaineCare deals with more than seven thousand providers, not counting subcontractors. Thus, as MaineCare officials have acknowledged, there may be more than twenty thousand providers. In a small state like

60. Section 1902(a)(23) of Title XIX of the Social Security Act.

Maine, that is an enormous number of providers to monitor. Those numbers raise questions of how quality is measured and the appropriateness of services that are selected.

States can receive permission to bring more competition into Medicaid through the waiver process. For example, a state could utilize a Section-1115 waiver to provide managed care to recipients. Within that waiver, managed-care companies have flexibility to selectively contract with providers. Maine however, does not utilize managed care; even if the state did, that option may be limited to just one service population and not across the entire system. The state, therefore, needs the ability and flexibility — where appropriate — to be able to competitively bid services or products to improve quality standards and performance. Examples where this might be useful are for durable medical equipment or with ACOs.[61]

All of these factors work against Maine's efforts to reverse the continued over-reliance on high-cost service venues and institutional care. For example:

- Maine spends 87% of its long-term care dollars on institutional/residential care. Nursing-home residents possess a relative high level of acuity as frail elders, who could not otherwise find appropriate community settings, have been shifted to private non-medical institutions (PNMI). PNMI-user costs, on average, are lower than comparable nursing-home care. However, the availability of PNMI settings has driven those aggregate costs to now exceed total nursing-home expenditures.
- The state maintains long waiting lists for long-term services and supports in the community for the most vulnerable recipients.
- MaineCare's residential child care costs per user exceed $120,000. New approaches are required to lower costs and provide the least restrictive setting.
- Almost two-thirds of Medicaid recipients in residential care and three quarters of those in nursing facilities have either a diagnosis of dementia or impaired decision-making skill.[62] Maine's long-term service and supports require expanded capacity for families wishing to utilize home-based care.
- Current Medicaid payment/program policies do not sufficiently facilitate the ability of maintaining adults with developmental disabilities to remain in their own homes. Only token financial assistance is available, and arranging for and accessing services is more complicated than if provided in the much more costly ICF/MR or group-home setting.
- MaineCare does not currently offer shared-living services for elders.

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61. An ACO allows doctors and hospitals to join voluntarily with others in new legal entities that are accountable for providing care across institutional and outpatient settings. The idea is to put physicians and hospitals in new organizational arrangements that share revenue and keep the savings if they provide quality care at less cost than FFS would normally pay. MaineCare has begun to implement this model but needs greater flexibility to lower the cost curve.

62. Julie Fralich et al., "Dementia in Maine: Characteristics, Care, and Cost Across Settings," Muskie School of Public Service, 2013.

Fiscal Trends and Cross-Pressures

The federal Medicaid structure is not the only factor pressing on Maine. On the financing side, the state has suffered a widening gap between general revenues and MaineCare expenditures due to fluctuations in the economy, a decline in federal financial support, poverty growth, and the escalation in health costs.

Since SFY 2011, the state has initiated measures to curb Medicaid enrollment growth, contain program cost, and improve the efficiency of services. Although these efforts have slowed the rate of growth in Medicaid enrollment and expenditures, caseloads continue to grow and the budget gap persists. Even with modest economic improvements, the MaineCare's fiscal prognosis projects a deficit for the biennium 2014–15 budget of $78 million. These budget projections are troublesome because MaineCare constitutes a lion's share of the state's annual budget (32.2% in SFY 2013).

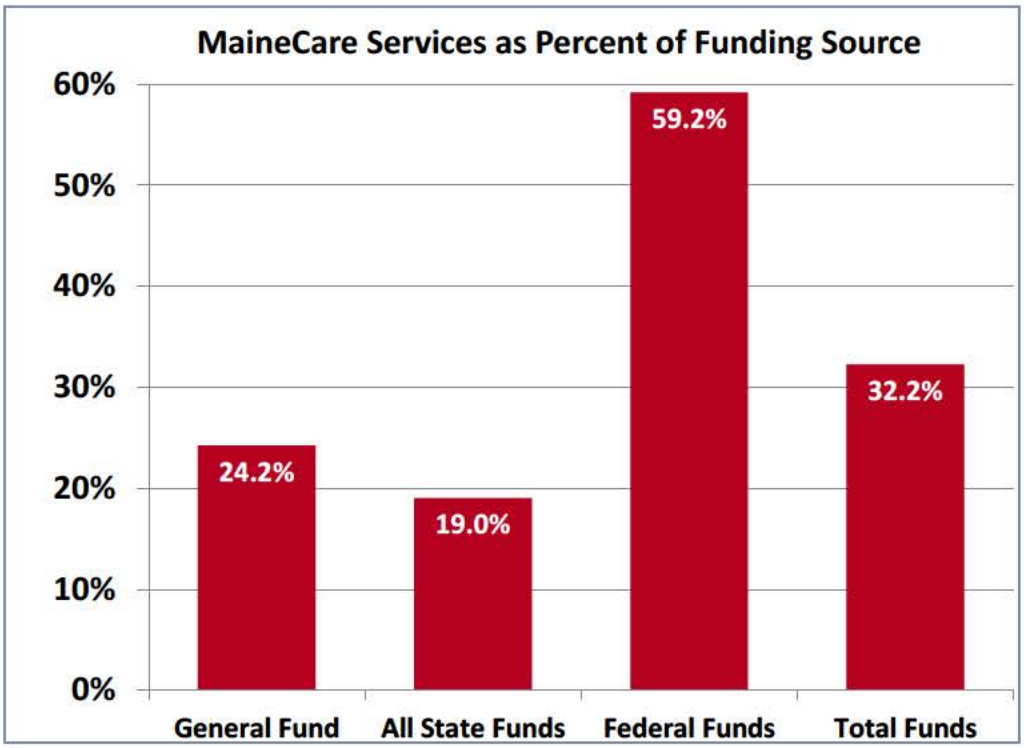
Even the recent success in moderating MaineCare growth will not be sufficient to overcome the long-run trend. When extrapolated by financial modeling, the trend shows that by SFY 2023–24, MaineCare will represent 36.2% of the general-fund budget, and 40.2% of the total budget, consisting of all funds.[63]

The program's high costs impinge upon the financial resources available for the state to address other pressing needs, spur economic growth, and/or prepare for an uncertain future. If demographic forecasts are correct, the range of choices open to the state will narrow as the majority of the Baby Boomers retire, program costs surge higher, and the gap between the rise in Medicaid expenditures and general revenues grows wider.

One of the root causes of MaineCare's fiscal problem is its funding structure. The intermingling of state and federal finances through the federal matching program splits political accountability for expenditures, creates instability in the state budget, and incentivizes the state to spend more, not less, in order to draw down more federal dollars. The federal government pays states Medicaid matching funds according to the FMAP, calculated based on a state's per-capita income. Sharing responsibility with the federal government for financing Medicaid in this fashion has affected, and will continue to affect, the state's ability to balance program costs, revenues, and other policy priorities. As federal Medicaid dollars are the single largest source of grant support to Maine, the consequences of changes in federal funding for the state cannot be overstated.

63. The Alexander Group, "Feasibility of Medicaid Expansion under the Affordable Care Act,", p. 61.

Chart 16-1: **MaineCare Services As Percent of Funding Source**



For example, reductions in FMAP between SFY 2011 and 2013 decreased federal contributions to the MaineCare program by approximately $250 million per year. That is because every one-point decline in Maine's FMAP equals approximately a loss of $25 million. The MaineCare cost-containment initiatives implemented over the same period partially offset a two-year general-fund deficit of $220 million (DHHS, February 2012 estimate) with general revenues covering the balance. The major initiatives included funding for childless adults by freezing enrollment and reducing the eligibility threshold for parents of children on MaineCare from 200% of the federal poverty level to 133%.

Compounding these pressures has been the roll out of the Affordable Care Act and other changes in federal guidelines that make it easier for abled-bodied individuals to access MaineCare. This means that MaineCare will see a larger than normal growth in its caseload.

Uncertainty about the state's capacity to handle the fluctuations in the economy as well as continued changes in federal financial assistance and guidelines underscore the need for comprehensive reform. Yet, the state's ability to take action has been impeded by the program's scope and cost, which make it a target for budget cuts. Indeed, since 2008, changes in the Medicaid program have largely taken the form of cost-cutting measures that, though in line with some principles of reform, are designed primarily to reduce the state-budget deficit.

In contrast, a global reform would represent an enterprise-wide and broad-based strategic redesign framework that would anticipate, rather than react to, such cross-pressures. Such global measures would also provide recipient-centered services, give recipient families more choices, offer targeted services at the right time and place, and implement pragmatic cost reductions that improve care quality. Further, a global-reform initiative with budget caps would provide accountability by challenging the "spending" culture at the state administrative level, which is incentivized to spend more money in order to receive more money, thus exacerbating budget challenges.

