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129th Legislature, First Regular Session

Commission to Study Long-term Care Workforce Issues

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Office of Policy and Legal Analysis

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129th LEGISLATURE
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Commission to Study Long-term Care Workforce Issues

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Executive Summary

The Commission to Study Long-term Care Workforce Issues was established by Public Law 2019, chapter 343, part BBBBB, in recognition of the tight labor market and resulting workforce shortage of direct care workers across the long-term services and supports continuum including home and community-based services, residential services and other support services. The Commission was charged with studying the following issues related to the long-term care workforce:

- Measuring current demand for direct care workers and projecting future needs;
- Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;
- Supporting career ladders throughout various long-term care settings;
- Identifying education needs and methods to fill education needs for direct care workers;
- Identifying barriers to hiring and methods to overcoming barriers to hiring;
- Developing strategies to improve the quality of long-term care jobs;
- Increasing opportunities for shared staffing among long-term care providers;
- Recommending public and private funding mechanisms to implement recommendations;
- Recommending a program to contribute to long-term direct care workers postsecondary education in related fields; and
- Recommending a pilot program to pool part-time home care workers' hours for purposes of providing greater employment opportunity and obtaining employee benefits.

The Commission held five meetings during the interim and is required to submit a report, with findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services. Suggested legislation is included in this report for some recommendations, however, for most recommendations the Commission did not determine a preference for whether the Committee should direct executive departments by legislation or by letter. Every recommendation made by the Commission was a consensus although the representatives from the Departments of Health and Human Services and Labor chose not to take positions on recommendations. The recommendations to the Committee are as follows.

Reimbursement

1. Increase wages for starting direct care workers to no less than 125% of the minimum wage.
2. Direct the Department of Health and Human Services to explore limiting reimbursement rates for temporary staffing agencies providing direct care worker services for long-term services and supports.
3. Increase reimbursement rates to reflect current and future structural additions to provider costs, including increases in minimum wage, paid time off, electronic visit verification requirements, background checks and potentially fingerprinting.
4. Direct the Department of Health and Human Services to identify ways to consolidate tasks currently performed by multiple staff in both home and community-based and residential settings.

5. Direct the Department of Health and Human Services to explore options to develop an alternative reimbursement methodology that includes the following:
    - Accounts for acuity level of clients of home and community based services, for both older adults and individuals with an intellectual disability or autism similar to the way case-mix is used in nursing facilities;
    - Allows additional reimbursement for merit or longevity pay increases for direct care workers;
    - Allows for increased reimbursement for specialized care including dementia care, bariatric care or behavioral needs;
    - Reimburses for ongoing training including for agency or nursing facility personnel taken off line to conduct training of employees; and
    - Includes direct care workers as paid staff in any multi-disciplinary care planning team with a reimbursement rate to recognize the value of that work.
6. Support legislation to enact a Rate Setting Commission that is independent of the Department of Health and Human Services that evaluates reimbursement rates for all long-term services and supports.

Workforce recruitment and retention

7. Direct the Department of Labor, in coordination with the Department of Economic and Community Development and the Department of Health and Human Services, to develop and implement a multimedia public service campaign that promotes direct care worker jobs as a career choice. Ensure that the campaign materials include new Mainers, men, younger people including high school students, older people and individuals with disabilities.
8. Direct the Department of Labor to conduct job fairs through the State focused on direct care workers for all long-term care settings.
9. Direct the Department of Health and Human Services offer direct care training programs in languages other than English and for ESL individuals.
10. Direct the Department of Health and Human Services to explore options, including those models outlined by PHI and National Conference of State Legislatures, for supportive supervision and mentoring for direct care workers.

Workforce development

11. Direct the Department of Labor to work with the Department of Education, Maine's institutes of higher education, and Maine's Career and Technical Education Centers to develop and target education and certification programs for direct care workers, including high school vocational education programs including the following:
    - Apprenticeship programs for direct care workers;
    - "Earn as you learn" programs for direct care workers; and
    - Pre-apprenticeship program for Maine's Career and Technical Education Centers.
12. Recommend to the Joint Standing Committee on Innovation, Development, Economic Advancement and Business that it amends LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program, to specify that direct care workers be considered eligible health care providers and direct care occupations be included for

priority consideration by the Maine Health Care Provider Loan Repayment Program Advisory Committee that is proposed in the bill.

