Long-Term Care Reform:

A Status Report

February, 1997

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Governor

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Commissioner

Fast Facts

Long-term Care in Maine

- The Department of Human Services spent $270,794,735 on long-term care services for 28,438 individuals last year.
- 90% of Maine adults believe that home is the preferred place to receive long-term care services.
- Only 13% of people using DHS-funded services received care at home in 1996.
- 80% of public long-term care dollars were spent on nursing homes in 1996.
- In the first six months of this fiscal year, more people were served in home care than in all of the previous year.
- 23% of Maine adults age 45+ are caring for an elderly family member.
- Adult day care programs grew last year from 29 to 40 programs statewide.
- The changes to the MED96 (Medicaid Medical Eligibility Determination) assessment allowed an additional 579 people to qualify for nursing facility care.
- Residential alternatives to institutional care doubled last year.
- Re-organizing home care programs reduced administrative costs by 20%.
- Medicaid now pays for 65% of nursing home residents, compared to 81% in 1993.

TABLE OF CONTENTS

Background 1

Long-term Care Initiative 3

Expanding Long-term Care Choices 5

Universal Pre-Admission Assessment 5

Residential Services 7
Development Activities 7
"Spousal Impoverishment" for Residential Care 8
Residential Care Case Mix Project 9
Adult Family Care Homes 10
Assisted Living Facilities 11

Home Care, Adult Day Programs and Respite Services 12
Home Care 13
Adult Day and Respite Services 14

System Improvements 14

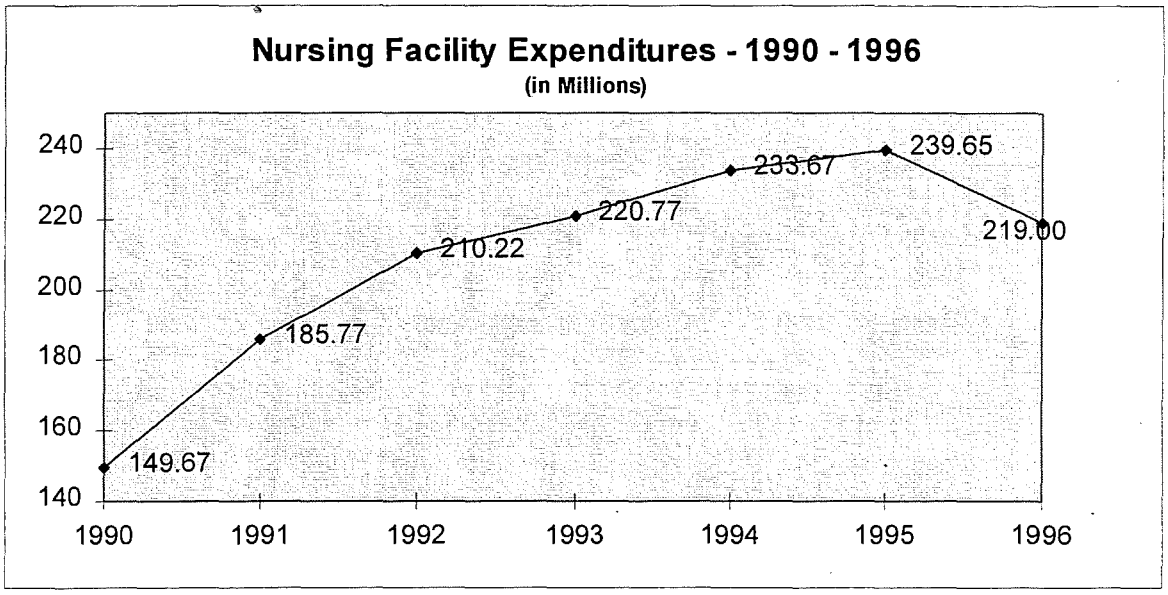
Long-term Care Steering Committee 14
Long Term Care Ombudsman Program 15
MED '96 Changes 15
Nurse Practice Act 16
Paperwork Reduction Task Force 17
MaineNET 17
New England Dual Eligible Consortium 19
Vision Group 20

Conclusion 21

Appendix A Nursing Facility Discharges by Payment Source
Appendix B Selected Long-term Care Statistics
Appendix C Residential Care Development
Appendix D Nursing and Residential Care Facilities by Hospital Service Area
Appendix E Long-term Care Steering Committee
Appendix F Paperwork Reduction Task Force
Appendix G Vision Group

Background

What caused the 1993 push for reform of Maine's long-term care system? At that time, there was a projected billion dollar deficit in the biennial budget. With only a slight increase in the number of persons served, long-term care costs had jumped almost 50% in the previous three years.



Seeing an opportunity simultaneously to save money and to implement older and disabled people's long-standing desire for alternatives to nursing homes, the 116th Legislature's Human Resources Committee fashioned a package of reforms. *The goal was to reduce reliance on expensive institutional care and to offer consumers more choices.*

Reinforcing this new policy direction was data showing that ten percent of nursing home residents had few, if any, nursing needs. The Human Resources Committee also looked to a series of reports, going back to 1980, which recommended "balancing" the long-term care system. Senior and disabled advocates strongly supported the reforms.

Eligibility for Medicaid-funded nursing home care changed to focus on persons with greater medical needs. The legislation also required nursing homes to maximize Medicare reimbursement (all federal funds) by certifying more beds for skilled care. In addition, the reforms closed loopholes that allowed nursing facilities to add beds, and costs to Medicaid, without specific legislative approval.

The long-term care system is complex and the components are highly interdependent. Every change had a ripple effect throughout the system. The Department, providers, and

families faced the formidable task of managing multiple changes in a short time frame. Pressed to meet budget and statutory deadlines, the Department did not fully anticipate the difficulty the changes would cause for families, or the degree of provider resistance to reform.

Efforts to offer alternatives to institutional care ran into problems because:

- All but a few nursing facilities refused to convert beds to less expensive forms of care. This created a shortage of residential alternatives for people denied nursing home admission.
- There were not enough funds for home care (half of the projected savings went toward the state budget deficit).
- Under the new eligibility rules, some individuals with dementia did not qualify and there were few residential alternatives for them.
- Nursing homes continued to admit private pay and Medicare residents who spent their personal resources, or used up their Medicare benefit, only to find they did not meet the state's new admission standards.
- The Department initially did not invest enough resources in educating families about the changes.
- Legal Services for the Elderly (LSE) filed a lawsuit in federal court claiming the changes in Medicaid admission criteria violated federal law. After the Court dismissed most of the claims, LSE and the Department agreed to settle the case.

Despite the problems, there were many positive changes:

- The Department adopted a "case mix" reimbursement system for nursing homes, under which homes received higher payments for residents with more impairments. The result was a dramatic decline in the number of "heavy care" patients who used to wait in hospitals, sometimes for months, for an available nursing home bed.
- Medicare (all federal funds) admissions increased significantly, which saved the State money.
- The percentage of nursing home residents supported by Medicaid decreased from 81 percent to 65 percent.
- Nursing home occupancy began to decline, which has resulted in more nursing homes deciding to convert some beds to less restrictive, less expensive forms of care.
- Use of home care, adult day care and caregiver respite programs increased.

- Universal pre-admission screening for all nursing facility applicants gives families information about all service options.

Long-term Care Initiative

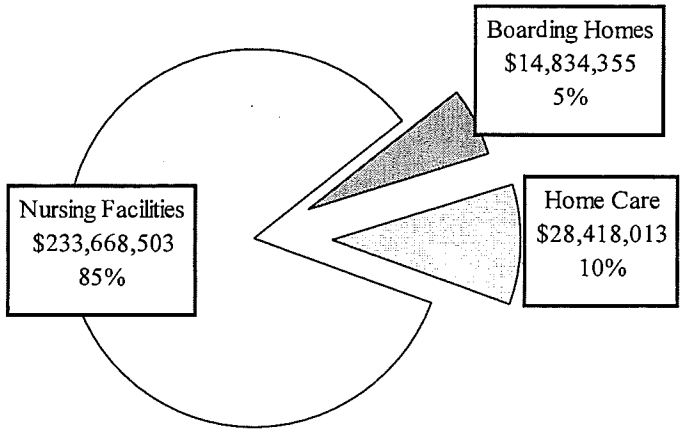
In 1996, Governor King made long-term care one of his three legislative priorities, in order to advance the effort to offer consumers more appropriate and more affordable choices. The goal is a long-term care system that will:

- *respect the dignity and choice of the individual*
- *support families in their caregiving responsibilities*
- *foster independence*
- *be affordable*
- *protect vulnerable people from abuse, neglect and exploitation*

Governor King's initiative, which received strong bipartisan support from the Legislature, signaled the start of a major re-programming of state and federal funds to support a more consumer-focused service system. Funding came from savings in the Medicaid account. The initiative also reflected a commitment to create a regulatory environment that would be more friendly to new models of service delivery. The legislation:

- Expanded home care, respite, day care, and residential services.
- Created a new regulatory framework for assisted living and funded programs for low income people.
- Encouraged nursing homes to create special units for persons with Alzheimer's disease who need supervision, but not nursing care.
- Revised the Certificate of Need Act to eliminate unnecessary requirements and allowed nursing facilities to "bank" excess beds.
- Changed the medical standard for nursing home admission to include more people with dementia and behavior problems, pending the development of more appropriate residential alternatives.
- Authorized the State to pay nursing homes for residents who are no longer eligible, until a safe and appropriate placement is available.
- Added staff for the Long-term Care Ombudsman Program (LTCOP), which investigates complaints of long-term care consumers.
- Amended the Nurse Practice Act to allow greater use of unlicensed assistive personnel.
- Established a Long-term Care Steering Committee, composed entirely of consumers and family members, to advise the Commissioner of Human Services.