The Solution: A Global Waiver

As currently constituted, the Medicaid program is a one-size-fits-all program. If a state offers a service to one population, it must offer the service to all. The only way to "waive" that provision is through a waiver, a process that can take many years.[64] How then could Maine make its Medicaid system more manageable, accountable, and transparent while offering greater flexibility to serve both recipients and taxpayers alike?

Ideally, converting MaineCare to a federal block-grant program would offer the best vehicle to achieve maximum flexibility while offering clear advantages for Maine and the federal government alike. The federal government would gain budgetary stability; funding would no longer be subject to state spending patterns and schemes to pull down ever-more federal funds. Likewise, Maine would rely on a fixed amount for Medicaid in its budgets and avoid chronic issues of underfunding, declines in federal match, and backfilling program-budget shortfalls. Such an approach would incentivize Maine to control costs, as the state would have clear budget limits and no unlimited entitlement to matching federal funds. A block grant would also give Maine near-total control over program design, eliminating the need for multiple federal waivers and approval of state-plan amendments. Authority to design and run the program would rest entirely with Maine, as would political accountability for outcomes and performance.[65] With greater control, Maine would have flexibility to innovate in program implementation and improve both quality of, and access to, care services.

Unfortunately, block grants are not allowed within the current legal framework; only an act of Congress could change that. The next best option is therefore a "global redesign" under the authority of Section 1115(a) of Title XIX of the Social Security Act. If granted, a global waiver would grant Maine the ability to appropriately tailor benefit packages, increase provider competition, and introduce innovative services. And it would allow Maine to restructure its

64. It is widely agreed upon by most policymakers, that if today, the government were to start a completely new public welfare system, it is almost certain that it would not be designed with this inefficient framework.

65. The federal government could set broad performance measures around health, safety, access, transparency and cost effectiveness.

entire program to establish a "sustainable cost-effective, person-centered and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care."

To date, two states have been granted this type of comprehensive flexibility, a reform that encompasses all Medicaid programs, waivers, and services but also delivers administrative relief: Rhode Island and New Jersey.[66] Both states have successfully used the flexibility achieved through a global waiver to redesign services, increase competition, simplify the administrative structure, and lower costs. Under Rhode Island's demonstration, CMS allowed the state to establish an overall spending cap on federal matching funds. The cap put the state at risk for expenditures in excess of the cap, as the state was required to continue providing coverage for its Medicaid population using state funds. In addition, the state was given the flexibility to make certain programmatic changes without having to follow conventional procedures. For changes that would otherwise need to be processed as an amendment to the state Medicaid plan, or for changes of the demonstration terms and conditions or that did not affect eligibility, the state only had to notify CMS. CMS officials noted that this was the first time they approved a demonstration of this type of administrative flexibility.

By seeking this kind of global reform, Maine, too, could achieve similar successes, assuring the sustainability of MaineCare for years to come. In fact, Maine is uniquely positioned to provide its sister states with a model for re-inventing the Medicaid program. The state's small population and eagerness to innovate offers numerous advantages to demonstrate innovative and comprehensive reform. Moreover, the state is currently a beta-test site for several health-related initiatives (e.g., health homes and ACOs) that would complement the goals of reform.

Under a comprehensive or single-waiver demonstration, DHHS would seek maximum flexibility to change delivery systems, increase transparency and choice, and share risk with the federal government. This would improve service delivery and promote recipient choice and independence while driving down both federal and state costs. DHHS would seek the ability to vary the amount, duration and scope of services offered to recipients — regardless of eligibility category — and the ability to target benefits to specific Medicaid populations. DHHS could also request a global cap on Medicaid expenditures, a proven motivation for reducing spending, over the life of the demonstration.[67]

A comprehensive Section-1115 research-and-demonstration waiver, encompassing all services and eligible populations served under a single authority, would deliver flexibility to manage all programs efficiently by:

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66. Illinois is currently considering a global waiver type reform.

67. It is unlikely that the current CMS administration would agree to any global cap on spending. This does not however, preclude the state from seeking such accountability.

- Consolidating all Medicaid programs, services, waivers, and CHIP under a single-waiver authority;
- Streamlining service definitions across populations;
- Making key improvements to the eligibility system (both processes and technology);
- Promoting increased utilization and choices of home- and-community-based services for individuals in need of long-term care;
- Integrating primary, acute, long-term care, and behavioral-health care;
- Allowing new and innovative care models like tele-health across all populations;
- Utilizing risk-based capitation across all populations;
- Promoting efficient and value-added health care through enhancing current Medicaid accountable-care organization pilots;
- Providing flexibility to promote primary- and preventive-care access by balancing eligibility and enrollment for services, benefits, and the rate of payment for services;
- Providing flexibility in administration of the program to implement competitive contracting, management efficiencies, and purchasing strategies;
- Promoting healthier behaviors and personal responsibility for recipient health care across the enterprise; and
- Instituting greater accountability for recipients and administrators of the programs.

More specifically, Maine would enjoy numerous administrative and program enhancements, including:

Waiver Streamlining. The state currently administers six HCBS waiver programs for various populations in need of long-term care. Each waiver has a varied set of service definitions, reimbursement policies, and rate structures for providers. Personal emergency-response systems services, for example, are offered in the consumer-directed attendant services waiver, the MaineCare state plan, and the state-funded program at different allowances. This is just one of many services offered by this particular waiver; its range of payment rates has created inadequate cost controls within DHHS. DHHS cannot afford to maintain a duplicative financial structure whereby the same service is provided at different rates based on multiple waivers. But a comprehensive, global waiver/redesign would allow DHHS — under a single waiver-reform mechanism — to standardize services, improve rate consistency, and realign services across the entire enterprise. It would also allow Maine the capability of building a unified assessment and coordination operation to deliver the right services, at the right time and place, for each population regardless of diagnosis.

Targeting Services and Rewarding Healthy Behavior. The flexibility offered from a global waiver will ensure that every recipient has access to the right services in the right settings and in the right place. Waiving “amount, duration, and scope” of services will allow MaineCare to more appropriately target services where needed, and not necessarily offer them for the entire service population. A one-size-fits-all federal model would be replaced with recipient and administrative flexibility. The state could tailor benefit packages for disease and medication management without having to offer these options for the entire population. The

flexibility might allow the option of rewarding recipients who participate in healthy behaviors and preventive measures.

New Innovation and Service-Delivery Models. With real flexibility, Maine would have the opportunity to quickly adopt newer models of care and payment systems, or adapt current innovations into MaineCare. Innovations like tele-health, global payments, episodic-care payments, and even creating an internal-care management system — one that capitates risk-based payments based on populations to selectively contracted providers based on quality — can become a reality across the entire system more expeditiously than the current operation.

Competition. A global waiver would allow the state to selectively contract with providers and competitively bid for goods and services. This has the potential to increase the quality offered and improve health while lowering expenditures.

Savings. Although estimating savings can always be challenging, Maine can look to Rhode Island's achievements. In December of 2011, the Lewin Group — in collaboration with the New England States Consortium Systems Organization and the Rhode Island Office of Health and Human Services — evaluated the effectiveness of the Rhode Island Global Consumer Choice Compact Waiver (Global Waiver) that CMS granted the state in January 2009. Lewin reported that Rhode Island saved $54 million over three years as a result of increased flexibility to move more of the Medicaid population into managed care, redesigned payment structures for certain services for children with special needs, and restructured provider reimbursement. The report also found that the provisions of the waiver allowed Rhode Island to claim $42 million in federal funds it would not otherwise have received. Maine could achieve similar results. Maine's system is certainly larger than Rhode Island but these savings numbers offer a conservative way of estimating Maine's potential.

Operational Flexibility and Recipient Choice. By delivering operational flexibility, a global waiver and redesign would create a stronger and more streamlined system that will identify recipients' needs, build service capacity, and enhance current-care management reforms to better meet the needs of the most vulnerable. Moreover, it would offer recipients greater choices. Having one waiver across all populations would allow DHHS to offer a service or benefit, currently only offered to one service population, to another population. For example, shared living, which is traditionally offered for the intellectually disabled population, could quickly be expanded for elders without an additional approval. It would allow flexibility — without requesting multiple waivers or initiating the state-plan amendment process over and over again — to pay providers based on providers meeting quality-care and value-based criteria rather than the current fee-for-service approach. It would allow innovative payment methodologies to encourage care coordination for all Medicaid 172ligible without exception.