13. Direct the Department of Health and Human Services to work with Maine's institutions of higher education and Career and Technical Education Centers to develop worker pools of students, including students with disabilities, interested in working as direct care workers on a part-time and/or flexible schedule basis.
14. Require all healthcare degree programs that require practicum experience to include practicum requirements and rotations in the long-term services and support sector.

Qualifications and training

15. Direct the Department of Health and Human Services to examine qualification requirements for entry-level direct care workers to align qualifications across settings wherever possible without compromising consumer safety.
16. Direct the Department of Health and Human Services to immediately reconstitute, update and implement the Maine Direct Service Worker Training Program.

Expanding existing support systems

17. Direct the Department of Health and Human Services to remove as many barriers to family members and guardians being paid caregivers as possible and allowable under federal law and regulations.
18. Direct the Department of Health and Human Services to review the hours allowable for adult day health services, respite services and other similar programs for adequacy in allowing individuals to remain at home with family members as long as desired by both the caregivers and the individuals receiving services.
19. Direct the Department of Health and Human Services to raise the caps and create more flexible cost models for assistive technology and environmental modifications for members receiving home and community-based services.

Consumer-directed services

20. Direct the Office of Aging and Disability Services within the Department of Health and Human Services to convene a work group of stakeholders within the department that includes providers, advocates and consumers, to determine how to expand the consumer directed options to individuals with developmental disabilities or autism and examine if consumer-directed options are fully utilized for all populations eligible for home and community-based services.

Pooling and connecting workers

21. Direct the Department of Health and Human Services to convene a stakeholder group of providers to explore methods to pool workers across providers and care settings or programs, including developing a method to provide benefits to the workers.
22. Direct the Department of Health and Human Services to explore creating a HIPAA-compliant digital platform to connect direct care workers, providers, self-directing

consumers and family members. The department must include providers in its exploratory effort.

Public Assistance

23. Direct the Department of Health and Human Services to explore options for increasing income levels for direct care workers who are receiving various public assistance benefits and ensure that department's case workers communicate this information to their clients.
24. Direct the Department of Health and Human Services to study public assistance programs across the spectrum to determine where higher income levels might be allowable under federal and state laws and rules and consider developing programs that provide more flexibility of increased hours among direct care workers and report findings to the Joint Standing Committee on Health and Human Services for statutory action.
25. Improve communication and navigation of maximum income levels to individuals receiving public assistance.

Grants

26. Direct the Division of Licensing and Certification in the Department of Health and Human Services to convene a work group to develop proposals for projects in nursing homes focused on best practices for recruitment and retention of direct care staff using Civil Money Penalty Reinvestment Program funds and submit those proposals to the Centers for Medicare and Medicaid Services.
27. Direct the Department of Health and Human Services to consider applying for a grant under the Lifespan Respite Care program grant offered by the ACL within the federal Department of Health and Human Services, or working with any appropriate organization that is eligible.
28. Direct the Department of Health and Human Services to investigate and apply for any grant opportunities that improve the quality of long-term care services and supports.

Oversight Committee

29. Enact an ongoing, independent Oversight Committee to review progress in implementing the recommendations of this Commission, address barriers to implementation, and make new recommendations as needed.

I. INTRODUCTION

During the first interim of the 129th Maine State Legislature, the Commission to Study Long-term Care Workforce Issues, referred to as "the Commission" in this report, was established by Public Law 2019, chapter 343, part BBBBB. It held five meetings during the interim. The duties of the Commission are set forth in Part BBBBB, section 4. The Commission was charged with studying the following issues related to the long-term care workforce:

- Measuring current demand for direct care workers and projecting future needs;
- Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;
- Supporting career ladders throughout various long-term care settings;
- Identifying education needs and methods to fill education needs for direct care workers;
- Identifying barriers to hiring and methods to overcoming barriers to hiring;
- Developing strategies to improve the quality of long-term care jobs;
- Increasing opportunities for shared staffing among long-term care providers;
- Recommending public and private funding mechanisms to implement recommendations;
- Recommending a program to contribute to long-term direct care workers postsecondary education in related fields; and
- Recommending a pilot program to pool part-time home care workers' hours for purposes of providing greater employment opportunity and obtaining employee benefits.