Long Term Care
State and Federal Expenditures - FY 94
(July 1, 1993 - June 30, 1994)



Long Term Care
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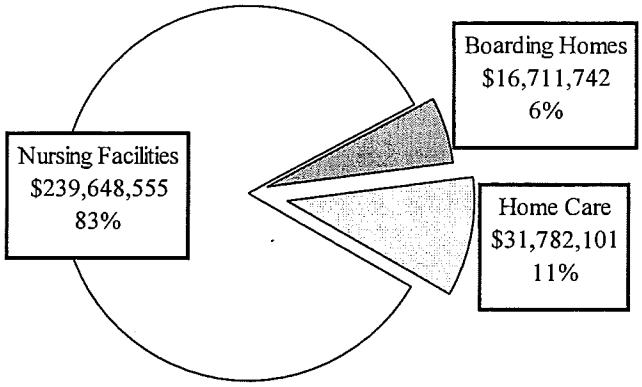
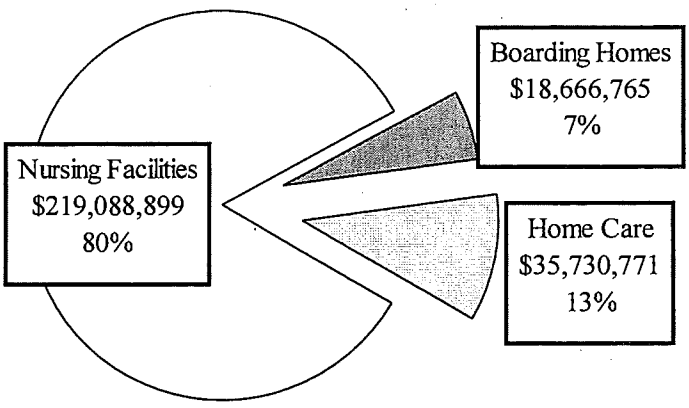
(July 1, 1994 - June 30, 1995)



Long Term Care
State and Federal Expenditures - FY 96
(July 1, 1995 - June 30, 1996)



Expanding Long-term Care Choices

Universal Pre-admission Assessment

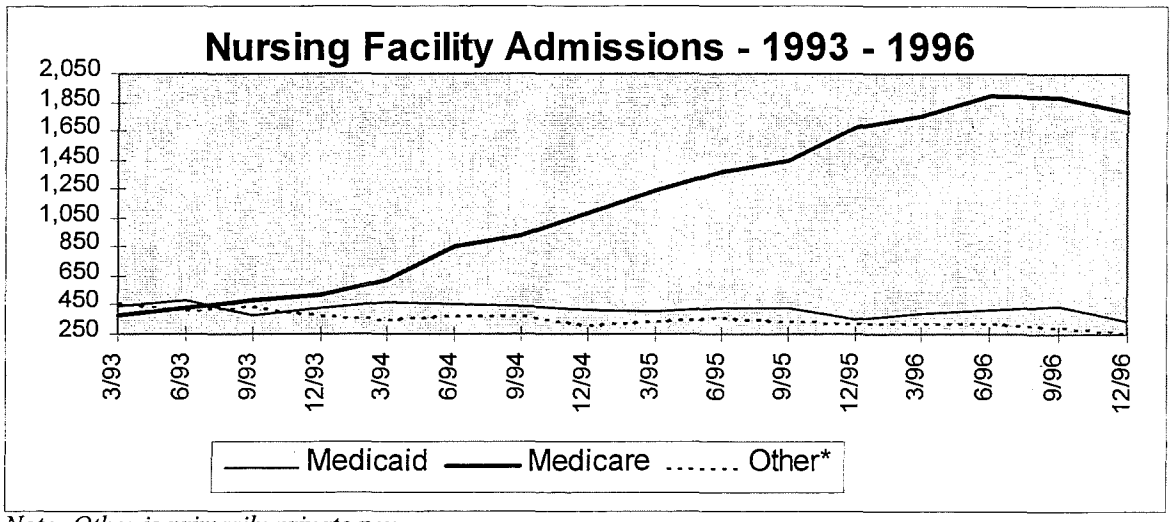
In 1993 the Legislature enacted a voluntary long-term care assessment program. In 1995 the program became mandatory for all persons seeking nursing home placement, regardless of payment source. The change was a response to nursing homes still admitting private pay residents who would spend their own resources, only to find they did not meet Medicaid's new medical standards for nursing home eligibility.

The assessment, performed by a registered nurse, and usually at the person's home, assists individuals and families to better understand what kinds of long term care services are available. We believe that if families have information earlier, they can make more prudent use of their own resources and delay reliance on public support.

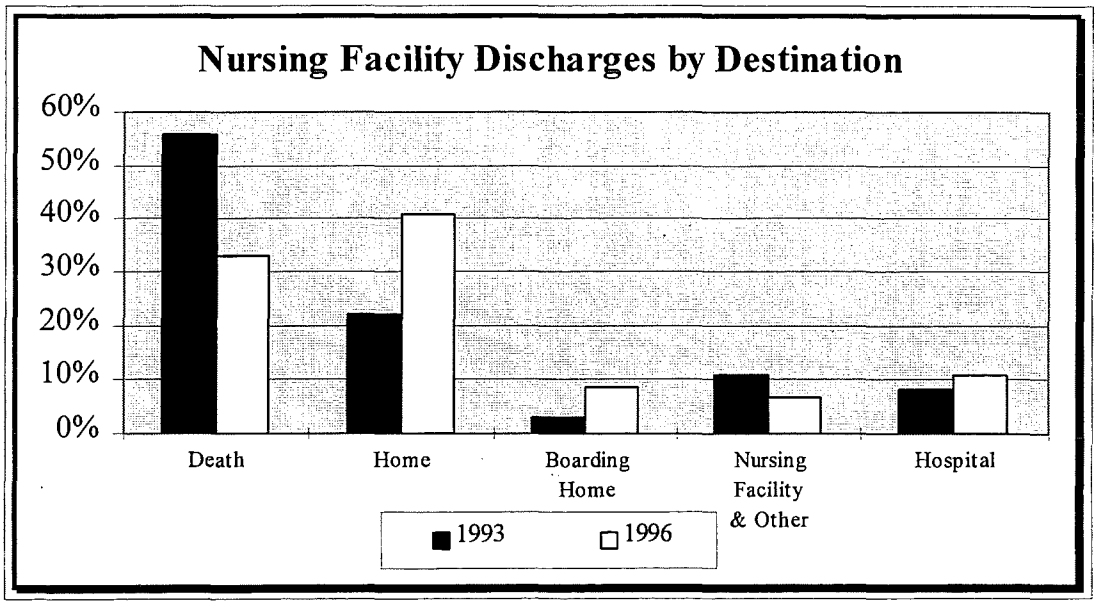
Since July 1996 Senior Spectrum, an area agency on aging, has managed the assessment program statewide. The Bureau of Elder and Adult Services (BEAS) awarded the contract to Senior Spectrum using a competitive bidding process. During the last six months of 1996, Senior Spectrum performed more than 8000 assessments. This total includes assessments for Medicaid medical eligibility as well as "advisory," or informational, assessments for persons who are in the early stages of planning for their care. The number of assessments is three times higher than expected and reflects the need to better inform families about long-term care options. The BEAS contracted with the Muskie Institute to evaluate the assessment service. The data suggests that the process, while complex, is successfully providing consumers and caregivers with information that is perceived to offer realistic options for long term care services.

Before pre-admission assessments, Medicaid paid for 81% of all nursing home residents, significantly higher than the national average of 50 percent. Once admitted, few people were discharged back to their own homes.

Since pre-admission assessments Medicaid now pays for only 65% of nursing home residents, resulting in a significant saving to the state budget. With the increased use of Medicare funds has come more focus on rehabilitation and discharge planning. In 1993, only 22% of nursing home discharges were to home. In 1996, that figure was up to 41%. (See Appendix A.)



Note: Other is primarily private pay.
Source: Maine Case Mix Demonstration Project, 1/97 Reports, Muskie Institute.



Source: Maine Case Mix Demonstration Project, 1/97 Reports, Muskie Institute.

Residential Services

Nursing and residential care capacity is measured in "beds" per 1000 persons age 65+. At 56 beds/1000 elderly, Maine has more nursing home beds than the national average of 50 beds/1000. Maine also pays nursing facilities at a higher rate than the national average. (See Appendix B). While there is no national standard for residential care, the Department initially established a standard of 20 beds/1000 elderly.

Residential services may delay, or even prevent, placement in a more institutional setting, such as a nursing home. They include residential care facilities (boarding homes), small adult family care homes, retirement homes, congregate housing services programs and upscale retirement communities. Maine needs more of all these alternatives to institutional care.

In 1996 the Legislature approved several changes intended to ease the development of more affordable residential long-term care services. The Certificate of Need Act (CON) was amended to eliminate the requirement that nursing homes obtain a CON in order to convert nursing facility beds to other levels of care. Nursing homes now may "bank" beds and, when need can be demonstrated, bring those beds back into operation under an expedited CON approval process. Since April 1996, 20 nursing facilities have "banked" a total of 286 beds.

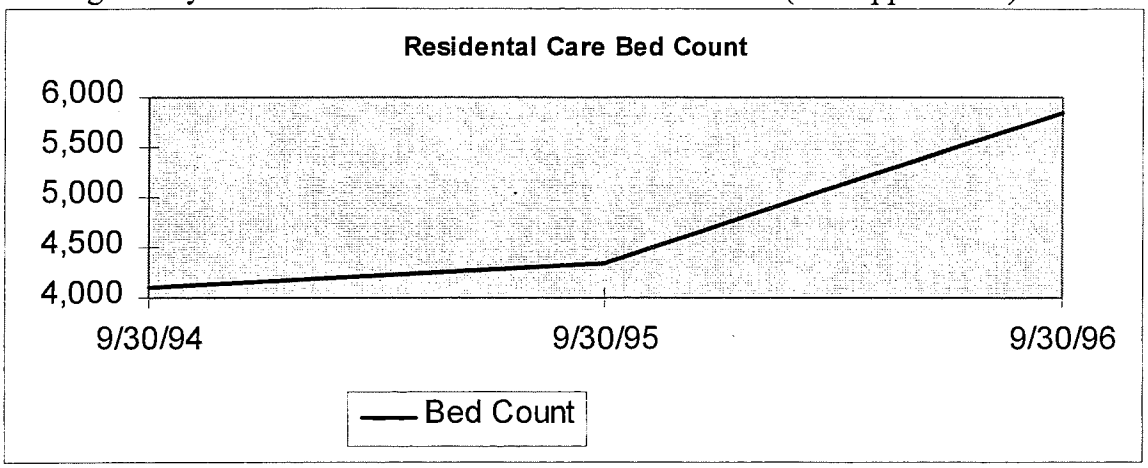
Responsibility for CON approvals for other long-term care projects was transferred to the Bureau of Elder and Adult Services. BEAS also works with the Bureau of Medical Services' (BMS) Licensing and Financial and Reimbursement Services divisions, the State Fire Marshal's Office and the Division of Audit. Each of these agencies is involved with proposed conversion projects before they can begin operation. No work can begin on a conversion application until the facility submits adequate cost and staffing data, which are necessary to evaluate the financial feasibility of the proposed conversion.