Institutional Culture Change. A global reform through a Section-1115 waiver is not a panacea for all the challenges facing MaineCare, but it represents a critical first step in transforming an administratively dysfunctional system into a manageable, accountable, and transparent program focused more on health improvement than process. By creating one

system across the enterprise, a global reform would help the state breakdown the inherent silos that exist across and within each division of MaineCare and other health-related divisions at DHHS. And by setting the pace for reform, it would allow Maine to use more innovative ideas to improve care quality at a price taxpayers can better afford, while simultaneously providing recipients with more choices. Indeed, a global waiver has the potential — if fully embraced by the governor, the legislature, and DHHS — to change the institutional culture of the public-welfare system, eliminate more of the "institutional" bias of the Medicaid program, and reverse the unsustainable fiscal course that holds the state budget, and Maine's taxpayers, hostage.

Streamlined Reporting and Transparency. Currently, Maine has to write separate reports for every single Medicaid waiver. This process requires unnecessary paperwork, time, and employee-power. With limited resources, Maine can ill afford to be spending time or redundant government processes on bureaucratic paperwork; preparing multiple reports that do not comport and are not read by many people. A single global waiver, however, would allow the state to construct a transparent MaineCare report with performance metrics that might actually be read by employees, federal officials, and, more importantly, legislators, executive branch members, and taxpayers.

Bureaucratic Relief. Maine's commendable efforts to bring innovation to MaineCare have run up against the time, effort, and duration it takes in dealing with Washington, D.C., to make just minor improvements. But a global reform, if properly designed with maximum flexibility, would allow the state to expeditiously address the needs of the most vulnerable by adding, modifying, or deleting services across populations with far less intrusion and bureaucratic oversight from the federal government.

Scope of Authority Requested under a Section-1115 Waiver

Under the authority of Section 1115(a)(1) of the Social Security Act, the following "waivers" of state-plan requirements contained in Section 1902 could be requested in order to enable Maine to implement a global reform/waiver demonstration.[68]

1. State-Wideness/Uniformity, 1902(a)(1)

- To restrict services to certain geographical areas of the state;
- To allow aspects of the program to be phased-in to new areas during the demonstration and to allow program elements to be phased-in during the demonstration; and
- To enable waiting lists for optional Medicaid services and populations.

2. Reasonable Promptness, 1902(a)(8)

- To maintain a waiting list for optional services and optional populations; and

68. Although this list is comprehensive, it is not exhaustive. If Maine chooses a global reform path, it will chart a redesign course that is state appropriate and it may choose other sections to waive.

- To require applicants for long-term care services to complete a targeted assessment.

3. Comparability, 1902(a)(10)(B)

- To provide nursing facility or home- and community-based services based on relative need as part of a person-centered assessment and options-counseling process for new applicants for such services;
- To provide services under the demonstration that would not otherwise be available under the state plan;
- To limit the amount, duration, and scope of services;
- To tailor benefit plans for income groups with a higher-deductible plan (e.g., flexible account);
- To enable the state to vary the amount, duration, and scope of services offered to demonstration populations, regardless of eligibility category, by calculating the value of Medicaid benefits based on a risk assessment, depositing an amount equivalent to this value in a flexible account, and permitting demonstration populations to use these funds to select a health-coverage package offered by either a PCCM, MCO, or private insurer; and
- To enable the state to use the flexible-accounts funds as incentives and disincentives with rewards and penalties to move recipients towards independence. These would also be used to tailor benefit plans.

4. Covered Services and Wraparound Benefits, 1902 (a)(10)(a)

- To allow the state not to cover wraparound services.

5. Income and Resource Rules, 1902(a)(10)(C)(i)

- To allow recipients who choose home- and community-based care to retain more income and resources;
- To consider only the income and resources of an applicant when determining financial eligibility for individuals in specific coverage groups;
- To enable the state to treat state contributions to flexible accounts, health-savings accounts or healthy-choice accounts, which provide incentives/payments to recipients who reach certain prevention and wellness targets, as non-countable income and resources for purposes of eligibility or cost-sharing determinations; and
- To allow the state to use the community Medicaid income-and-resource rules for individuals seeking skilled nursing facilities services rather than long-term care rules.

6. Cost Sharing, 1902(a)(14), insofar as it incorporates Section 1916

- To expand cost-sharing requirements that exceed the statutory limits for recipients in certain populations;
- To utilize premiums;
- To charge ER copayments that exceed federal regulation; and
- To permit prepayments of a premium.

7. Freedom of Choice, 1902(a)(23)

- To restrict freedom of choice of provider through mandatory enrollment in a care-management option and through selective contracting. Also, to mandate premium assistance if applicable.

8. Provider Agreements, 1902(a)(27)

- To allow for the provision of care by individuals who have not executed a provider agreement with the state Medicaid agency.

9. Direct Payments to Providers, 1902(a)(32)

- To permit payments to be made directly to recipients or their representatives.

10. Retroactive Eligibility, 1902(a)(34)

- To waive the requirement that Medicaid be provided for only three months prior to the month in which an application for assistance is made.

11. Payment Review, 1902(a)(37)(B)

- To the extent that prepayment review may not be available for disbursements by individual recipients to their caregivers/providers.

12. Case-Management Flexibility

- To waive the requirements, if necessary, of case-management regulations so that Maine has flexibility to target care management.

13. Flexible Accounts, 1902 (a)(10)(C)(i)

- To enable Maine to exclude funds in a flexible account from the income-and-resource test established under state and federal law for the purposes of determining Medicaid eligibility.

14. Actuarial Soundness, CFR 438.6 (c)

- To enable the state to contract with MCOs (if the state chooses to do so) whose rates are below the amount determined to be actuarially sound. The state would contract with MCOs that meet all programmatic requirements and will obtain value and quality by contracting below the actuarially sound amounts. (The state does not currently utilize MCOs, but the demonstration would allow contracting with MCOs for a target population.)

15. Proper and Efficient Administration, 1902(a)(4) and 42 CFR 438.52, 438.56

- To permit the state to automatically reenroll an individual who loses Medicaid eligibility for a period of ninety days or less in the same managed-care plan in which he or she was previously enrolled, if applicable;

- To permit the state to restrict the ability of members to cancel, without cause, enrollment after an initial thirty-day period from a managed-care plan, and to cancel enrollment, with cause, to 365 days;
- To permit the state not to cover non-emergency transportation for certain populations.

16. To permit the state to align prescription-drug coverage to private coverage plans and to require that requests for prior authorization for drugs be addressed within seventy-two hours, rather than twenty-four hours, 1902 (a)(54)

- This waiver authority will allow the State to align prior authorization standards with standards in the commercial market.

17. To permit the state to provide coverage through different delivery systems for different Medicaid populations with different premium amounts, 1902 (a)(17)

- Also to permit retroactive coverage.

18. To provide federal financial participation on delivery-system reform-incentive payments, which are not reimbursement for health-care services and which do not apply for determining DSH spending or federal upper payment limits, 1902 (a)

19. The state may also attempt to request relief under Title XXI, namely:

- Sections 2102, 2103, and 2105 for benefit package requirements, cost-sharing, exemptions for certain populations, family-coverage limits, and employer-sponsored coverage.

Expenditure Authority Example. Under the authority of Section 1115(a)(2), the state might have the ability to add new service populations. Some examples might be:

- Expenditures for demonstration population No. 1: Parents pursuing behavioral-health treatment with children temporarily in state custody.
- Expenditures for demonstration population No. 2: Children who would otherwise be voluntarily placed in state custody.
- Expenditures for demonstration population No. 3: Elders at risk for long-term care and in need of home- and community-based service.
- Expenditures for personal-care services provided by caregiver spouses, adult children, or extended family members who provide care to disabled children, adults, or the elderly.
- Expenditures for incidental purchases paid out-of-cash allotments to participants who are self-directing their services prior to service delivery.
- Expenditures related to flexible health-care accounts.
- Expenditures related to periods of presumptive eligibility for individuals needing long-term care services.