The Commission is required to submit a report, with findings and recommendations, including suggested legislation, to the Health and Human Services Committee by November 7, 2019.[1] Public Law 2019, chapter 343, part BBBBB is contained in Appendix A and the full list of Commission members is contained in Appendix B. Suggested legislation is contained in Appendix C.

The Commission held five meetings on the following dates: September 11, September 26, October 24, November 14 and December 10. All meetings were open to the public and were broadcast by audio transmission over the Internet. Agendas of all Commission meetings and other information relating to the study can be found online at: http://legislature.maine.gov/long-term-care-workforce-commission.

II. BACKGROUND

Demographics

The Commission was enacted as part of the biennial budget in recognition of the tight labor market and resulting workforce shortage of direct care workers in both home and community-based services and residential services.[2] Background information presented by the Department of Health and Human Services at the first meeting relating to unstaffed hours and waitlists for services and the demographics of the population in Maine illustrates that the mismatch between

[1] The Legislative Council granted permission to the Commission to hold an additional meeting and the deadline for the report was extended to December 15, 2019.

[2] The Commission was originally enacted in 2018 in Public Law 2017, chapter 460, Part B-5 but all members were not appointed and the Commission never convened, and the language was included in the biennial budget in 2019.

services needed and workers available will only become more acute. In addition, PHI's presentation to the Commission on October 24, reiterated this current and increasing demand for direct care workers by citing the growing population of older adults nationally and in Maine, combined with consumer preferences for home and community-based care over institutional care, and policy and programmatic changes such as the changes to clinical eligibility for nursing facilities in 1990 in Maine that have resulted in the highest level of acuity in the country.[3]

Maine is currently the oldest state in the nation with a mean age of 44.3 in 2017.[4] The Department of Administrative and Financial Services data cited by the Department of Health and Human Services shows the population aged over 65 years of age in Maine is growing. In 2016, two counties in Maine had more than 25% of the population aged over 65 years of age. In 2026, it is predicted that 14 counties will have more than 25% aged over 65 years of age and in 2036, all Maine counties are expected to have this demographic pattern.[5] According to the department's presentation, 52-70% of individuals turning 65 today will eventually need some form of assistance with their activities of daily living.

Long-term services and supports continuum

Long-term services and supports span a continuum from non-clinical services such as homemaker services (housekeeping), meals on wheels and adult day services to the institutional services in nursing facilities and Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IIDs). In the middle of the continuum there is a variety of home and community-based services provided by personal support specialists (PSSs), home health nurses, CNAs, direct support personnel (DSPs), and other direct care workers in a client's home, and in adult family care homes, private nonmedical institutions (PNMIs) and other types of independent housing services. It is important to remember that clients receiving home and community-based services may qualify, based on acuity, for an institutional level of care. For example, clients receiving home and community-based services under a Medicaid waiver, by definition, qualify for an institutional level of care.

The payer sources for long-term services and supports for older adults, adults with disabilities or individuals with developmental disabilities or autism include MaineCare (Medicaid), state-funded programs, private pay, and limited Medicare reimbursement for skilled nursing facility services after hospitalization. A thumbnail sketch of the MaineCare and state-funded programs that provide long-term services and supports is as follows:

MaineCare (Medicaid) reimburses for long-term services and supports under the following sections of Chapter 101, the MaineCare Benefits Manual:

- Section 2 – adult family care homes;
- Section 12 consumer-directed attendant services;
- Section 18 – home and community-based waiver services for adults with brain injury;
- Section 19 home and community-based waiver services for older adults and adults with disability;

[3] http://legislature.maine.gov/doc/3430.
[4] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.
[5] http://legislature.maine.gov/doc/3181.

- Section 20 – home and community-based waiver services for adults with other related conditions;
- Sections 21 and 29 home and community-based waiver services, and support services, respectively for adults with an intellectual disability or autism;
- Section 26 adult day health services;
- Section 40 home health services;
- Section 50 ICF-IID facilities;
- Section 67 – nursing facilities;
- Section 96 – private duty nursing services;
- Section 97 PNMI; and
- Section 102 – rehabilitation services.