Many nursing homes express frustration at the time required to complete a conversion project. The Department continues to look for ways to simplify the parts of the process that are under DHS aegis.

Development Activities

The Department has consistently encouraged nursing homes to convert excess bed capacity to residential care, a less expensive, less medical model of services. DHS also funded the development of new, specialized residential care facilities to serve persons with dementia, such as Alzheimer's, mental illness and head injury. *Since 1993, 1049 new "beds" have come on-line, more than half of that total during 1996.* The new beds include 550 beds at 31 nursing homes that were converted to residential level of care. (See Appendix C)

In spite of the significant increase in residential alternatives, Maine still has too many nursing facility beds and too few residential care resources. (See Appendix D)



The Bureau of Elder and Adult Services intends to fund construction of up to 300 additional residential care beds, using a competitive bidding process that will give priority to "under-bedded" areas of the state. The decision to go with new construction was based on new facilities being less expensive than nursing home conversions, and in some parts of the state, nursing homes are still reluctant to convert beds to residential care. Any uncommitted funds from this process will support other residential models that the Bureau will develop in partnership with Maine State Housing Authority and the private sector.

Funds from a federal Alzheimer's demonstration grant support training for residential care providers. Maine is only one of ten states nationwide to receive one of these grants. Grant funds also support Geriatric Evaluation Units in Biddeford (University of New England), Steep Falls (Sacopee Valley Medical Center) and Penobscot County (Community Health and Counseling).

"Spousal Impoverishment" for Residential Care Services

Medicaid pays for nursing home care and residential care. Medicaid expects residents to contribute towards the cost of their care in both settings. There are differences between nursing home and residential care in what income can be "deducted" or disregarded, before the balance must go toward the person's cost of care. The rules for residential care are set by state policy. For most people, the Department takes the person's gross monthly income and deducts an allowance for payment of the Medicare premium, and $70 for personal needs. The rest must be used to pay for the cost of room and board in the facility. Medicaid reimburses only for services in a residential care facility, not room and board. Room and board cost, to the extent the resident cannot pay them, are subsidized by the state with all state funds. Residential care is considered "community care" under Medicaid federal rules and there is no penalty for transferring assets, as there is when one applies for nursing home care. Maine is one of only six states that provides Medicaid reimbursement to people in residential care facilities.

The policy is different in a nursing home. Federal law allows more deductions before determining how much the resident must contribute towards the cost of nursing home care. One of the allowable deductions is an allocation to the spouse at home. Federal rules allow the spouse at home to receive up to $1295/month and to keep $79,000 in assets, in addition to the home. Other assets must be used to pay for nursing home care unless they were transferred for fair market value, or transferred 36 months before applying for Medicaid.

The differences in financial eligibility rules between these two settings of care can create difficult choices for families. The federal nursing home rules provide a powerful financial incentive to keep a spouse in a nursing home. Assuring the financial security of the spouse in the community can become a higher priority, even when residential care may be more appropriate and less costly.

A group composed of Department, Legal Services for the Elderly, Ombudsman and Alzheimer's Association staff reviewed the issues and agreed that the State should provide some subsidy to the community spouse of persons in residential care facilities. Advocacy groups favor a policy that would apply the federal nursing home rules to residential care settings. The estimated General Fund cost would be $1,400,000 annually. The Department proposes a more modest solution that would subsidize the community spouse up to 100 percent of poverty ($645/month) and cap assets at $2,000. This is the same asset limit imposed on eligibility for other "community" Medicaid services. The estimated General Fund cost is $300,000 annually and the Governor has included this request in the Part II budget.

Residential Care Case Mix Reimbursement Project

Residential Care case mix is one aspect of the Department's long-term care initiative. One of the goals of the initiative is to increase options for consumers. In order to increase the number of residential care options for consumers, the Department wants to ensure there is an equitable payment system that recognizes the amount of resources utilized in caring for residents and ensures the quality of services provided.

The following are the goals of the Department's Residential Care Case Mix Initiative:

- Improve the quality of care and quality of life for residents.
- Improve methods to monitor and improve the quality of life.
- Provide incentives to facilities for residents to "age in place."
- Improve equity of payment to providers.

The benefits of Case Mix reimbursement for residential care facilities include:

- Facilities staff at levels that meet their residents' needs.
- Facilities can increase their reimbursement by admitting residents in higher case mix groups.

- Facilities can maintain their reimbursement by admitting residents in case mix groups like their base year residents' case mix group.
- Facilities receive increased reimbursement for residents whose care needs increase through time.

The process for implementing case mix includes the following steps:
- Comprehensive, accurate assessment of client's strengths, needs and preferences. (Accomplished)
- Time study to determine resource utilization for clinical characteristics. (Accomplished)
- Development of payment groups.
- Development of reimbursement methodology.

Provider Work Groups convened by the Bureau of Medical Services:
- Quality Workgroup
  Reviewed data provided on resident characteristics
  Reviewed draft quality indicators and made suggestions for new quality indicators
- Reimbursement Workgroup
  Reviewed the differences between case mix resident assessment and eligibility assessment.
  Reviewed reimbursement methodologies: cost-based and price-based
- Joint Quality and Reimbursement Workgroup
  Trained Case Mix review nurses on the distinctiveness of the residential care service setting
  Drafted salary survey

The BMS conducts monthly training on the comprehensive assessment for facility staff across the state; visits facilities to provide training on the comprehensive assessment; provides facility specific and statewide average data on resident characteristics and facility quality indicators; and provides statewide training on new methods for all providers.

Adult Family Care Homes

Adult Family Care Homes serve small groups of residents (no more than five) in a home-like setting. The cost is generally one-half that of institutional care and these homes are popular in states such as Hawaii, Colorado, Oregon and Washington. They are a good alternative for individuals who need someone available around the clock, but do not have the level of medical needs that would qualify them for nursing facility level of care.

The Legislature limited development to no more than twenty Medicaid-funded homes and twenty private pay homes, in response to reports about quality problems in homes in the West. Development has been slower than the Department anticipated. To date, seven homes have licenses and are approved for Medicaid residents. The homes are in Brewer, Bangor, Lee, Lincoln, Cherryfield, Rangeley, and Topsham.

Family care home operators must participate in nine days of training. Homes also must meet fire safety and architectural accessibility standards. Operators may have licenses for no more than two homes. The reason for the two home limit is to avoid situations where one operator might manage a "chain" of small homes. This practice would not be not consistent with the Adult Family Care Home model where the operator lives in the home. We believe this requirement has discouraged some developers who wanted to build a number of homes and then lease them to live-in operators. The initial financial investment has also been a barrier to individuals or couples considering this business.

Five of the seven homes used Maine State Housing Authority (MSHA) funds to finance renovations. MSHA has issued a Request for Proposal to finance two new homes and three renovation projects.

Assisted Living

Assisted living is an emerging, and popular, model of long-term care. Housing and services are customized to the needs of the individual. A person rents an apartment and then buys services depending on his or her individual needs. Most assisted living projects serve higher income elders. Since 1981 Maine has had a small program, the Congregate Housing Services Program, that provides limited supportive services, such as meals and housekeeping, to tenants living in subsidized elderly housing. It serves about 200 people each year at 25 sites statewide.

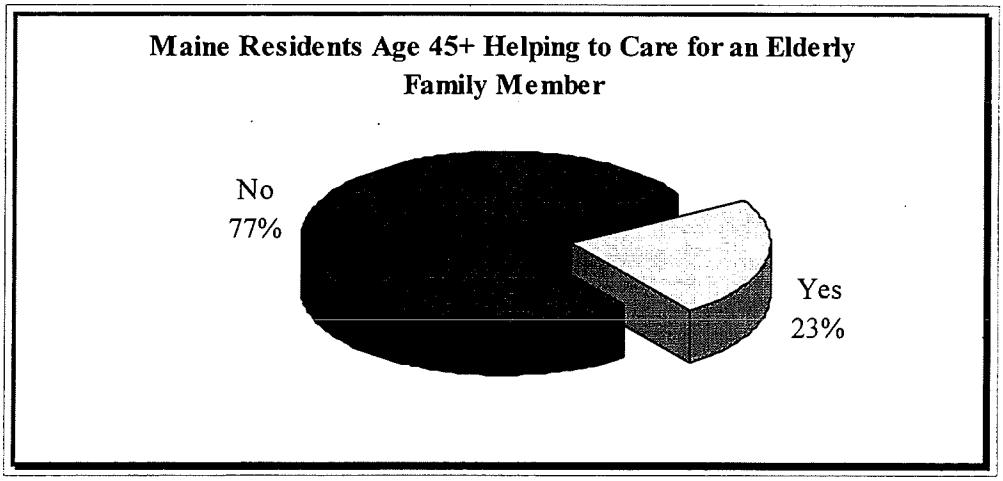
In 1995 the Legislature established a Task Force on Assisted Living to recommend how to regulate these new models, and how to make them more available to lower income persons. The findings of the Task Force were adopted as Chapter 670, An Act to Provide for Assisted Living Services.