Global Budget Cap. Although it is unlikely that CMS, under the current federal administration, would allow a state to impose a global, aggregate budget cap on its entire Medicaid program, a spending cap is the best way to spur innovation, impose accountability on

administrators and providers, and deliver value to recipients and taxpayers.[69] Currently, the norm is, that if a state spends a dollar it cannot afford, the federal government is pleased to match it with dollars it does not have. Rhode Island's spending cap, for example, allowed the state to save tax dollars, innovate, and improve service quality. Although critics debate whether the cap was the reason why the Ocean State saved money and changed the system, there is no debating the results. Over the five-year course of the waiver, from 2009 to 2014, Rhode Island lowered the cost curve and improved care quality. Some highlights from that experiment:

- Contrary to earlier projections of 7% to 8% growth, Medicaid expenditures came under control. Expenditures grew 5.3% in SFY 2010 and 0.9% in SFY 2011, but decreased 1.1% in SFY 2012.
- This lowering of the state's Medicaid spending trajectory came about even as the caseload increased 4.5% in 2010, 3.4% in 2011, and 2.1% in 2012.
- Declining per-member per-month (PMPM) costs also demonstrate efficiency gains: $813 in SFY 2010, $794 in SFY 2011, and $770 in SFY 2012.
- A comparison with national data from the federal HHS Office of the Actuary confirms the promise of the global waiver. Rhode Island's Medicaid-expenditure growth was projected to exceed the national average. Instead, the state's pattern now falls far below the estimated national-budget growth of 4.6% over the same four-year span. The estimated national-PMPM growth over the same period is 1.3%.

Global budget caps are designed to:

- promote cost-effective prevention and early intervention;
- eliminate services of questionable value;
- reduce excess health care system capacity;
- reverse the current incentive providers have under fee-for-service to provide more services to earn a higher income; and
- spur innovation because limitations drive urgency.

An aggregate cap on spending, however, can only work with real flexibility and the will to reform. The fiscal challenges facing MaineCare require prudent stewardship of federal and state resources. A budget cap can be a successful tool in controlling costs, spurring innovation to improve quality, and potentially reinvesting the savings to create new services for the most vulnerable populations.

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69. Health economists and others are increasingly promoting global spending caps or payments as a strategy to slow growth of health-care expenditures. A *New England Journal of Medicine* article examining health-care cost control options concluded that a promising payment reform is a global payment or cap to cover all health-care needs of a population of patients. An aggregate cap imposes the same type of cost control as a global payment. See James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, "Options for Slowing the Growth of Health Care Costs," *New England Journal of Medicine* 358, no. 14 (April 3, 2008).

Getting Started

The first step to achieving a global-waiver reform is to decide whether or not a single waiver with flexibility is appropriate for Maine. Once that decision is made, DHHS should host a series of internal meetings among senior staff to explore exactly what type of flexibility it would seek and what initiatives it would pursue. After these decisions are made, DHHS could pursue the following due-diligence steps:

1. Appoint the MaineCare director as the project lead. Since the MaineCare director oversees the majority of health-care related services at DHHS, he or she would be the appropriate project leader. The project leader would need additional support throughout this process since he or she would still maintain oversight over current operations.

2. Create a Medicaid Reform Office and staff the effort with one to two project managers not only to ensure that timelines and deliverables are met appropriately but also to alleviate any additional work on current MaineCare staff. Also, selectively choose one key staff member from each MaineCare division to work approximately twenty hours per week on this project — at a minimum, the reform office should have persons with the following expertise: financial and budget, program, policy/regulation, and data-mining management. This team of four to six persons will report to the project leader, and it can begin outlining and organizing the following steps:

    a. Potential deliverables and a project-management timeline;
    b. Potential provisions of federal regulation that the state might attempt to waive;
    c. Potential state law and regulation changes that might be necessary;
    d. As a condition of reform, researching health-care costs that are currently not matched by the federal government for potential federal Medicaid match;
    e. New initiatives the state might like to pursue;
    f. How the state might reform current programs using this new flexibility;
    g. How it might use the flexibility from waiving certain federal rules to pursue c and d above.
    h. Research the effect of an aggregate budget cap and whether or not the state would like to pursue this as part of the reform.
    i. Craft a preliminary internal concept paper of no more than fifteen pages to present to the commissioner that would outline steps a through d above.
    j. Outline a “with and without waiver” forecast model, including major eligibility groups and MMIS requirements, to establish baseline and methodology to determine costs for at-risk populations that could have been claimed to MaineCare but were not.

This process should take no more than three months and be kept under tight deadlines. The preliminary and internal concept paper should be presented to the DHHS commissioner and the governor’s office at the end of the three-month due-diligence period.

After careful deliberation and research, DHHS would then decide if this path to reform is appropriate. If the answer is in the affirmative, a detailed concept paper would then be drafted that would ultimately be shared with the federal government and for stakeholder input.

Conclusion

The pressing challenges of Medicaid, from its deeply entrenched institutional bias and growing caseload to its projected cost overruns and "crowding out" of state budgets, demand a proactive response. Without reforms across the entire enterprise, MaineCare's ability to serve the most vulnerable of populations — namely the intellectually disabled and indigent elderly — stands at risk, even as more and more of the abled-bodied population are added to the caseload. A global reform through a Section-1115 demonstration waiver, modeled after what Rhode Island secured in 2009, offers the best mechanism for Maine to redesign its MaineCare program, its payment structures and entire system, and secure its future. Maine needs the flexibility to create and manage a Medicaid program that is consistent with the state's needs and culture. Under the current national legal framework, a global waiver offers the best opportunity for Maine to create a broad outcome-based health system that will be recipient-centered and accountable. And by following a stakeholder model of global-waiver design that would value input from all facets of state government, recipients, and providers, the Pine Tree State would lead the nation by bending the cost curve, simplifying and streamlining its Medicaid system, and improving care quality.

Appendix A: Income Criteria for DHHS Programs

Chart A-1: TANF and PaS Income Tests

TANF and PaS Program Income Tests, Standard of Need, and Maximum Payment Charts for On-going Assistance Units

ADULT INCLUDED

BASIC				SPECIAL NEED					
Number in filing unit	Gross Income Test	S.O.N.	Maximum Grant	Gross Income Test	S.O.N.	Maximum Grant +	Special Need	= Total	Max. Gap
1	485	294	230	578	394	230	100	330	64
2	762	463	363	855	563	363	100	463	100
3	1,023	620	485	1,116	720	485	100	585	135
4	1,286	780	611	1,379	880	611	100	711	169
5	1,548	938	733	1,641	1038	733	100	833	205
6	1,811	1,096	856	1,904	1196	856	100	956	240
7	2,072	1,255	981	2,165	1355	981	100	1081	274
8	2,335	1,414	1,105	2,427	1514	1,105	100	1205	309
Additional Member	+262	+159	+124	+262	+159	+124	+100	+124	

ADULT NOT INCLUDED

BASIC				SPECIAL NEED					
Number in filing unit	Gross Income Test	S.O.N.	Maximum Grant	Gross Income Test	S.O.N.	Maximum Grant +	Special Need	= Total	Max. Gap
1	285	174	138	332	274	138	100	238	36
2	546	332	262	639	432	262	100	362	70
3	808	491	386	901	591	386	100	486	105
4	1,071	649	508	1,164	749	508	100	608	141
5	1,334	809	634	1,427	909	634	100	734	175
6	1,597	967	756	1,690	1067	756	100	856	211
7	1,859	1,125	880	1,952	1225	880	100	980	245
8	2,120	1,284	1,004	2,213	1384	1,004	100	1104	280
Additional Member	+262	+159	+124	+262	+159	+124	+100	+124	

7 CFR 273.9(a)(3), 273.10(e)(2)(ii)(C), 273.10(e)(4)(i) R12/13 #182-18

SNAP PROGRAM — BASIS OF ISSUANCE

December 27, 2013

48 States and the District of Columbia

These tables [on the next page] are extended to meet the needs of certain categorically eligible households. Therefore, the amounts shown on the tables are higher than the net income limits for some household sizes. Households which are not categorically eligible must have incomes below the appropriate income limits.

To determine a household's monthly benefit using the Basis of Issuance tables:

1) Calculate the household's net monthly income. Households which are not categorically eligible will have net monthly incomes which are lower than or equal to the amounts shown in Column C on this page [Chart A-2 on next page.].
2) Find the allotment by reading in the attached tables down to the appropriate income and across to the appropriate household size.
3) Persons in household sizes one and two and which are categorically eligible will be eligible for benefits of at least $15, even if the tables do not show a benefit amount at their net income levels.

To calculate the benefit manually (in lieu of Step 2 above) or if the household is size 21 or larger:

1) Multiply the net monthly income by 30 percent.
2) Round the product up to the next whole dollar if it ends in 1–99¢.
3) To obtain the household's allotment, subtract the result from the Maximum Benefit (Column D) for the appropriate household size. However, if the computation results in $1, $3, or $5, round up to $2, $4 or $6, respectively.
4) If the allotment is for a **one**- or **two**-person household and is less than $15, or is a negative number, round to the minimum benefit of $15 for one- or two-person households.