State-funded (i.e. non-Medicaid) programs that reimburse for long-term services and supports include but are not limited to:

- Chapter 11 – Consumer-directed personal assistance services;
- Section 61 Adult day services;
- Section 63 In-home and community support services for elderly and other adults;
- Section 68 – Respite care for people with Alzheimer's or related disorder; and
- Section 69 Independent Services and Supports (the Homemaker program).

Service shortages waitlists, unstaffed hours, closures and hospitalizations

An individual who qualifies or is eligible for services under MaineCare or state-funded programs may not necessarily receive those services. Medicaid is an entitlement program but states may create waitlists for services when they are provided under a Medicaid waiver. For state-funded programs, states may institute waitlists. Increasing the number of people who receive services under waivers or state-funded programs or increasing the number of hours or augmenting services requires additional budgetary funding. However, even when an individual who is entitled to services under Medicaid, or is approved and funded under a waiver or a state-funded program, that person may still not receive services if there are insufficient providers to provide services (unstaffed hours or funded offers seeking support in the community).

The Department of Health and Human Services provided information to the Commission on waiting lists and unstaffed hours at the first meeting.[6] In 2019, there were 40 eligible individuals waiting for Section 18 services, 20 waiting for Section 20 services, 1,580 waiting for Section 21 services, 191 waiting for Section 29 services, 123 waiting for Section 63 services and 664 waiting for Section 69 services (see the department's presentation for the specific date of each wait list). There are also members no longer on the waitlist who have funded offers for Sections 18 and 20 who are seeking support in the community or seeking a group home provider and therefore lacking services. For unstaffed hours, as of June 30, 2019 with data from one of two service coordination agencies, Section 63 clients had 512 registered nurse hours per month and 2,192 personal support hours per month unstaffed. For Section 19, unstaffed hours amounted to 728 RN hours per month and 2,114 PSS hours per month. Under Section 96, unstaffed hours were 1,842 RN hours per month and 2,674 PSS hours per month. Under the homemaker program, Section 69, there was 1,640 unstaffed hours per month. The unstaffed hours data does

[6] http://legislature.maine.gov/doc/3181.

not include consumer-directed hours. In consumer-directed programs, the consumer is the employer managing the consumer's own hiring and firing rather than an agency, and unstaffed hours data is not collected and the extent of unstaffed hours is unknown. Particularly concerning is that when home and community-based service hours go unstaffed, vulnerable individuals lack the services intended to keep them both safe and independent. When these approved hours go unstaffed the likelihood the consumer will end up needing a higher institutional level of care or hospitalization both of which are more expensive.

The Commission also requested information from Department of Health and Human Services about the number of nursing facility and PNMI Appendix C beds in response to news stories about closures of nursing facilities or residential care homes. Sarah Taylor, Director of the Division of Licensing and Certification, briefed the Commission on September 26th. She stated that in 2014, the state had 105 nursing facilities and now there are 94. At the bed level, Director Taylor stated that between 2015 and summer 2019, Maine lost 337 nursing facility beds and gained 154 level 4, PNMI, Appendix C beds (there was no significant change to the number of beds at other levels of assisted living over the last two years). There are also three Certificate of Need (CON) reviews underway that could further change the numbers: Sandy River North Country plans to replace 121 nursing facility beds with a new 90-bed facility; Woodlands plans a new 42 bed assisted living facility in Madison; and Newton plans to replace a facility with 74 nursing facility beds and 38 residential care beds with a new facility with 64 and 30 beds respectively. Also important to this picture is occupancy data. Director Taylor stated that in 2015, nursing facility beds were at a 90.23% occupancy rate and residential care was at 91.29%. In the summer of 2019, the occupancy rates were 90.01% for nursing facilities and 89% for residential care. Therefore, although the state may be losing beds, the occupancy rates are not significantly different. The Commission recognizes but did not investigate whether nursing facility closures decreased the number of beds available in any given geographic area of the state leaving a significant unmet need.