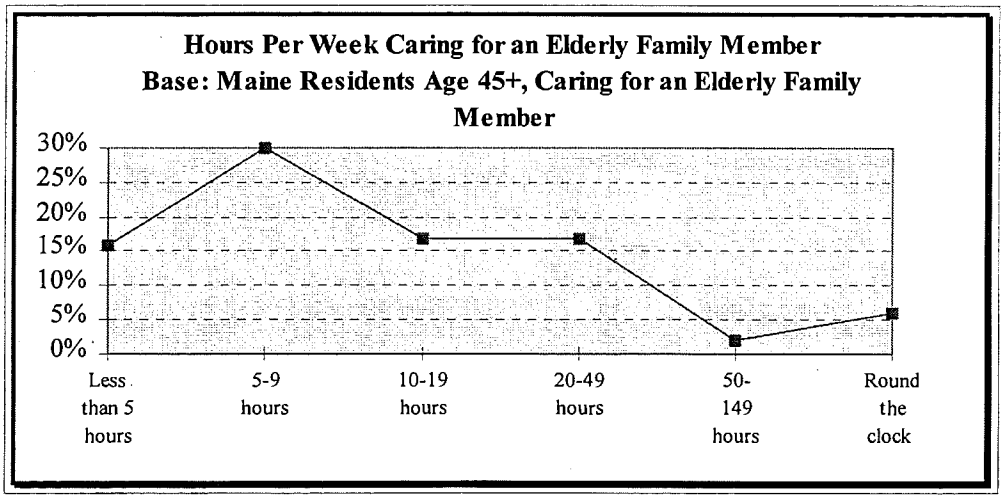
The Department's Division of Licensing and Certification brought together consumers and providers to develop rules for licensing various types of assisted living, as envisioned by the Assisted Living Task Force. The Division widely circulated the draft rules for comment and made presentations to the Medicaid Advisory Committee, Long-term Care Steering Committee, Home Care Alliance, State Fire Marshal's Office, and Maine Health Care Association. They expect to adopt final rules in time to comply with the May 1997 legislative deadline.

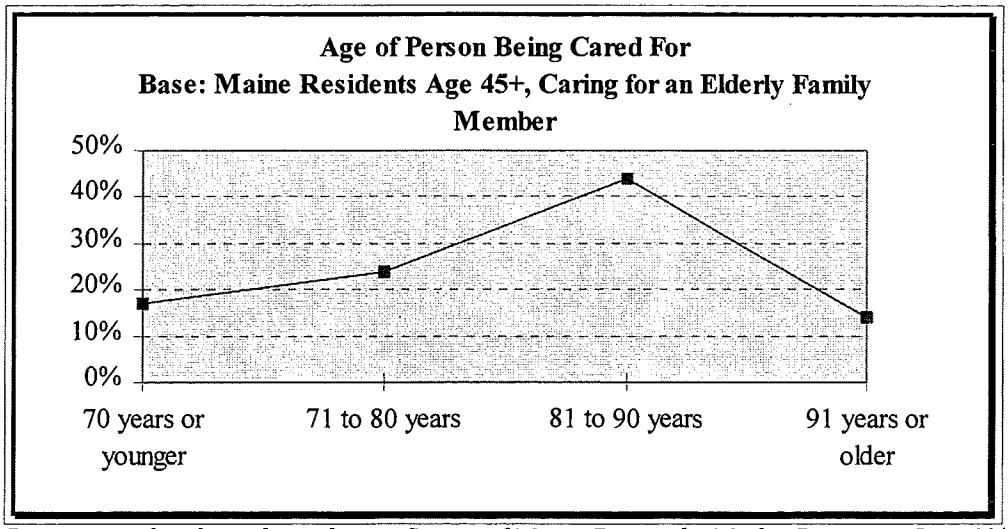
The challenge in assisted living is to design projects that are affordable for low income seniors. The BEAS and MSHA are cooperating on the development of three new projects in Saco, Westbrook and Camden. They will provide individual apartments and extensive supportive services to 90 low income residents. Funding for the services was appropriated by the Legislature in 1996.

Home Care, Adult Day and Respite Services

These services are the building blocks that support family caregivers. As the population ages, more adults are caring for an elderly relative. *In Maine, 23% of adults over age 45 report caring for an elderly family member.*







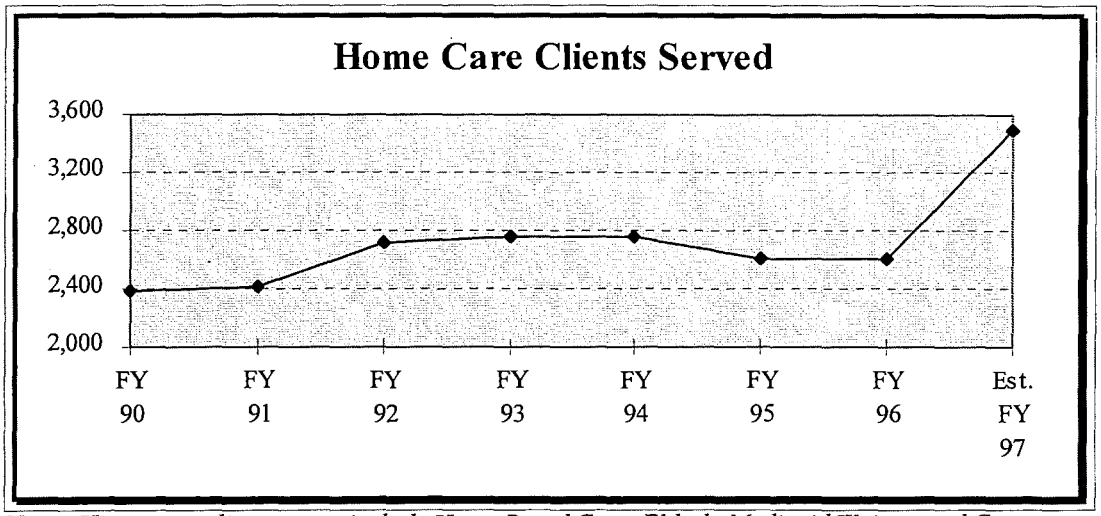
Data source for above three charts: Survey of Maine Citizens by Market Decisions, Inc., 10/96.

In order to make a difference for individuals and families, home and community services must be available when needed. For many years, Maine's home care programs operated with waiting lists of 500+ persons at any one time. Day care and respite services also were limited, especially in rural areas. In 1996 the Legislature made a significant investment in expanding these affordable options.

Home Care

In July 1996, 437 people were on the waiting list for the Elderly Home Based Care program. In the six month period between July and December 1996 not only was the waiting list eliminated, but 250 additional individuals were admitted. *More people received services in this six month period than in all of last year.*

Beginning in July the BEAS re-organized the administration of home care programs for seniors. Elder Independence of Maine, a program of Western Area Agency on Aging, now manages the program statewide. The BEAS selected Elder Independence of Maine through a competitive bidding process. The new organizational structure resulted in a 20% saving in administrative costs and 50% reduction in care management expenditures. Care management is now provided only as needed. The savings, plus the new funds appropriated last session, have enabled the program to serve many more people than anticipated. *A 56% increase in funding translated into more than a 100% increase in individuals served.*



Note: Home care client counts include Home Based Care, Elderly Medicaid Waiver, and Congregate Housing Services. For Elderly Medicaid Waiver, FY 95 is an approved estimate, FY 96 and 97 are preliminary estimates.

Because this new system was a significant change for program participants, the BEAS has contracted with Medical Care Development, a non-profit agency, to conduct an independent evaluation of the system. In October the BEAS also did a mail survey of 1200 people who were on home care programs at the time of the re-organization. More than 600 people responded, and 90% reported satisfaction with their home care services.

Of those reporting dissatisfaction, the majority were experiencing problems with their home care worker, not with Elder Independence of Maine. About five percent of the respondents specifically mentioned regretting the loss of care management services.

There still are 50 people on a waiting list for the home care program for younger, disabled adults. Alpha One administers this program under a contract with the Maine Department of Labor.

The 117th Legislature appropriated new funds for homemaker services. Homemakers assist older people and adults receiving protective services with laundry, shopping, bill paying, and housecleaning. The BEAS awarded the service through a competitive bidding process to Home Resources of Maine (all of southern, western and central Maine), Aroostook Home Care (Aroostook County), and Sunrise Home Care (Washington County).

Adult Day Programs and Respite Services

Adult day programs and respite care assist both the individual and family caregivers. Giving the caregiver a break, and providing some needed social activity for the older person, can often extend the time someone remains in their own home.

Maine now has 40 adult day care programs throughout the state, up from 29 last year. Funds appropriated last session supported the development of seven new sites and expanded services at six sites statewide. Programs use participant fees, state funds, and Medicaid to pay operating expenses. Staff of the BEAS Alzheimer's demonstration program have assisted several sites to obtain private foundation financing through the Brookdale Foundation, which focuses on the needs of persons with Alzheimer's.

The five Area Agencies on Aging administer $450,000 in new funds for respite services for family caregivers. The money can pay for someone to come into the home to relieve the caregiver for short periods of time. It also pays for institutional respite (nursing or residential care) while the caregiver goes away, for a vacation or medical care. Participants pay $4/hour for in-home respite and 20 percent of the cost of nursing or residential respite. An average of 250 families monthly use the service.

System Improvements

Long-term Care Steering Committee

The nine gubernatorial appointees to this committee include consumers of the long-term care and independent living services, family members of individuals receiving services, or persons over 65 years of age. The Committee began its work in September 1996.

Their legislative charge is to "provide input to the commissioner of Human Services on all policy initiatives, laws and rules concerning law-term care and assisted living in order to ensure that...programs reflect the needs and preferences of the elderly and individuals with disabilities."

Committee members have done an intensive and extensive job of educating themselves about Maine's current long-term care system, its successes and its shortcomings. The committee has reviewed and commented on proposed rules for assisted living services; presented testimony to the Bureau of Insurance on the proposed Blue Cross/Blue Shield/ hospital joint ventures in Portland and Lewiston; decided to support legislation to extend equivalent spousal impoverishment protections to residents of boarding homes; and 4) agreed to act as advisory to the MaineNET demonstration project developing a managed care system for Medicaid eligible elders and adults with disabilities. Members attend regular monthly meetings as well as various other conferences and hearings related to long-term care. (See Appendix E for list of members)

Long-term Care Ombudsman Program

As the long-term care system shifts away from almost exclusive reliance on nursing home settings, it is important that the systems for quality assurance and oversight are adequate. In 1994, the Department and the nursing home industry supported the Ombudsman's request for a tax on nursing home beds to replace funds eliminated during previous budget cuts. In 1996, using additional funds appropriated as part of the long-term care initiative, the Ombudsman added staff in order to provide statewide coverage for the first time in the program's 18 year history. It also created a corps of 50 volunteer ombudsman who regularly visit nursing homes, residential care facilities and adult family care homes. *In the last six months of 1996 the LTCOP responded to more calls than in all of the previous year.*

MED 96 Changes

In 1994 the Department revised nursing home admission criteria to focus on persons most in need of this intensive level of care. The new criteria were based on need for nursing care and for assistance with activities of daily living such as eating, getting in and out of bed, and using the bathroom. The goal was to create more homelike, less institutional settings for persons with less intensive needs. Research shows that people who have dementia, but have few medical problems, do better in residential care settings geared to their specific needs.