Chart A-2: **SNAP Income Tests**

Household Size	Monthly Income Elderly/Disabled Separate Household* 165% of Poverty	Maximum Gross Monthly Income* 130% of Poverty	Maximum Net Monthly Income* 100% of Poverty	Maximum Benefit
	Column A	**Column B**	**Column C**	**Column D**
1	$1,580	$1,245	$958	$189
2	$2,133	$1,681	$1,293	$347
3	$2,686	$2,116	$1,628	$497
4	$3,239	$2,552	$1,963	$632
5	$3,791	$2,987	$2,298	$750
6	$4,344	$3,423	$2,633	$900
7	$4,897	$3,858	$2,968	$995
8	$5,450	$4,294	$3,303	$1137
Each additional member	+ $553	$436	$335	$142

*Maximum Gross and Net Monthly Income figures are not used for computing the benefit amount. They are included as a reference for determining the household's eligibility.

Chart A-3: **Child Care Income Tests**

MAXIMUM INCOME GUIDELINES: CHILD CARE SERVICES

250% of the FY13 Federal Poverty Level or 85% of the SMI for State Funds (SPSS), Fund for a Healthy Maine (FHM) Child Care Development Funds (CCDF), Temporary Assistance to Needy Families (TANF).

Effective April 1, 2013 until further notice

FAMILY SIZE	ANNUAL INCOME	MONTHLY INCOME (ANNUAL/12)	WEEKLY INCOME (ANNUAL/52)
1	$28,756	$2,396	$553
2	$38,792	$3,233	$746
3	$48,828	$4,069	$939
4	$58,916	$4,910	$1,133
5	$68,952	$5,746	$1,326
6	$78,988	$6,582	$1519
7	$81,745	$6,812	$1,572
8	$83,561	$6,963	$1,607
9	$85,377	$7,115	$1,642
10	$87,194	$7,266	$1,677

Appendix B: Eligibility Criteria for DHHS-OFI Programs

Chart B-1: **Eligibility Criteria for all OFI Programs**

Administered by the Department of Health and Human Services
Office for Family Independence
January 1, 2014

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
Food Supplement -Federal Funds -State General Funds	• Low-income individuals residing in Maine • **Applicants/participants** must meet income and asset guidelines unless categorically eligible • U.S. citizen or qualified non-citizen • Time-limited eligibility period for able-bodied adults without dependents unless they meet certain exemptions. **Due to unemployment levels in Maine, this limited eligibility period has been waived by FNS until 9/30/2014.** • Post-secondary students must meet certain conditions • Some non-citizens may be eligible for state-funded benefits	• Gross income must be at or below **$2,116** per month (disabled or over 60 years old, no gross test) • Net Income must be at or below **$1,628** per month • No income test for categorically eligible • **185% FPL is $3,011 per month**	• **$2,000** asset limit for all households with no members age 60 or older • **$3,250** maximum asset limit if household consists of at least one member that is 60 years old or older and/or a member who is disabled • Must meet work-registration requirements • Individuals violating parole are not eligible • Individuals fleeing a felony conviction are not eligible • **Households can be categorically eligible if income under 185% FPL (eligible for TANF-Funded Maine Resource Guide)** • **Households that close due to certain TANF closure reasons, may receive a fixed Transitional Food Assistance benefit for up to five months.**	**$497**	$308 per month for a family of 3

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
SNAP-Education	SNAP eligible families and those up to 185% of FPL	• Families with income up to 185% of FPL. • **185% FPL is $3,011 per month**	Not applicable	No cash benefit. Families may participate in nutrition education classes designed to help participants eat healthy within a tight budget and be more physically active.	No cash benefit

TANF (Temporary Assistance for Needy Families)
 	
–TANF Block Grant
–State MOE
–Dedicated Funds from Child Support Collections used as MOE
	• Families with an eligible child
	• Eligible Child:
	  • Deprived of parental support.
	  • Under age 18.
	  • Living with parent or specified relative in Maine.
	  • U.S. citizen or qualified non-citizen.
	  • In need must meet income and asset guidelines.
	  • A child in involuntary child welfare custody is ***not*** an eligible child.
	• Women in last trimester.
		• Pretest: $1,023 month
		• Need Stand: $620 month
			• Asset limit of $2,000
			• Exclusions:
			• 1 Car
			• Home lived in
			• Family Development Accounts (FDA) ($10,000 Limit)
			• Must assign child support to state.
			• Must meet work participation requirements. (See item 5.)
			• Individuals violating parole are ***not*** eligible for TANF.
			• Individuals fleeing a felony conviction are not eligible for TANF.*
				$485 monthly basic
				$585 monthly with special needs housing allowance.
				(Up to $7,020 year basic grant with spec. needs housing allowance)
					$391 month

PaS (Parents as Scholars) –TANF Block Grant –State MOE	Same as TANF. Also, must: • Be enrolled full-time in 2- or 4-year degree program. • Not have marketable bachelor's degree. • Not have skills to earn at least 85% of Maine's median wage. • Be pursuing degree that will improve ability to support a family. • Be able to succeed in educational program chosen.	Same as TANF	• Same as TANF, and • Must meet assessments in accordance with ASPIRE-TANF rules.	Same as TANF	$464 month

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
RCA (Refugee Cash Assistance) –Federal Funds	• Refugee defined by federal government INS • No deprivation criteria. • Limited to 8 months beginning with land date. • Most eligibility criteria are same as TANF.	Same as TANF	• Assets in homeland not counted. • Income from resettlement agency not counted. • Income and assets from sponsor not counted.	Same as TANF	$268 month
Medical Review team determines disability claims for TANF-IC and MaineCare (Admin. Is cost allocated)	• Any disabled individual 21–65. • A disabled individual under age 22 and a student regularly attending school or college or training designed to prepare him/her for a paying job. • Children 18 years old or younger ineligible for any other MaineCare Program with a disabling condition.	N/A	Disabling condition is expected to last longer than 12 months.	N/A	MaineCare coverage
SSI State Supplement –State MOE (for MaineCare)	• Low-income individuals who do not have sufficient work quarter credits to get full Social Security benefits. The State Supplement supplements the SSI benefit, which is a cash benefit to low-income elderly and disabled individuals. Eligibility for SSI has nothing to do with work quarters for SSA. • Must be disabled or over 65 years old.	Income is based solely on the individual or couple and countable income must be below $720 for an individual and $1,081 for a couple.			• 1 Person = $10 month • 2 Person = $15 month

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
DDS (Admin is cost allocated.)	Disabled individuals up to age 65	N/A	Must meet SSA insured status or income and resource guidelines	N/A	SSA cash coverage
ASPIRE-TANF -TANF Block Grant -State MOE	• TANF and PaS recipients who must participate or who volunteer to participate in work activities. • See PaS also.	Same as TANF	• Complete assessments that inform individualized employment plans. • Must participate in work activities that may include employment, volunteer work, training and education.	No total maximum benefits for ASPIRE Support Services.	Approximately $3012 per year per participant for 2012.
Alternative Aid Assistance -TANF Block Grant -State MOE	Families who qualify for TANF benefits who seek short-term help to obtain or retain employment.	Same as TANF	• Alternative Aid is available once in any consecutive 12-month period. • Cannot be a TANF recipient. • Assistance is a vendor payment.	Up to $1,455 for 3 months.	$803 per benefit period.

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits

Emergency Assistance
 	
–TANF Block Grant
–State MOE
	• Families with eligible children.
	• Eligible child:
	  • Under 21 years.
	  • Living with specified relative in Maine or lived with specified relative within 6 mos. Prior to application.
	• Women in last trimester.
		• Entire household must get TANF, PaS, SSI, Food Stamps, or MaineCare.
		OR
		• Family's income must be below 100% of Federal Poverty Level $1,431 month.
			• Once-a-year limit.
			• Must be in specific crisis situations such as evictions and utility shut-offs.
			• Limited assistance per category of assistance.
			• Limited assistance must cure crisis.
				$600 per year	$91.06 per year

General Assistance –State General Funds	• Any resident of the State of Maine may apply. • There is not a length of residency requirement.	There are 2 budgets that need to be completed to determine eligibility. • The deficit is the difference between the applicant's income and the overall maximum for the household size. • Overall maximums vary. Some counties have two different overall maximums. The maximum changes each year and is 110% of the applicable housing fair-market rents established by HUD. • The other budget is the unmet need, which is the difference between the applicant's income and the households 30 day need. • The applicant is eligible for the lesser of the deficit or unmet need. No more assistance will be granted unless there is an emergency. The applicant is eligible for emergency assistance.	• This is a voucher program. The voucher is issued to the vendor. • Applicant is expected to use their income and resources to provide for their own basic needs. Clients are expected to apply for all other potential resources, TANF, SSI, Food Stamps, Unemployment benefits, and rehabilitative services. • Applicant may be required to perform Workfare for the municipality or a non-profit organization in exchange for General Assistance based on the individual municipality.	• The overall maximums vary by county and some counties have two maximums. • By averaging a household of 3 with zero income could receive $785 in assistance to help with basic needs.	In FY 2007, the average amount of assistance was $329.