It is unclear what the impact of staffing shortages is on nursing facilities and residential care homes. Rick Erb of the Maine Health Care Association (representing facility-based long-term care) was asked about the effect of staff shortages on admissions, closures of wings and/or unfilled beds. Dropping below mandatory staffing levels in nursing facilities is an immediate violation of federal laws and regulations so these facilities must resort to more expensive temporary staffing and overtime when necessary to maintain adequate staffing ratios. Mr. Erb stated that there are multiple examples of facilities closing wings or keeping beds empty due to lack of staffing and that it is universal around the state and not a regional issue. A survey of 81 facilities showed that 60% of those facilities had limited admissions due to staffing shortages in the last 90 days.[7] Commission member Mary Jane Richards of North Country, whose company has two of the CON reviews mentioned above, and Director Taylor agreed that the impact of staffing shortages on occupancy needs to be tracked to provide a clearer picture of the interrelationship between nursing home closures, occupancy and staffing vacancy rates.

When no long-term services and supports are available at all, some individuals end up essentially living in hospitals after the medical crisis or event that sent the person there in the first place, has been treated. Lisa Harvey-McPherson from Northern Light presented information on hospitalized patients awaiting placement in a nursing or residential facility. She stated that using

[7] http://legislature.maine.gov/doc/3182.

Eastern Maine Medical Center as an example, with 90 days of data, there were 47 patients each week in hospitals for more than 10 days. Some patients need specific services that can be identified such as bariatric or gero-psych or have guardianship issues, but there was still an average of 13 patients that did not fall into a specialty population. As mentioned above, there is no data for when non-specialty populations needing placements are not accepted because of staffing vacancies at facilities.[8]

Reimbursement rates

The Commission had extensive discussions at every meeting about reimbursement rates under MaineCare and state-funded programs, the need to increase wages for direct care workers and the inadequacy of the current reimbursement rates to cover the costs of providing services currently or account for future structural additions to cost. Reimbursement rates for direct care workers in nursing facilities and providing home and community-based services have been the subject of several legislative studies, rate studies and legislation in recent years.

Burns & Associates conducted a rate study of Personal Support Specialists (PSS) under MaineCare Sections 12, 19 and 96 and State-funded programs under Section 63 and Chapter 11 with a report along with a wage model issued on February 1, 2016. Burns & Associates collected cost data from providers in a survey mailed in December 2014 and used Bureau of Labor Statistics (BLS) data from 2014. The wage models were fully implemented over the course of two Legislatures. Rates were increased in Public Law 2015, chapter 267 (the biennial budget) for PSS services for MaineCare Sections 19 and 96, state-funded Section 63, and Adult Day health services; Resolve 2015, chapter 50 increased rates for Section 12. Resolve 2015, chapter 83, passed in April 2016, implemented 50% of the increases developed in the Burns & Associates wage model. Public Law 2017, chapter 459, Part B, enacted in July 2018, increased reimbursement effective July 1, 2018, to fully implement the increases developed in the wage model. However, Commission members noted that the wage models are already outdated and the shortfall between reimbursement rates and cost is increasing.

Nursing facility and PNMI reimbursement and employee pay was the subject of two legislative studies in 2013 and 2014. Public Law 2013, chapter 549, enacted in 2014, increased funding for nursing facilities, regularly rebases every two years so that cost settlements are based on more recent real costs, increased the peer group upper limit to 110% of the median for some costs, and established supplemental payments to facilities with more than 70% of MaineCare populations in the number of total residents. However, the appropriation in Public Law 2013, chapter 549 was insufficient to fund the provisions in the law requiring an additional appropriation the following year in Public Law 2015, chapter 267 (the biennial budget). Rick Erb noted, in a presentation to the Commission, that nursing facility unfunded costs have again returned to the level experienced prior to the enactment and funding of Public Law 2013, chapter 549.[9]

Public Law 2015, chapter 267 (the biennial budget) also increased rates to PNMIs and adult family care homes. In Public Law 2017, chapter 304, PNMIs were allowed to request an adjustment to the prospective rate in the form of an extraordinary circumstance allowance which includes increases in minimum wage or social security expenses, changes in the number of

[8] http://legislature.maine.gov/doc/3180.
[9] http://legislature.maine.gov/doc/3505.