Unfortunately, only a few of Maine's 140 nursing homes agreed to convert existing units in order to continue serving people with dementia and others who no longer qualified under the new criteria. This created an immediate problem, both in the community and in nursing homes, of people being found ineligible and having no residential alternatives available.

In 1996 the Legislature directed the Department to modify the nursing home admission criteria to accommodate more persons with cognitive and behavior problems. At the time, the Department estimated that 300 more people would qualify for care under the broader standards. The estimate was based on the number of people with dementia who were denied nursing home eligibility in the previous year.

The Department consulted with interested groups to develop the expanded criteria for dementia and adopted rules in June 1996 to implement them. Senior Spectrum has used the new "dementia screen" with 2642 individuals. Of that total, 579 people qualified for nursing facility level of care. More than half of those individuals already were in a nursing facility. In the fall of 1996 the Department proposed revising the dementia screen because the numbers of people qualifying exceeded the funds that the Legislature had budgeted. However, lower overall admissions than expected have allowed the Medicaid nursing home account to accommodate the higher numbers of dementia admissions in the near term. If the numbers continue to increase, the impact on the nursing home account will happen in the next biennium.

The Department has contracted with the Muskie Institute at the University of Southern Maine to evaluate whether the new dementia screen is a valid method for determining need for nursing home care. The Muskie Institute also will update an earlier study of Alzheimer's special care units in nursing homes and residential care facilities. This information will assist the work group established by the Department to develop standards for services to persons with Alzheimer's. Once adopted, only facilities meeting the standards will be able to accept persons qualifying under the dementia screen.

The Department also amended reimbursement rules to include a payment for ineligible residents who are "awaiting placement" in another setting. The payment level varies and is based, in part, on whether the person was on Medicaid before he or she became medically ineligible for nursing home care. Approximately 60 people have benefited from this additional payment source.

Nurse Practice Act

A key to expanding affordable home care options is to ease the restrictions on what functions health and assistive personnel may provide. A major barrier has been the reluctance of nurses to train or supervise unlicensed personnel, although nurses often train and supervise family members in the home care setting. In 1996 as part of the long-term care reform initiative, the Legislature amended the Nurse Practice Act to allow nurses to coordinate and oversee the activities of unlicensed health care assistive personnel.

The Maine State Board of Nursing has formed a committee to define for practicing nurses the Board's interpretation of oversight and coordination.

Paperwork Reduction Task Force

A resolve passed in the last legislature required the Department of Human Services to convene a task force on paperwork reduction in nursing facilities to study "the problem of paperwork required for patient assessment, care and reimbursement and the survey process." The task force was to take into consideration the needs of the patient and family, the nursing and professional staff of the nursing facility, the department and other interested parties and search for methods of meeting the legitimate needs of all parties in the most efficient, efficacious and collaborative manner possible." The six nurses representing nursing facilities, four representatives of the Department, the Ombudsman and a representative of the Muskie Institute Center for Health Policy met first on May 29, 1996, and then every other week until their final meeting on January 9, 1997. Task force members agreed to remove certain duplicative and redundant documentation requirements in several areas, and in a pilot project, are testing a new care planning concept that should eliminate some of the paperwork now required of Certified Nursing Assistants (CNA) and free them up for more direct resident care. A final report of the task force will be submitted to the legislature. (See Appendix F for list of members)

MaineNET

MaineNET is the Department's planning and demonstration project for managed care for older persons and adults with disabilities.

MaineNET intends to address two long-standing concerns with services delivered to older people and adults with disabilities. Services are fragmented, making them confusing, difficult to access and sometimes ineffective, particularly for those who have a range of needs, and for those who are dually eligible for Medicare and Medicaid. The cost of providing the services has grown at a rate that is not sustainable. The project's goals are:

- To design a financing and delivery system that assures timely access to cost effective, high quality, and appropriate services in the least restrictive setting;
- To provide incentives for the delivery of services that foster independence and consumer involvement, improve functional ability and/or maintain an individual's highest practical functioning and well being; and
- To control service use and costs through the implementation of a managed care financing and delivery program.

MaineNET is different from other national initiatives with similar target populations and objectives. The rural nature of the demonstration areas (Somerset, Kennebec and Aroostook counties) will test the viability of managed care in rural areas with sparse populations and little managed care infrastructure. New alliances among providers, flexible approaches for phasing in capitation, and technical assistance to both provider and consumer communities will be required to achieve the demonstration's objectives.

The demonstration will document the effort required to adapt existing managed care organizations to meet the special needs of the target populations, and to build capacity within community organizations and providers to administer a managed care delivery system.

Also, MaineNET is targeting a broad population of older persons and adults with disabilities (i.e., not just frail elderly, or high cost users) and including a comprehensive array of primary, acute and long term services.

Another important aspect of the MaineNET demonstration is incorporation of risk adjustment factors in the capitation rate structure that reflect differences in the characteristics of individuals within the target population. Maine will use its experience in case mix reimbursement for nursing facilities to account for variations in service intensity among the target population.

In late 1994, the Maine Department of Human Services received a three year grant from the federal Health Care Financing Administration to plan and design an integrated model for the financing and delivery of managed health care and social services for older persons and adults with disabilities. Maine was the only state to received such a grant. Implementation will begin after receipt of waivers from the Federal Health Care Financing Administration.

Since the start of the project, advisory committees including consumers, advocates, legislators, state agency officials and providers have monitored the MaineNET project. Initially, this role was carried out by the Long Term Care Task Force, which was appointed by Commissioner Sheehan to advise the Department on MaineNET and other reforms affecting the long term care system in Maine. After the Legislature, created the Long-term Care Steering Committee, the Department asked the Committee to assume the advisory functions for the project.

Staff meet regularly with the Medicaid Advisory Committee, which has taken an active role in monitoring Medicaid managed care developments in Maine. Also, monthly meetings are held with the Maine Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSA) to ensure that citizens served by both departments will have a smooth transition into managed care.

Three workgroups were established to provide technical support to the project: Quality, Service Delivery, and Payment. Workgroup membership was solicited from providers, provider associations, consumer advocates and consumers, and includes approximately 120 individuals and organizations. The Workgroups meet on a quarterly basis, except for the Quality Workgroup that meets monthly. The Workgroups reviewed a MaineNET status report in June 1996, and will review and make recommendations on the final waiver application to the Health Care Financing Administration.

An external Site Selection Committee composed of consumers, consumer advocates and state legislators convened to make a recommendation to the Commissioner regarding the selection of geographic sites for the MaineNET demonstration. Considering those recommendations, the Commissioner chose Aroostook, Somerset and Kennebec counties.

In early 1996, in advance of Medicaid managed care for AFDC recipients, the Commissioner of Human Services conducted a series of public hearings to discuss the changing service delivery environment and how it will impact consumers and providers. Seven hearings were held across the State in Bangor, Presque Isle, York County, Auburn, Camden, Portland and Damariscotta. They were followed with six additional public hearings specific to MaineNET held in October and November 1996 throughout the proposed demonstration area. (Meetings were held in Houlton, Caribou, Fort Kent, Augusta, Skowhegan, and Waterville.) A MaineNET brochure was developed for distribution at all the public hearings.

Two methods will meet the Health Care Financing Administration's public notice requirement for the submission of a Research and Demonstration Waiver under Section 1115 of the Social Security Act. Public meetings were held in each of the geographic areas selected for MaineNET. A direct mailing was sent to all Medicaid-eligible older persons and adults with disabilities and all Medicaid providers in the demonstration areas, inviting them to come and learn more about and provide input into MaineNET. Notices of the public meetings were also placed in the Bangor Daily News, the Kennebec Journal and the Waterville Sentinel. In addition, the draft of the 1115 Waiver application was available upon request for a thirty day review and written comment period. The application is available to all MaineNET Workgroup members and attendees at the public meetings.

Clearly, the scope of this project represents substantial challenges to the State, but the Maine environment is conducive to innovation and change. With a limited number of providers and strong advocacy communities, it is possible for all key stakeholders to have active and meaningful participation in program design. These benefits cannot be overstated as they allow ready feedback and input into the development process, and the assurance that reforms respond to real needs and issues.

New England Dual Eligible Consortium

Given the large percentage of people in the MaineNET target group eligible for both Medicaid and Medicare, Medicare is a critical component that must be incorporated ultimately in order to achieve the project's goals. However, given the relative lack of managed care infrastructure in Maine generally, and the rural nature of the proposed demonstration areas, Maine is proposing a staged demonstration that will focus initially on establishing a Medicaid managed care program and will phase in Medicare over time.

Maine is collaborating with other New England states on the design of programs that could integrate Medicare and Medicaid financing and delivery of health care services. The federal Health Care Financing Administration is particularly reluctant to relinquish management of the Medicare program to individual states. The New England states believe that a regional approach might be more acceptable.

"Vision" Group

Nursing facility-based services are changing in Maine, and across the country. Consumers prefer more autonomy and privacy; payers want demonstrated outcomes; consumer advocates want alternatives to large, institutional settings; owners feel micro-managed; and the old rules just do not apply anymore.

A work group composed of twenty provider, consumer, and Department of Human Services representatives met during the fall of 1996. The group explored the possibility for creating residential, long-term care services to better meet the needs of consumers, families and providers. This group chartered itself as an outgrowth of the May 1996 "Vision 2000" Conference. During a series of almost weekly meetings, the group catalogued the shortcomings of the current financing and delivery systems and delineated the values essential to a successful long-term care system: individuality, community and stewardship.

The work group envisions demonstration projects in a few selected communities in Maine that would test the feasibility of new ways of delivering housing and services to persons with long-term care needs. Demonstration projects might include the following features:

- "Unbundling" payments for housing and services in all settings, including nursing homes
- Using vouchers to give consumers and families more control in choosing long-term care settings and services
- Waiving licensing requirements that are not critical to consumer health and safety
- Enrolling consumers and families in a care collaborative in which they and the provider share active responsibility and risk for decisions about health care and other services
- Investing in educating consumers, health care professionals, and regulators in a new paradigm for long-term care services
- Licensing a provider, or consortium of providers, with a single license to manage or deliver services in a variety of settings, based on consumer needs and preferences
- An insurance component in which premiums might be subsidized with public funds

The work group is looking for nothing less than a thorough re-thinking of the assumptions of what it means to need long-term care services; and how they are delivered, regulated, financed, and paid.