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
Medical Coverage –Federal Funds –State MOE	For families with children ages birth to 18 years of age.	150% Federal Poverty Level (FPL) for children • $2,442 month for a family of 3 133% FPL for parents • $2,165 month for a family of 3 • 100% FPL in 1/2013 ($1,628 for a family of 3)	• Asset limit of $2,000 for a family. • No asset limit if coverage is for a child only.		Medical coverage Avg. Yearly benefit for a Adult = $4,104 Child = $1,500 (OMS is getting updates to these figures)
	Transitional Medical	No income limit for 6 months.	• 150% – 185% = 3% net income, OR • May qualify for expansion of C.R. 150%–200%		
	Elderly and Disabled	100% FPL • $958 single • $1,437 couple	Asset limit for the elderly and disabled is $2,000 for 1 and $3,000 for 2.		
	Disabled individual under age 22	100% FPL • $958 single • $1,437 couple			
	Non-categorical age 21 thru 64	No coverable group after 12/31/13			
	Pregnant Women	200% FPL • $3,255 for a family of 3	No asset limit		
	QMB	150% FPL • $1,341 single • $1,810 couple	• Must be eligible for Medicare Part B • $50,000 (single) $75,00 (2 or more people) liquid asset limit	Part B premiums are paid, also Part B coinsurance and deductibles	
	SLMB	170% FPL • $1,532 single • $2,068 couple	• Must be eligible for Medicare Part B • $50,000 (single) $75,000 (2 or more people) liquid asset limit	Part B premiums are paid	

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum **Benefits for a Family of 3 (1 Adult)**	Average Benefits
	Qualifying Individuals	185% FPL • $1,676 single • $2,262 couple	• Must be eligible for Medicare Part B coverage • $50,000 (single) $75,000 (2 or more people) liquid asset limit	Part B premiums are paid	
	Working Disabled	250% FPL • $2,394 single • $3,232 couple	• 150% – 200% = $10 premium • 200% – 250% = $20 premium		
	Low Cost Drugs for the Elderly and Disabled (DEL)	185% FPL • $1,676 for an individual • $2,262 for a couple			
		Terminated 3/2013			
	Maine Rx Plus	350% FPL • $5,697 for a family of 3			
	Limited Benefits for Persons HIV Positive	250% FPL • $2,394 for 1	• 150% – 200% = $231.04 premium • 200% – 250%% = $62.07 premium		
	CubCare	150% – 200% FPL • $2,442 – $3,255 for a family of 3	• Premiums $8 – $64 • Based on income and # of children covered		
(Medicare) DEL Program –State MOE (for MaineCare)	Part D help can be accessed through the Del program				
Child Support Enforcement –Federal Funds –State General Funds	Enforcement and collection activities on behalf of both welfare and non-welfare children.	N/A	• Establish paternity. • Existence or establishment of court order or administrative order.		To TANF households: • Up to the first $50 of Child Support goes to family as Pass Through.

Program	Who is Eligible	Income Guidelines for Families of 3	Other Criteria	Maximum Benefits for a Family of 3 (1 Adult)	Average Benefits
					Additional Child Support (to fill the GAP) depending on countable income of the family. • GAP is the difference between Standard of Need and TANF Payment Level.
TCC (Transitional Child Care) –TANF Block Grant –State MOE	• Families received TANF or PaS in 1 of 3 prior months. • Increased earnings or hours of work. • Eligible until youngest child turns 13 years old or becomes income ineligible. • Working families still eligible for TANF can opt off and get TCC.	Families' gross income must be equal to or less than 85% of the state's median income for the family size.	• Family pays fee of 2% to 10% of gross income compared to State's median income level. • Total amount of assessed fees to a family is capped at 10% of family's gross income. • Family remains eligible as long as parent remains employed, income is less than 85% of State's median income, and children are under age 13.	• There are individual caps for each child up to the State's CC Market Rate Survey. • Updated every 2 years.	Child Care Benefit
TT (Transitional Transportation) –TANF Block Grant –State MOE	Family members who obtained employment while on TANF or PaS and worked off the program.	• Less than 125% FPL – 24¢ mile up to $10 day. • 126% through 185% = 12¢ mile up to $5 day • 186% = 6¢ mile up to $1 day.	Eligible for up to 12 months if continue to working and remain off TANF.	See income guidelines	Transportation Benefit

Appendix C: Child Care Reimbursement Rates

Chart C-1: DHHS 2013 Child Care Reimbursement Rates

	Licensed Child Care Center				Licensed Family Child Care Maximum Rate				Unlicensed Child Care Maximum Rate			
	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time
ANDROSCOGGIN												
Infants	155.00	116.25	77.50	38.75	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
Toddlers	150.00	112.50	75.00	37.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	133.00	99.75	66.50	33.25	115.00	86.25	57.50	28.75	80.50	60.38	40.25	20.13
School Age	120.00	90.00	60.00	30.00	90.00	67.50	45.00	22.50	63.00	47.25	31.50	15.75
AROOSTOOK												
Infants	140.00	105.00	70.00	35.00	95.00	71.25	47.50	23.75	66.50	49.88	33.25	16.63
Toddlers	140.00	105.00	70.00	35.00	95.00	71.25	47.50	23.75	66.50	49.88	33.25	16.63
Preschool	125.00	93.75	62.50	31.25	90.00	67.50	45.00	22.50	63.00	47.25	31.50	15.75
School Age	76.00	57.00	38.00	19.00	85.00	63.75	42.50	21.25	59.50	44.63	29.75	14.88
CUMBERLAND												
Infants	225.00	168.75	112.50	56.25	160.00	120.00	80.00	40.00	112.00	84.00	56.00	28.00
Toddlers	215.00	161.25	107.50	53.75	155.00	116.25	77.50	38.75	108.50	81.38	54.25	27.13
Preschool	187.00	140.25	93.50	46.75	150.00	112.50	75.00	37.50	105.00	78.75	52.50	26.25
School Age	130.00	97.50	65.00	32.50	115.00	86.25	57.50	28.75	80.50	60.38	40.25	20.13
FRANKLIN												
Infants	145.00	108.75	72.50	36.25	117.50	88.13	58.75	29.38	82.25	61.69	41.13	20.56
Toddlers	145.00	108.75	72.50	36.25	115.00	86.25	57.50	28.75	80.50	60.38	40.25	20.13
Preschool	125.00	93.75	62.50	31.25	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50
School Age	115.00	86.25	57.50	28.75	90.00	67.50	45.00	22.50	63.00	47.25	31.50	15.75

	Licensed Child Care Center				Licensed Family Child Care Maximum Rate				Unlicensed Child Care Maximum Rate			
	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time
HANCOCK												
Infants	180.00	135.00	90.00	45.00	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	170.00	127.50	85.00	42.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	145.00	108.75	72.50	36.25	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
School Age	70.00	52.50	35.00	17.50	87.50	65.63	43.75	21.88	61.25	45.94	30.63	15.31
KENNEBEC												
Infants	160.00	120.00	80.00	40.00	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
Toddlers	145.00	108.75	72.50	36.25	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	120.00	90.00	60.00	30.00	110.00	82.50	455.00	27.50	77.00	57.75	38.50	19.25
School Age	125.00	93.75	62.50	31.25	90.00	67.50	45.00	22.50	63.00	47.25	31.50	15.75
KNOX												
Infants	170.00	127.50	85.00	42.50	135.00	101.25	67.50	33.75	94.50	70.88	47.25	23.63
Toddlers	170.00	127.50	85.00	42.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	160.00	120.00	80.00	40.00	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
School Age	75.00	56.25	37.50	18.75	120.00	90.00	460.00	30.00	84.00	63.00	42.00	21.00
LINCOLN												
Infants	170.00	127.50	85.00	42.50	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
Toddlers	160.00	120.00	80.00	440.00	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
Preschool	140.70	105.53	70.35	35.18	125.00	93.75	62.50	31.25	97.50	65.63	43.75	21.88
School Age	140.70	105.53	70.35	35.18	95.00	71.25	47.50	23.75	66.50	49.88	33.25	16.63
OXFORD												
Infants	145.00	108.75	72.50	36.25	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	136.05	102.04	68.03	34.01	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	128.74	95.06	63.37	31.69	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50
School Age	100.00	75.00	50.00	25.00	95.00	71.25	47.50	23.75	66.50	49.88	33.25	16.63