licensed beds and changes in licensing requirements. In 2018, Public Law 2017 chapter 460, part B, required annual cost of living allowances attributable to increases in wages and salaries for personal care for nursing facilities, adult family care homes, PNMIs, adult day services and homemaker services until rate studies conducted by a third party are completed and increased the supplemental payments to low-cost high Medicaid nursing facilities. The law also granted a one-time 10% increase in wages and associated benefits and taxes for 2018 that only applied for one year. During the First Regular Session of the 129th Legislature, LD 1758, as amended by the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs, continues the 10% increase on an ongoing basis at a cost of $5.9 million in general funds in fiscal year 2019-2020 and fiscal year 2020-21. This bill was initially held by the Governor. A letter to the Joint Standing Committee on Appropriations and Financial Affairs from the Governor clarified her position on the bill including allowing the funding to go forward.[10]

Direct Support Professionals rates for services provided under MaineCare Sections 21 and 29 to individuals with intellectual disabilities or autism were increased in Public Law 2017, chapter 459, part A, which was enacted in July 2018. That law also increased reimbursement for the direct care services in Sections 21 and 29. In addition, the law enacted a statutory requirement for rates to take into account "the costs of providing care and services in conformity with applicable state and federal laws, rules, regulations and quality and safety standards and local competitive wage markets."[11] The law requires a regular review every two years.

Commission members and other providers presenting information and testimony at Commission meetings all stated that reimbursement rates are insufficient to allow for new and increasing costs. Initiated Bill 2015, chapter 2 increased the minimum wage with the first increase occurring in January 2017; the rate is $12 an hour as of January 2020. Public Law 2019, chapter 156 requires paid time off to be provided to employees from January 1, 2021. Employers with over 10 employees will be required to provide at least one hour of paid time off for each 40 hours worked. Other structural additions to provider costs include federal electronic visit verification requirements, background checks and the possibility of fingerprinting. The Burns & Associates' PSS rate study was based on 2013-14 costs and took place prior to any of these federal or state laws and regulations.

During the meeting held on November 14, the Commission had presentations from John Watson from Cedars, Jennifer Putnam for the Maine Association for Community Service Providers (MACSP) who provide Section 21 and 29 services, Rick Erb representing nursing facilities and residential care homes and Mike Stair representing Home Care & Hospice Alliance of Maine, to illustrate the lagging of reimbursement rates compared to current costs and upcoming expenses.[12] Jennifer Putnam stated that the January 2020 minimum wage of $12 an hour is above the amount included in the reimbursement for Direct Support Professionals. The hourly rate paid in 2019 of $27.72 an hour includes an hourly cost for labor of only $11.20 (the rate also includes benefits, taxes, training, program expenses, general administration and a portion of the service provider tax) and that had been increased from $9.17 an hour in Public Law 2017, chapter 459. Ms. Putnam also mentioned that even in Western Maine, it was not possible to attract DSPs at $12/hour as this was less than employees at a local big box store or gas stations were earning.

[10] http://legislature.maine.gov/doc/3610.
[11] 22 MRSA §3195.
[12] http://legislature.maine.gov/long-term-care-workforce-commission.

Employees started at $12.75 an hour, over $13 if they had qualifications and $16.82 for OTs. It was also necessary to resort to overtime or temporary agency staffing which began at $27/hour exacerbating the shortfall. Mike Stair's presentation estimates the impact of higher minimum wage, paid time off, electronic visit verification, fingerprinting, the new PSS curriculum requirements and revaluation bonds will have on costs to home care providers. John Watson's presentation illustrated the structural gaps inherent in the complicated methodology for reimbursing nursing homes that are gradually impacting access to care, particularly for MaineCare members.

Workforce Recruitment and Retention

A critical component of reducing the workforce shortage within the long-term services and supports field is increasing recruitment and improving retention rates. Providers across the continuum of care were represented on the Commission and all consistently reported difficulty in hiring workers and experiencing a level of employee turnover at the highest level they had ever seen. Members of the Commission and providers who testified spoke of turnover rates from 50% to 70% of employees in one year. One member of the Commission noted employees were leaving for smaller incremental increases in pay than ever before. According to the Department of Labor, personal care and service jobs are the most difficult to fill[13] and are projected to grow from 2016 to 2026 by 3.9% from 33,574 to 34,881 jobs.[14] National studies show a "conservative" estimate of turnover rate ranging from 45% to 66% with the average cost of turnover at $2,200 per person.[15]