Consumer participation in a care collaborative demonstration would be voluntary. Therefore, the projects would probably work best in communities that could offer consumers a choice between the traditional system and the demonstration.

The work group proposes obtaining grant or foundation funding to support the process of selecting demonstration sites, educating all participants, obtaining necessary waivers from state and federal regulators and payers, and evaluating the outcomes. If the Department obtained waivers, existing state and federal funds would continue to be available to pay for services. (See Appendix E for list of participants)

Conclusion

In 1996 more than six out of ten people received their long term care in a nursing home, the most expensive setting for care. At the same time, 90% of Maine residents say that home is their preferred setting for services.

As Maine moves into the 21st century, our systems of public and private support for a growing aging population must be ample and affordable across our State. Most importantly, Maine seniors and adults with disabilities ought to have the choice to remain in their homes and communities whenever possible. Right now, our system has too few choices for many of Maine's people. We need a system that includes everything from help at home to highly specialized nursing care.

Maine's reform efforts are receiving national attention and recognition. Other states are looking at how they might adapt elements of the long-term care initiative. At the same time, the Department continues to look at how we can improve programs and services. Because improving the long-term care system is a priority, the Department selected it as the pilot program for performance budgeting.

Our objectives for the next three years are:

1. Increase by twenty percent the percentage of consumers who report having choices in meeting their long-term care needs.

    - Assess and refer 100% of adults who present themselves for long term care services to determine individual needs and preferences.
    - Increase non-institutional based assisted living options consistent with individual assessed needs and preferences and system capacity, supporting only as much nursing facility care as needed.
    - Provide public information, education, and outreach so that adults may request and access long term care service options which match their individual needs and preferences.

2. Increase by ten percent the quality , outcomes, and consumer satisfaction of all long-term care programs.

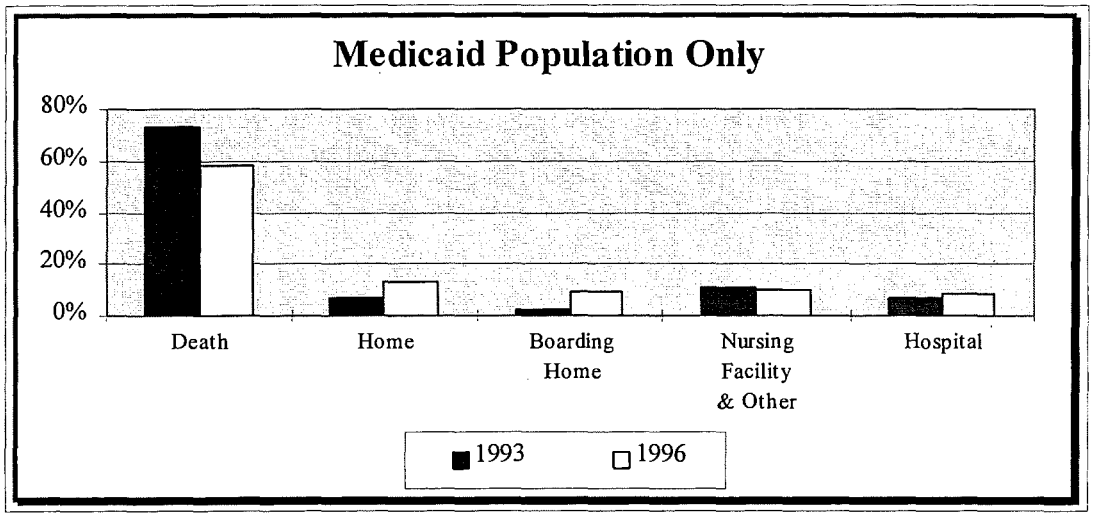
    - Develop and determine baseline quality measures for all long term care programs.
    - Develop and determine baseline consumer satisfaction and outcome measures for all long term care programs.
    - Conduct an annual Long Term Care Institute to recognize and promote innovative practices.

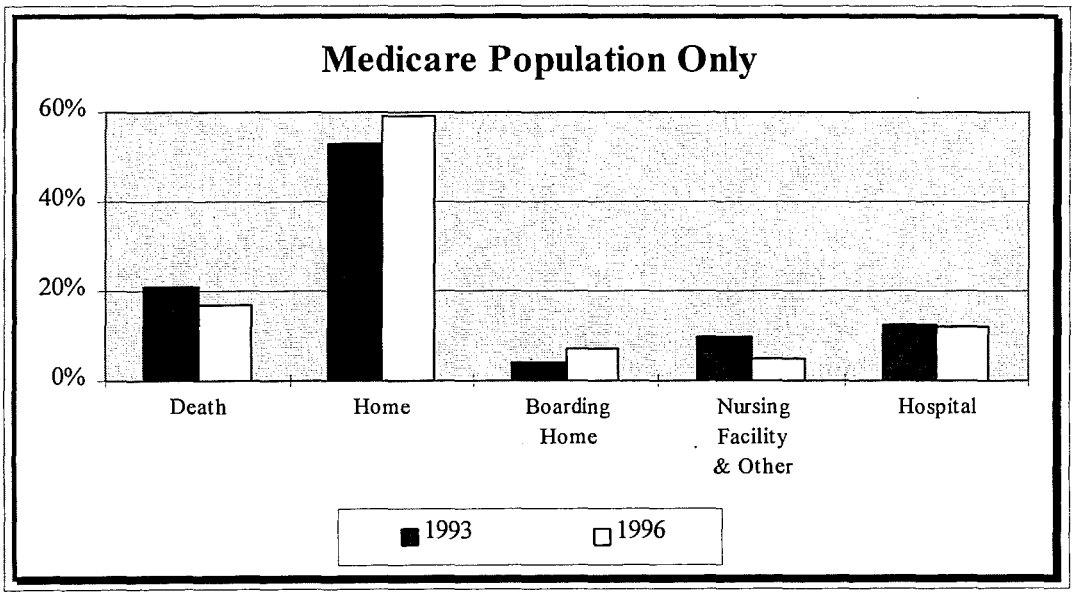
3. Increase by ten percent the reported continuity, accessibility, simplicity and value of the long-term care system.

    - Develop and determine baselines for reported (by consumers, providers, the public) continuity, accessibility, simplicity, and value of the long term care system.
    - Consolidate the financing and delivery of home and community-based programs.
    - Implement the MaineNET managed care demonstration.
    - Conduct a regional demonstration project to test a new residential long term care paradigm.
    - Simplify the internal administrative/management functions of the long term care system.

APPENDIX A

Nursing Facility Discharges by Payment Source





Source: Maine Case Mix Demonstration Project, 1/97 Reports, Muskie Institute.

APPENDIX B

Nursing Home Expenditures Per Person 65+

Table 16: 1992 Nursing Home Expenditures Per Person Age 65+

	PER AGE 65+			
STATE	NH EXPEND.	SCORE	RATING	RANK
ARIZONA	314.02	-1.34	VERY LOW	1
FLORIDA	346.92	-1.24	VERY LOW	2
OREGON	363.39	-1.19	VERY LOW	3
NEVADA	377.58	-1.15	VERY LOW	4
UTAH	387.09	-1.12	VERY LOW	5
IOWA	481.57	-0.83	LOW	6
VIRGINIA	486.56	-0.82	LOW	7
SOUTH CAROLINA	487.87	-0.81	LOW	8
IDAHO	504.2	-0.77	LOW	9
MISSOURI	507.92	-0.75	LOW	10
OKLAHOMA	522.91	-0.71	LOW	11
MICHIGAN	529.74	-0.69	LOW	12
NEW MEXICO	540.29	-0.66	LOW	13
WEST VIRGINIA	542.46	-0.65	LOW	14
KANSAS	542.95	-0.65	LOW	15
TEXAS	544.67	-0.64	LOW	16
CALIFORNIA	559.23	-0.6	LOW	17
NORTH CAROLINA	571.21	-0.56	LOW	18
ALABAMA	586.86	-0.52	LOW	19
COLORADO	608.84	-0.45	LOW	20
MISSISSIPPI	630.13	-0.39	LOW	21
KENTUCKY	633.31	-0.38	LOW	22
MONTANA	636.41	-0.37	LOW	23
WYOMING	652.12	-0.32	LOW	24
WASHINGTON	655.08	-0.31	LOW	25
ARKANSAS	655.63	-0.31	LOW	26
TENNESSEE	662.56	-0.29	LOW	27
PENNSYLVANIA	665.87	-0.28	LOW	28

DELAWARE	675.16	-0.25	AVERAGE	29
SOUTH DAKOTA	679.59	-0.24	AVERAGE	30
MARYLAND	700.05	-0.18	AVERAGE	31
NEBRASKA	705.63	-0.16	AVERAGE	32
HAWAII	721.38	-0.11	AVERAGE	33
GEORGIA	743.48	-0.04	AVERAGE	34
ILLINOIS	756.2	-0.01	AVERAGE	35
NEW JERSEY	817.98	0.18	AVERAGE	36
INDIANA	848.7	0.27	HIGH	37
LOUISIANA	857.7	0.3	HIGH	38
VERMONT	868.91	0.33	HIGH	39
NORTH DAKOTA	926.17	0.51	HIGH	40
WISCONSIN	930.63	0.52	HIGH	41
OHIO	946.16	0.57	HIGH	42
NEW HAMPSHIRE	1,168.69	1.24	VERY HIGH	43
RHODE ISLAND	1,207.46	1.35	VERY HIGH	44
MINNESOTA	1,247.51	1.47	VERY HIGH	45
MAINE	1,309.52	1.66	VERY HIGH	46
MASSACHUSETTS	1,342.19	1.76	VERY HIGH	47
CONNECTICUT	1,497.94	2.23	VERY HIGH	48
NEW YORK	1,540.22	2.36	VERY HIGH	49
ALASKA	1,555.44	2.4	VERY HIGH	50
DIST. OF COLUMBIA	1,623.44	2.61	VERY HIGH	51
UNITED STATES	735.83			

Source: Derived using the 1992 Age 65+ Population Estimates in Table 2 and Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