	Licensed Child Care Center				Licensed Family Child Care Maximum Rate				Unlicensed Child Care Maximum Rate			
	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time
PENOBSCOT												
Infants	160.00	120.00	80.00	40.00	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	158.00	118.50	79.00	39.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Preschool	140.00	105.00	70.00	35.00	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
School Age	100.00	75.00	50.00	25.00	110.00	82.50	55.00	27.50	77.00	57.75	38.50	19.25
PISCATAQUIS												
Infants	150.00	112.50	75.00	37.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	150.00	112.50	75.00	37.50	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50
Preschool	150.00	112.50	75.00	37.50	120.00	90.00	60.00	30.00	84.00	63.00	42.00	21.00
School Age	150.00	112.50	75.00	37.50	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50
SAGADAHOC												
Infants	175.00	131.25	87.50	43.75	135.00	101.25	67.50	33.75	94.50	70.88	47.25	23.63
Toddlers	170.00	127.50	85.00	42.50	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
Preschool	170.00	127.50	85.00	42.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
School Age	140.00	105.00	70.00	35.00	130.00	97.50	65.00	32.50	91.00	68.25	45.50	22.75
SOMERSET												
Infants	130.00	97.50	65.00	32.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	130.00	97.50	65.00	32.50	105.00	78.75	52.50	26.25	73.50	55.13	36.75	18.38
Preschool	136.51	102.38	68.26	34.13	105.00	78.75	52.50	26.25	73.50	55.13	36.75	18.38
School Age	65.00	48.75	32.50	16.25	76.00	57.00	38.00	19.00	53.20	39.90	26.60	13.30
WALDO												
Infants	187.00	140.25	93.50	46.75	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	185.00	138.75	92.50	46.25	120.00	90.00	60.00	30.00	84.00	63.00	42.00	21.00
Preschool	168.00	126.00	84.00	42.00	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
School Age	100.00	75.00	50.00	25.00	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50

	Licensed Child Care Center				Licensed Family Child Care Maximum Rate				Unlicensed Child Care Maximum Rate			
	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time	Full Time	Part Time	Half Time	Qtr. Time
WASHINGTON												
Infants	175.00	131.25	87.50	43.75	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
Toddlers	165.00	123.75	82.50	41.25	120.00	90.00	60.00	30.00	84.00	63.00	42.00	21.00
Preschool	135.00	101.25	67.50	33.75	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50
School Age	130.00	97.50	65.00	32.50	125.00	93.75	62.50	31.25	87.50	65.63	43.75	21.88
YORK												
Infants	195.00	146.50	97.50	48.75	150.00	112.50	75.00	37.50	105.00	78.75	52.50	26.25
Toddlers	185.00	138.75	92.50	46.25	140.00	105.00	70.00	35.00	98.00	73.50	49.00	24.50
Preschool	165.00	123.75	82.50	41.25	135.00	101.25	67.50	33.75	94.50	70.88	47.25	23.63
School Age	125.00	93.75	62.50	31.25	100.00	75.00	50.00	25.00	70.00	52.50	35.00	17.50

Infant means a child six weeks through twelve months of age.
Toddler means a child thirteen months through thirty-six months of age.
Pre-schooler means a child more than thirty-six months of age but not yet enrolled in full-time kindergarten.

	Full Time	Part Time	Half Time	Quarter Time
Infant/Toddler/Preschool	30+ hours/week	20–29 hours/week	10–19 hours/week	0–9 hours/week
School Age	30+ hours/week	11–29 hours/week	6–10 hours/week	0–5 hours/week

Table of Charts

List of Frequently Used Acronyms

ACO	Accountable-Care Organization
ACA	Affordable Care Act of 2010
ACES	Automated Client Eligibility System
AFDC	Aid to Families with Dependent Children
AG	The Alexander Group
ARRA	American Recovery and Reinvestment Act of 2009
ASPIRE	Additional Support for People in Retraining and Employment
BIP	Balancing Incentives Program
CC	Child Care
CCDF	U.S. Child Care Development Fund
CMS	U.S. Center on Medicare and Medicaid Services
CY	Calendar Year
DHHS	Maine Department of Health and Human Services
DRA	Deficit Reduction Act of 2005
DSER	Maine DHHS Division of Child Support Enforcement and Recovery
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FY	Fiscal Year
FMAP	Federal Medical Assistance Percentage
FNS	U.S. Food and Nutrition Service
FPL	Federal Poverty Level
GA	General Assistance
HCBS	Home- and Community-Based Services
HIPP	Health Insurance Premium Payment

HHS	U.S. Department of Health and Human Services
LTC	Long-Term Care
LTSS	Long-Term Services and Support
MA	Medical Assistance
MDOL	Maine Department of Labor
MMIS	Medicaid Management Information Systems
MOE	Maintenance-of-Effort (TANF program)
NASBO	National Association of State Budget Officers
OCFS	Maine's Office of Child and Family Services
OFI	Maine's Office for Family Independence
OMS	Office of MaineCare Services
PaS	Parents-as-Scholars program
PHIP	Private Health Insurance Premium Program
PNMI	Private Non-Medical Institutions
PMPM	Average cost, Per-Month Per-Member
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
SFY	State Fiscal Year
SCHIP	State's Children Health Insurance Program. Also known as CHIP.
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
TANF	Temporary Assistance for Needy Families
TCC	Transitional Child Care
WEI	Work Eligible Individual
WPR	Work Participation Rate

Contributors to this Report

Gary D. Alexander, J.D.

Gary D. Alexander is the founder, president, and CEO of the Alexander Group. He is a nationally recognized health-care and Medicaid expert, welfare reformer, and budget specialist. For more than sixteen years, he has transformed underperforming state health and welfare agencies into accountable, value-oriented, and data- and performance-driven systems by pioneering structural reforms and state-of-the-art technology solutions that have improved outcomes and quality, lowered health-care costs, reduced fraud and waste, re-engineered employment programs, modernized access, and eliminated budget deficits. A pragmatic and decisive leader, Alexander has a track record not only of identifying problems but also assembling the right mix of talent, policy makers, and stakeholders to generate data-driven solutions with quantifiable results to some of the most vexing challenges facing federal, state, and local governments.

Prior to founding the Alexander Group, Alexander served as Pennsylvania's secretary of public welfare as well as Governor Tom Corbett's senior health and welfare advisor from 2011 to 2013. In that dual role, he oversaw overall operations, management, and policy development for one of the largest public-welfare agencies in the nation, a department with a budget of $27.5 billion, six hospitals, five state intermediate facilities, ninety-four offices, more than sixteen thousand employees, and 2.2 million public-assistance recipients.

When he arrived in Pennsylvania, the state's Department of Public Welfare faced double-digit growth, an uncoordinated service structure, and a fragmented organization. To fix these problems, he crafted and implemented a cutting-edge plan to eradicate fraud and waste called the *Enterprise-wide Program Integrity and Improvement Initiative.* This initiative has been lauded by Medicaid and welfare-reform experts and earned the department a national innovation award for Excellence and Best Practice from the Council of State Governments.

Prior to his tenure in the Keystone State, Alexander pioneered similar reforms as Rhode Island's secretary of health and human services, and human-services director, from 2006 to 2011. He is the author and architect of the 2009 landmark Rhode Island Global Medicaid Waiver that, for the first time, delivered unprecedented flexibility to a state to redesign its Medicaid program. Relieving the state of burdensome federal mandates and requirements, this groundbreaking reform improved care quality, outcomes and access, lowered public costs, created more choices for recipients — including more appropriate care settings — and properly aligned services and benefits. The waiver's long-term care redesign is also being used as a

model of reform around the nation. In its first two years, the waiver not only saved the state approximately $100 million but also kept total Medicaid spending at billions of dollars below the agreed-upon spending limit. By improving quality, choice and access for recipients and introducing accountability into Medicaid, Alexander's initiative has been cited as a model of entitlement reform, particularly Medicaid and health care reform by various experts and publications, including the *Wall Street Journal* and the *Providence Journal*.

Alexander has worked on both sides of the aisle and has a reputation for reaching consensus to solve complex problems. Members of the U.S. Congress, state elected officials, and policy makers seek his advice on welfare and Medicaid reform. He holds a Bachelor of Arts from Northeastern University and a Juris Doctor from Suffolk University School of Law.