Sandy Butler presented her longitudinal homecare worker retention study from 2009-2011 using surveys and interviews to learn about factors contributing to turnover and retention with the caveat that her study had been carried out a few years ago prior to federal and state legislative changes to health insurance requirements and minimum wage increases (she is currently working on another study that is smaller).[16] The workers in the survey were 94.6% women, 93.5% European American or Caucasian with 3.4% born outside the U.S., 62.5% earned less than $20,000 a year, were generally in better health than the U.S. population although worse for body pain and occupational injuries, worked an average of 18 hours a week and generally liked their jobs. Survey data from those who left their jobs showed they were more likely to be younger, lack health insurance, have lower scores on mental health (depression and anxiety) and more intense feelings of personal accomplishment. Interviews honing in on the reasons for leaving showed three main themes: the job was not worthwhile due to low pay, lack of benefits and travel reimbursement, inconsistent hours and not enough clients in their area; personal reasons including family issues, medical problems, retirement, moving, returning to school or no longer caring for a family member; and burnout including agency problems, difficult clients, false accusations and death of clients. Dr. Butler highlighted surprising findings including more intense feelings of personal accomplishment related to leaving; lower physical function, e.g. disabilities, leading to longer tenure; and rural residence predicts a longer tenure possibly because of fewer job opportunities in those areas. She also found that lower wages did not

[13] http://www.maine.gov/labor/cwri/jvs/occupation.html.
[14] https://www.maine.gov/labor/cwri/outlook.html.
[15] Scales, Kezia, PHI. (2018), *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, p. 4 found at https://phinational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/.
[16] http://legislature.maine.gov/doc/3244.

predict termination but that higher wages did predict longer tenure and that older workers were less likely to leave and more likely to stay longer in the job.

Testimony from commission members and by providers testifying at public comment periods indicate that providers have tried to attract and retain workers with pay increases, sign on bonuses, offering health insurance and paid time off, employee recognition days, birthday and rising star awards, free training and revolving loan programs for car insurance and repairs, but that turnover rates have remained stubbornly high. In addition, Commission members also heard from workers, including Commission member Rachel Small, that the health insurance offered was still too expensive to purchase.

Direct care worker training

The "direct care worker" umbrella includes a number of different job titles in different sections of MaineCare and state-funded programs, each with its own entry qualifications and training requirements. The term includes Personal Support Specialist (PSS), Direct Support Professional (DSP), Certified Nursing Assistant (CNA), Home Health Aide (HHA), Independent Support Specialist (ISS), Mental Health Rehabilitation Technician (MHRT), Certified Residential Medication Aide (CRMA) and several others. The Department of Health and Human Services briefed the Commission on the requirements within each program.[17] The Commission had several discussions about whether it would be useful to have a common curriculum to enable movement of workers within the field.

Nadine Edris of the Muskie School of Public Service presented the training program called the Maine Direct Service Worker Training Program that was developed under a Health Resources and Services Administration grant awarded to the Department of Health and Human Services in 2010.[18] Under this 3-year grant, the department established a cross-agency workgroup and partnered with the Muskie School to develop and test a competency-based, blended, coordinated training program for direct care workers. The curriculum included a common entry-level training with specialized, non-overlapping modules with job-specific content. The curricula were developed after Muskie examined state and federal laws, policies, rules and guidelines to identify the training requirements for 11 types of direct care workers,[19] a core curriculum and specialty curricula for the three types of direct care workers: PSS, MHRT-1, and DSP.

The Maine Direct Service Worker Training Program adheres to adult learning principles using a variety of instructional materials and technological support. The core curriculum includes: roles and responsibility; personal care and home support; consumer needs, rights and choices; communication and interpersonal skills; safety; and documentation. The next level of training is specific to the jobs of PSS, MHRT-1, or DSP. A third level of optional trainings modules was also created, for example, dementia and challenging behaviors. The Muskie School collected and analyzed data in several areas such as student and teacher satisfaction with the material and formats, overall attrition rates, and attrition rates for each training delivery method (in-person and on-line).[20] The data was collected to further refine the training program. The training

[17] http://legislature.maine.gov/doc/3181.
[18] http://legislature.maine.gov/doc/3261.
[19] PSS, CNA, CNA-M, CRMA, CDPA, DPS, FPSO, HHA, ISS, MHRT-I, and CIPSS (Muskie School of Public Service at the University of Southern Maine, 2017 found at http://legislature.maine.gov/doc/3179).
[20] The results are available at http://legislature.maine.gov/doc/3178.

program was successfully piloted several times by providers including Commission member Jillian Jolicoeur of Assistance Plus, but the curriculum was never fully implemented.