Go to Table 17 **Return to U.S. Map**

Medicaid Average Daily Nursing Home Costs

Table 14: Medicaid Average Cost Per Day in a Nursing Home

STATE	COST PER DAY	SCORE	RATING	RANK
OKLAHOMA	36.44	-1.08	VERY LOW	1
IOWA	40.24	-0.97	VERY LOW	2
WYOMING	41.13	-0.94	VERY LOW	3
ARKANSAS	43.35	-0.88	VERY LOW	4
KANSAS	43.46	-0.87	VERY LOW	5
TEXAS	44.69	-0.83	LOW	6
MISSOURI	45.8	-0.8	LOW	7
MISSISSIPPI	45.99	-0.8	LOW	8
SOUTH DAKOTA	48.77	-0.71	LOW	9
GEORGIA	49.86	-0.68	LOW	10
VIRGINIA	51.96	-0.62	LOW	11
UTAH	52.77	-0.59	LOW	12
SOUTH CAROLINA	54.06	-0.55	LOW	13
LOUISIANA	54.38	-0.54	LOW	14
TENNESSEE	56.11	-0.49	LOW	15
KENTUCKY	56.76	-0.47	LOW	16
NEBRASKA	57.36	-0.45	LOW	17
ILLINOIS	57.65	-0.44	LOW	18
ALABAMA	57.79	-0.44	LOW	19
COLORADO	58.32	-0.42	LOW	20
WISCONSIN	58.52	-0.42	LOW	21
OREGON	59.23	-0.4	LOW	22
IDAHO	63.53	-0.27	LOW	23
NORTH CAROLINA	63.74	-0.26	LOW	24
MONTANA	63.75	-0.26	LOW	25
NORTH DAKOTA	64.73	-0.23	AVERAGE	26
ARIZONA	64.76	-0.23	AVERAGE	27
NEW MEXICO	65.76	-0.2	AVERAGE	28

MARYLAND	67.48	-0.15	AVERAGE	29
INDIANA	68.94	-0.1	AVERAGE	30
FLORIDA	69.9	-0.08	AVERAGE	31
OHIO	72.43	0	AVERAGE	32
MINNESOTA	73.01	0.02	AVERAGE	33
WASHINGTON	74.1	0.05	AVERAGE	34
CALIFORNIA	76.09	0.11	AVERAGE	35
VERMONT	76.65	0.13	AVERAGE	36
RHODE ISLAND	78.47	0.18	AVERAGE	37
NEW HAMPSHIRE	78.53	0.18	AVERAGE	38
PENNSYLVANIA	79.23	0.21	AVERAGE	39
DELAWARE	81.71	0.28	HIGH	40
MAINE	81.75	0.28	HIGH	41
WEST VIRGINIA	83.04	0.32	HIGH	42
MASSACHUSETTS	83.32	0.33	HIGH	43
MICHIGAN	86.08	0.41	HIGH	44
NEW JERSEY	90.65	0.55	HIGH	45
NEVADA	101.92	0.89	VERY HIGH	46
CONNECTICUT	103	0.92	VERY HIGH	47
HAWAII	119.51	1.42	VERY HIGH	48
NEW YORK	145.19	2.19	VERY HIGH	49
DIST. OF COLUMBIA	177.83	3.17	VERY HIGH	50
ALASKA	223.61	4.55	VERY HIGH	51
TOTAL U.S.	71.03			

Source: Derived using 1993 Medicaid Nursing Home Expenditures and 1992 data from Health Data Associates, 1994.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

Go to Table 15 Return to U.S. Map

Total Home & Community Based Long Term Care Expenditures

Table 17: 1992 Total Home and Community Based Long Term Care Expenditures Per Person Age 65+

STATE	HCBS PER PERSON 65+	SCORE	RATING	RANK
NEW YORK	1179.62	6.41	VERY HIGH	1
OREGON	369.49	1.42	VERY HIGH	2
ALASKA	311.52	1.07	VERY HIGH	3
CALIFORNIA	239.56	0.62	HIGH	4
DELAWARE	225.44	0.54	HIGH	5
WASHINGTON	211.62	0.45	HIGH	6
MASSACHUSETTS	194.93	0.35	HIGH	7
NORTH CAROLINA	189.89	0.32	HIGH	8
MAINE	189.07	0.31	HIGH	9
WISCONSIN	184.15	0.28	HIGH	10
WEST VIRGINIA	157.84	0.12	AVERAGE	11
MINNESOTA	154.45	0.1	AVERAGE	12
CONNECTICUT	152.66	0.09	AVERAGE	13
MARYLAND	150.65	0.08	AVERAGE	14
TEXAS	143.87	0.03	AVERAGE	15
ARKANSAS	142.99	0.03	AVERAGE	16
INDIANA	137.7	0	AVERAGE	17
IDAHO	134.54	-0.02	AVERAGE	18
DIST. OF COLUMBIA	132.57	-0.04	AVERAGE	19
NEW JERSEY	125.06	-0.08	AVERAGE	20
NEW HAMPSHIRE	120.4	-0.11	AVERAGE	21
NEW MEXICO	117.14	-0.13	AVERAGE	22
OKLAHOMA	114.72	-0.15	AVERAGE	23
ILLINOIS	105.61	-0.2	AVERAGE	24
KENTUCKY	101.55	-0.23	AVERAGE	25
HAWAII	99.92	-0.24	AVERAGE	26
MONTANA	97.46	-0.25	LOW	27

GEORGIA	97.11	-0.25	LOW	28
VIRGINIA	90.23	-0.3	LOW	29
WYOMING	84.22	-0.33	LOW	30
VERMONT	82.93	-0.34	LOW	31
ALABAMA	80.28	-0.36	LOW	32
RHODE ISLAND	79.68	-0.36	LOW	33
NEBRASKA	77.85	-0.37	LOW	34
LOUISIANA	73.16	-0.4	LOW	35
SOUTH CAROLINA	72.21	-0.41	LOW	36
OHIO	71.82	-0.41	LOW	37
FLORIDA	71.7	-0.41	LOW	38
UTAH	71.47	-0.41	LOW	39
MISSOURI	69.7	-0.42	LOW	40
MICHIGAN	68.84	-0.43	LOW	41
ARIZONA	65.62	-0.45	LOW	42
COLORADO	65.56	-0.45	LOW	43
IOWA	57	-0.5	LOW	44
NORTH DAKOTA	53.66	-0.52	LOW	45
KANSAS	48.13	-0.56	LOW	46
NEVADA	46.65	-0.57	LOW	47
SOUTH DAKOTA	45.6	-0.57	LOW	48
PENNSYLVANIA	37.82	-0.62	LOW	49
TENNESSEE	36.23	-0.63	LOW	50
MISSISSIPPI	29.27	-0.67	LOW	51
UNITED STATES	$199.23			

Source: Derived using the Age 65+ Population Estimates in Table 2 and Table 33, using Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

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Go to Table 18 Return to U.S. Map

APPENDIX C

Residential Care Resources On Line

Bureau of Elder and Adult Services

Maine Department of Human Services

05-Feb-97

Population	Facility	City	NF Beds Decertified	New Medicaid RCF Beds	Effective Date
Alzheimers					
	Sandy River	Farmington	16	14	1/22/96
	Sedgewood Common	Falmouth		10	7/1/93
	Madigan Estates	Houlton		20	5/1/95
	The Lamp	Lisbon	36	30	9/1/95
	Westgate Manor	Bangor	20	18	10/23/96
	Clover HC	Auburn	12	11	2/9/96
	Clover HC II	Auburn	8	9	2/15/96
	Rumford Community	Rumford	16	16	4/2/96
	Madigan House II	Houlton	0	12	8/28/96
	Fryeburg Health Care	Fryeburg	26	21	9/23/96
	Crescent House	Cape Elizabeth	0	30	7/1/96
	Springbrook Health C	Westbrook	25	23	9/1/96
	Pleasant Heights II	Fairfield	15	15	10/1/96
			174	**229**	
Geriatric					
	Rocky Hill	Westbrook		15	4/1/95

Population	Facility	City	NF Beds Decertified	New Medicaid RCF Beds	Effective Date
	Parkview	Springvale		24	2/20/95
	Maine Veterans Home	West Paris	20	16	2/1/97
	Walters Home	Hallowell		10	7/1/93
	Eighty Main Street	Farmington		5	7/1/93
	Hillcrest	Sanford	28	14	3/21/96
	Penobscot Nursing H	Penobscot	20	18	1/1/97
	Sebasticook Commun	Pittsfield		14	5/10/96
	Harbor Hill	Belfast	25	30	10/1/96
	Richmond Eldercare	Richmond		12	2/9/96
	Montello Manor	Lewiston	24	20	7/15/95
	Pinewood Terrace	Farmington		20	4/29/96
	Island Nursing Facility	Deer Isle	20	23	1/1/96
	Hicks Assisted Living	Fryeburg	27	20	4/15/95
	Grandview House	Bangor		10	5/1/95
	Parkview Lodge	Springvale		17	2/1/95
	Woodlands	Waterville		30	4/15/96
	Borderview Manor	Van Buren	14	14	4/1/95
	Volmer's Residential	Vassalboro	30	23	7/1/94
	Gilbert Manor	Gardiner		6	7/1/93

Population	Facility	City	NF Beds Decertified	New Medicaid RCF Beds	Effective Date
	Highview Manor	Madawaska	16	16	8/21/96
	Hancock House	Hancock		9	5/1/96
	Kountry Komfort	Sabattus		16	7/1/96
	Oceanview	Lubec	8	8	5/28/96
	Parkview Nursing Car	Livermore Falls	15	15	9/1/96
	Pleasant Hilll Health C	Fairfield	24	16	4/1/96
	Country Manor	Coopers Mill	24	20	8/2/96
	Mt. View Acres	Sanford	0	19	2/1/96
	Windward Gardens	Camden		8	7/1/93
	Gray Birch	Augusta	43	37	1/1/97
	Skofield House	Brunswick	51	43	8/8/95
	Heritage Manor	Winthrop	14	11	8/1/96
	Intown Manor	Lewiston		35	7/1/93
	Victorian Residence	Farmingdale		14	7/1/93
	Russell Park	Lewiston	20	18	5/27/96
	Montello II	Lewiston	4	4	3/15/96
	Ledgeview NF	West Paris	24	24	6/18/96
	Camden HC	Camden	20	18	8/25/96
	Fontbonne Communit	Waterville		11	10/1/96