Murray M. Blitzer

Murray M. Blitzer brings to the Medicaid and human-services work of the Alexander Group more than thirty years of experience in public administration and finance with a specialty in Medicaid and human services. He was the chief financial officer of the Rhode Island Department of Human Services, overseeing a $1.5 billion budget and more than a thousand employees. He also served as a deputy to the Senate fiscal officer and as an advisor to the Senate majority leader in the Rhode Island legislature. In that later role, he implemented a budget hearing and review process that allowed state senators equal participation in formulating policy. Blitzer began his career in the Rhode Island State Budget Office, where he designed and implemented the structure for the state's Consensus Medical Assistance and Caseload Estimating Conference, applying professional forecasting tools to more than $2 billion in health-care and welfare spending. Throughout his public career, Murray has successfully worked to reduce the cost of government and deliver Medicaid services that have had a positive impact on the lives of many recipients. Blitzer holds a Bachelor of Science in resource technology and economics from the University of Rhode Island.

Donalda M. Carlson

A specialist in the field of family development and economic-support programs, Donald M. Carlson is the Alexander Group's expert on economic support, welfare eligibility, and welfare-to-work employment issues. Over a career spanning more than thirty years, she has held administrative and leadership positions focused on helping women, children, and low-income needy families through a broad range of services covering health education, basic and adult education, training and employment programs for public-assistance recipients, individuals with learning disabilities, prisoner re-entrants exiting the adult correctional institutions, and unemployed adults in need of job-related services and supports. Until 2010, Carlson was the associate director for the R.I. Department of Human Services Economic Support Programs, where she managed program development and implementation of service delivery of TANF,

Child Care Assistance, SNAP, FSET, and Medical Assistance programs. She also led the state's modernization and employment-reform initiatives. Noteworthy is her work in planning and restructuring eligibility staff and computer-processing systems leading to streamlined assessments, determinations, and case-management practices. She was also responsible for the redesign of Rhode Island's welfare-to-work program.

Throughout her career, Carlson worked extensively with state and federal governments as well as business and labor leaders, both locally and nationally. She served as special advisor to the State of Rhode Island in improving access and outcomes in early care and education for children, basic education, and post-secondary education for adults. And she has worked directly with community-based organizations in the delivery of a wide range of welfare-to-work programs. Additionally, she was a contributing resource in planning and developing a more effective "System of Care" for children affected by abuse and neglect within their homes and communities.

Carlson has not only served on numerous boards and commissions that have been charged with employment and placement services but also worked with public and private contract providers to assist unemployed and under-employed. She has worked with legislators and state government leaders in all areas of administration, reporting, and program integrity in all assistance programs within Rhode Island.

Steve Kogut, Ph.D.

A senior associate with the Alexander Group, Dr. Kogut specializes in pharmacoeconomics and managed-care pharmacy. His scholarly contributions span across a range of topics, including health economics and policy, public health, and health-care systems. He has worked with various national stakeholders to improve medication use in populations, including the Center for Medicare and Medicaid Services (CMS) and the Pharmacy Quality Alliance. His state-level activities include projects with the Rhode Island Medicaid pharmacy program and with Healthcentric Advisors, the state's Medicare-contracted Quality Improvement Organization.

Dr. Kogut is an associate professor of pharmacy practice at the University of Rhode Island and a registered and practicing pharmacist. A former member of the Rhode Island Board of Pharmacy, Dr. Kogut is currently a member of the State of Rhode Island Medicaid Drug Utilization Review Board. He holds a Ph.D. from the University of Rhode Island, an M.B.A., Bryant University, and a B.S. in Pharmacy from the University of Rhode Island. Published widely in scholarly journals, his research focus is the application of pharmacoeconomic research in managed-care environments; the evaluation of health-information technologies; quality in medication use; technologies for improving medication use; and off-label prescribing.

Robert W. Patterson

A social, welfare, and health-care policy analyst, Robert W. Patterson has eighteen years of senior-level policy experience — including serving in the George W. Bush administration and the Thomas W. Corbett administration of Pennsylvania — as policy advisor, speechwriter, professor, editor, and op-ed columnist. As a political appointee at both federal and state levels, he has worked closely with top-level government officials to generate solutions to problems and helped those administrations advance policies that focus on rebuilding the social and economic foundations of the American middle class.

Prior to joining the Alexander Group in 2013, Bob served as a senior policy advisor to Gary Alexander, then secretary of public welfare of the Commonwealth of Pennsylvania. From 2004 through 2009, Patterson served in the Bush administration as a policy advisor and speechwriter at the U.S. Department of Health & Human Services and as the senior speechwriter at the U.S. Small Business Administration. He also served as a staff consultant to the White House Task Force for Disadvantaged Youth.

Between 2009 and 2012, Bob served as an adjunct professor of government at Patrick Henry College in Purcellville, Va., teaching an upper-level course on political rhetoric and speechwriting. Also during that time, Bob was the editor-in-chief of *The Family in America: A Journal of Public Policy,* the flagship quarterly of the Howard Center for Family, Religion & Society based in Rockford, Illinois. In that role, Bob transformed what had been a monthly monograph series into a respected journal and launched a new website and the journal's symposium series on Capitol Hill. In addition to his scholarly work for *The Family in America*, Bob has been a regular op-ed contributor to the *Philadelphia Inquirer* as well the *Washington Examiner* and *National Review Online.* His writings have also appeared in the *Daily Beast,* the *Claremont Review of Books*, and the *Weekly Standard.*

Bob holds a bachelor's degree from Cairn University in Philadelphia as well as graduate degrees from Wheaton College in Illinois and Westminster Theological Seminary in Philadelphia.

Erik D. Randolph

Erik D. Randolph spent twenty-eight years of his professional career in government, including twenty-one years with experience in fiscal analysis of legislation and government programs that involved determining fiscal impacts, forecasting costs and revenues, budgeting, and working with financial and economic models. He began his career as a program evaluator with the U.S. General Accounting Office, which was renamed the Government Accountability Office in 2004. He then worked five years for two different states in the fields of economic development and science and technology policy. Afterwards, he achieved the position of senior analyst for Chairman Dwight Evans (D) of the Committee on Appropriations, Pennsylvania

House of Representatives. He also spent two years as a special policy and fiscal assistant advising Mr. Alexander when he served as secretary of public welfare under Governor Tom Corbett (R) of Pennsylvania. He has taught principles of economics for seventeen years. He holds a Master of Science degree from Rensselaer Polytechnic Institute and two bachelor degrees from the Pennsylvania State University.

Jennifer M. Wier

Jennifer M. Wier is a C.P.A. with more than seventeen years of experience. She has expertise in Medicaid and is also knowledgeable about information systems, systems modeling, and data mining. Since 2009, she has been a member of the Division of Arkansas Legislative Audit, where he has reported on all Medicaid and human-service programs to the General Assembly and has acted as an independent liaison between legislators and program administrators. In that role, she has not only analyzed the program from both quantitative and qualitative perspectives, but she has also audited its financial and policy components. Well versed in federal Medicaid regulations, she has also assisted in the drafting of legislation affecting several components of the program in Arkansas, including provisions affecting provider enrollment and the creation of the Office of Medicaid Inspector General. She has a Bachelor of Science in accounting from the University of Arkansas, Little Rock, and is a member of the Arkansas Society of Professional Accountants and the Arkansas Information System Audit and Control Association.

The Alexander Group, LLC (AG) is a government and business consulting firm that delivers cutting-edge data-driven solutions, strategic-business development, and innovative health-care and technology platforms — to improve efficiency, effectiveness, and quality for our clients. AG possesses unique expertise in the government health-care marketplace, built upon two decades of not only operating large-scale health and human-services agencies but also pioneering reforms that saved states billions of dollars and improved service quality. Founded in 2013 by reformer Gary D. Alexander, the firm is the only group of public officials who have designed, implemented, and managed nationally acclaimed reforms like the *Rhode Island Global Medicaid Waiver* and, in Pennsylvania, *The Enterprise-Wide Program Integrity Plan* and *The Health and Human Services County Block Grant*.

The firm's specialties range from health-care and social-welfare to management consulting — including but not limited to health-care plan design, Medicaid, Medicare, long-term care and accreditation services — to organizational design and restructuring, transportation, transaction assistance, and legislative and fiscal analysis. AG helps states and localities navigate the intersection of business and public policy while identifying opportunities that enhance the bottom-line and advance the health and well-being of citizens. Rather than remediate complex and outdated health-care plans or assistance programs piecemeal, we help states reform and restructure their entire health and human services systems. Deploying cost-effective savings methodologies to ensure a value-, transparent-, and efficiency-based system, our reforms drive innovation, improve service quality and performance, incentivize accountability and consumer engagement, modernize operations, and root out fraud, waste, and abuse.