Population	Facility	City	NF Beds Decertified	New Medicaid RCF Beds	Effective Date
	Norway Convalescent	Norway	12	10	6/19/96
	Ragged Mountain	Rockport		16	9/1/96
	Marshal Residential	Machias	2	4	3/1/96
			485	**713**	
Head Injured					
	Newton Street	Portland		6	7/1/93
	Spiller Park	Gorham		6	2/7/96
				12	
HIV-AIDS					
	Peabody House	Portland		6	6/1/96
				6	
Mental Health					
	RAFTS	Greene		6	7/18/95
	Gray Manor	Gray		30	7/1/93
	Berwick Estates	North Berwick		6	7/1/93
	Gordon Greene	So. Portland		8	10/15/96
	Hampden Meadows	Hampden		8	12/15/95
	Windham Pines	Windham	0	8	10/3/95
	Mt. St. Joseph's	Waterville	15	15	3/13/96
	Country Meadows	Bangor		8	2/29/96

Population	Facility	City	NF Beds Decertified	New Medicaid RCF Beds	Effective Date
			15	89	
		Grand Total:	674	1049	

APPENDIX D

State of Maine January 1997

Inventory and Analysis of Long Term Care Institutional Beds					Targets:		NF/1000:	50
(excludes hospital swing beds)							RC/1000:	20
			NF	Medicaid				
Hospital Service Areas			Beds	RC Beds	NF +	RC +		
Area 1, York			135	83				
	>65 Pop.	5949						
	NF Ratio	23						
	RC Ratio	14						
	Target NF	297			162			
	Target RC	119				36		
Area 2, Sanford			303	74				
	>65 Pop.	5142						
	NF Ratio	59						
	RC Ratio	14						
	Target NF	257			-46			
	Target RC	103				29		
Area 3, Biddeford			519	116				
	>65 Pop.	9083						
	NF Ratio	57						
	RC Ratio	13						
	Target NF	454			-65			
	Target RC	182				66		
Area 4, Portland			1808	464				
	>65 Pop.	29212						
	NF Ratio	62						
	RC Ratio	16						
	Target NF	1461			-347			
	Target RC	584				120		
Area 5, Bridgton			115	41				
	>65 Pop.	2462						
	NF Ratio	47						
	RC Ratio	17						
	Target NF	123			8			
	Target RC	49				8		

			NF	Med. RC	NF +	RC +		
Area 6, Norway			338	49				
	>65 Pop.	3429						
	NF Ratio	99						
	RC Ratio	14						
	Target NF	171			-167			
	Target RC	69				20		
Area 7, Lewiston			949	377				
	>65 Pop.	14503						
	NF Ratio	65						
	RC Ratio	26						
	Target NF	725			-224			
	Target RC	290				-87		
Area 8, Brunswick			186	47				
	>65 Pop.	4665						
	NF Ratio	40						
	RC Ratio	10						
	Target NF	233			47			
	Target RC	93				46		
Area 9, Bath-Boothbay			102	0				
	>65 Pop.	3826						
	NF Ratio	27						
	RC Ratio	0						
	Target NF	191			89			
	Target RC	77				77		
Area 10, Damariscotta			70	0				
	>65 Pop.	1962						
	NF Ratio	36						
	RC Ratio	0						
	Target NF	98			28			
	Target RC	39				39		

			NF	Med. RC	NF+	RC+		
Area 11, Augusta			681	299				
	>65 Pop.	9927						
	NF Ratio	69						
	RC Ratio	30						
	Target NF	496			-185			
	Target RC	199				-100		
Area 12, Rockland			374	166				
	>65 Pop.	7468						
	NF Ratio	50						
	RC Ratio	22						
	Target NF	373			-1			
	Target RC	149				-17		
Area 13, Rumford			152	16				
	>65 Pop.	2818						
	NF Ratio	54						
	RC Ratio	5.6778						
	Target NF	141			-11			
	Target RC	56				40		
Area 14, Farmington			220	75				
	>65 Pop.	4590						
	NF Ratio	48						
	RC Ratio	16						
	Target NF	230			10			
	Target RC	92				17		
Area 15, Skowhegan			235	60				
	>65 Pop.	4195						
	NF Ratio	56						
	RC Ratio	14						
	Target NF	210			-25			
	Target RC	84				24		

			NF	Med. RC	NF+	RC+		
Area 16, Waterville			389	221				
	>65 Pop.	8497						
	NF Ratio	46						
	RC Ratio	26						
	Target NF	425			36			
	Target RC	170				-51		
Area 17, Belfast			110	70				
	>65 Pop.	3197						
	NF Ratio	34						
	RC Ratio	22						
	Target NF	160			50			
	Target RC	64				-6		
Area 18, Blue Hill			124	23				
	>65 Pop.	1979						
	NF Ratio	63						
	RC Ratio	11.622						
	Target NF	99			-25			
	Target RC	40				17		
Area 19, Bar Harbor			163	0				
	>65 Pop.	1920						
	NF Ratio	85						
	RC Ratio	0						
	Target NF	96			-67			
	Target RC	38				38		
Area 20, Pittsfield			146	14				
	>65 Pop.	1672						
	NF Ratio	87						
	RC Ratio	8						
	Target NF	84			-62			
	Target RC	33				19		

			NF	Med. RC	NF+	RC+		
Area 21, Dover-Foxcroft			204	80				
	>65 Pop.	3957						
	NF Ratio	52						
	RC Ratio	20						
	Target NF	198			-6			
	Target RC	79				-1		
Area 22, Bangor			701	148				
	>65 Pop.	14542						
	NF Ratio	48						
	RC Ratio	10						
	Target NF	727			26			
	Target RC	291				143		
Area 23, Ellsworth			190	14				
	>65 Pop.	3197						
	NF Ratio	59						
	RC Ratio	4.3791						
	Target NF	160			-30			
	Target RC	64				50		
Area 24, Machias			132	58				
	>65 Pop.	2407						
	NF Ratio	55						
	RC Ratio	24						
	Target NF	120			-12			
	Target RC	48				-10		
Area 25, Calais			133	10				
	>65 Pop.	2381						
	NF Ratio	56						
	RC Ratio	4						
	Target NF	119			-14			
	Target RC	48				38		

			NF	Med. RC	NF+	RC+		
Area 26, Lincoln			133	10				
	>65 Pop.	2072						
	NF Ratio	64						
	RC Ratio	5						
	Target NF	104			-29			
	Target RC	41				31		
Area 27, Millinocket			44	0				
	>65 Pop.	1641						
	NF Ratio	27						
	RC Ratio	0						
	Target NF	82			38			
	Target RC	33				33		
Area 28, Houlton			200	74				
	>65 Pop.	2938						
	NF Ratio	68						
	RC Ratio	25						
	Target NF	147			-53			
	Target RC	59				-15		
Area 29, Presque Isle			183	42				
	>65 Pop.	3724						
	NF Ratio	49						
	RC Ratio	11						
	Target NF	186			3			
	Target RC	74				32		
Area 30, Caribou			211	88				
	>65 Pop.	2639						
	NF Ratio	80						
	RC Ratio	33						
	Target NF	132			-79			
	Target RC	53				-35		

			NF	Med. RC	NF+	RC+		
Area 31, Fort Kent			209	96				
	>65 Pop.	2117						
	NF Ratio	99						
	RC Ratio	45						
	Target NF	106			-103			
	Target RC	42				-54		
Statewide Totals Beds			9459	2815	-1053	547		
Total Population>65	167,111							
Statewide NF Beds/1,000	56.60							
Statewide RCF Beds/1,000	16.85							
Summary of Decertification Activity in Nursing Facilities								
	Original Number of NF Beds				10243			
	Number Decertified to Date				784			
	Total NF Beds				9459			
Note: RCF Includes Medicaid Residential Care Facilities and Adult Family Care Homes								

APPENDIX E

Long-term Care Steering Committee

Catherine Bell, Houlton
Willard Callender, Jr. (Chair), South Portland
Harmon Harvey, Hallowell
Arnold Leavitt, Auburn
Eileen Lonsdale, Brunswick
Philip Ohman (Vice-chair), Gray
Ron Stewart, Wilton
Deborah Williams, Topsham

APPENDIX F

Task Force on Paperwork Reduction in Nursing Facilities

Mollie Baldwin, Department of Human Services
Claire Brannigan, Sedgewood Commons
Nancy Chamberlain, Mt. St. Joseph Holistic Care Community
Jane Chapin, Department of Human Services
Debra Couture, Department of Human Services
Jeanne Delicata (Chair), The Barron Center
Debra Fournier (Vice-chair), Southridge Living Center
Julie Fralich, Muskie Institute
Brenda Gallant, Long-term Care Ombudsman Program
Elissa Lauze, Auburn Nursing Home
Nancy Mattis, Southridge Living Center
Alison Moore, Department of Human Services
Deborah Vilasuso, South Portland Visiting Nurses Association

APPENDIX G

Vision 2000 Group

Toby Atkins, MD
Pat Berger, Mt. St. Joseph Holistic Care Community
Jerry Cayer, d'Youville Pavillion
Betty Forsythe, Department of Human Services
Brenda Gallant, Long-term Care Ombudsman Program
Christine Gianopoulos, Department of Human Services
Eleanor Goldberg, Alzheimer's Association
Greg Gravel. Kennebec Long-term Care
Dennis Hett, Northern New England Association of Homes and Services for Aging
Diane Jones, Department of Human Services
Rebecca Kees, The Provider Group
Gail MacLean, Consultant
Darlene Mooar McBean, Eighty Main Street
Duane Rancourt, The Viking/Crescent House
Lori Roll, Island Nursing Home
Joseph Sirois, Rumford Community Home
Denise Vachon, The Park Danforth
Nola Weston, Maine Health Care Association
Linda Woolley, Senior Spectrum

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Ann Twombly, Affirmative Action Officer, has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84, and 91) and the U.S. Department of Education (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Ann Twombly at 221 State Street, Augusta, Maine 04333. Telephone number: (207) 287-3488 (Voice) or 1-800-332-1003 (TDD), or to the Assistant Secretary of the Office of Civil Rights, Washington, D.C.

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