The Commission was also briefed on the update of the PSS curriculum developed by the Department of Health and Human Services, Division of Licensing and Certification. The curriculum had last been updated in 2003 and those materials are no longer in print. The new curriculum is required as of January 1, 2020. For Commission members who represent providers and train their own staff, this requirement provides an additional cost.

III. RECOMMENDATIONS

The Commission developed the following recommendations for review by the Joint Standing Committee on Health and Human Services. Several of the recommendations direct executive departments to raise reimbursement rates, convene stakeholder groups, develop projects, or explore policy options. Suggested legislation is included in this report for some recommendations. However, for most recommendations, the Commission did not determine a preference for whether the Committee should direct executive departments by legislation or by letter.

Reimbursement for Current and Future Structural Costs

Commission members had extensive discussions during each meeting about the need to increase wages for direct care workers. From a business perspective, the current reimbursement rates paid for long-term services and supports are insufficient to account for impending increases in minimum wage including the $1/hour increase that goes into effect on January 1, 2020. In addition, the current reimbursement rates do not account for future structural additions to provider costs such as paid time off, PSS curriculum requirements, electronic visit verification and background checks and possible fingerprinting.

A significant new requirement for home and community-based service providers that is proving to be an expensive and complicated mandate is the electronic visit verification (EVV) requirements included in Section 12006 of the federal 21st Century Cures Act.[21] Under the Cures Act, states must use an EVV system for Medicaid funded personal care services, including those covered by 1915(c) waivers and 1115 demonstrations, and home health services that require an in-home visit by a provider. The law requires the EVV system to be in place for personal care services by January 1, 2020 and January 1, 2023 for home health services (Section 40 services under MaineCare) although Maine, along with a number of states, has received an extension for the former to January 1, 2021 from the Department of Health and Human Services, Centers for Medicare and Medicaid Services. The Maine Department of Health and Human Services has established a deadline of July 1, 2020 for providers of personal care services to submit claims with EVV records. The records verify the type of service performed, the individual receiving the service, the date of the service, the location of the service delivery, the individual providing the service, and the time the service begins and ends. Noncompliance with the EVV requirements result in reductions in FMAP up to 1%.

[21] Public Law 114-255.

The Maine Background Check Center Act[22] establishes a list of offenses that disqualify any individual for employment as a direct access worker (although an individual may apply for a waiver of the disqualification under certain circumstances). Providers of long-term care services and supports are required to use the Maine Background Check Center (MBCC), a web-based system operated by the Department of Health and Human Services, to run a pre-employment background check for all direct care workers (the law also requires background checks on all workers who were employed at the time the law was enacted) and checks must be conducted every five years; the center also constantly monitors an individual's criminal history. The MBCC does not currently include fingerprinting so criminal background checks are limited to state level convictions, analysis of the abuse and neglect and sex offender registries and employment related registries (e.g. professional boards).

Currently, each background check costs $56 and is not portable for the individual. This lack of portability combined with significant turnover rates, has caused the costs of completing background checks to become an increasing cost for employers that is not included in the current reimbursement rates. This problem may only become worse if the federal requirement to fingerprint childcare employees and applicants is expanded to employees and applicants in the long-term services and supports industry. While providers are not opposed to the concept, there is concern that there is no source of funding and current reimbursement rates are not sufficient to cover the current cost of background checks without adding fingerprinting (estimated to increase each background check by $40 [23]).

When providers are unable to find staff in a tight labor market conditions, they have increasingly been forced to resort to hiring temporary agency staff to maintain staff to resident ratios at considerably more expense; providers do not receive additional reimbursement for this cost. Massachusetts recently capped rates that could be paid for temporary nursing staff at hospitals and nursing facilities.[24] Maine should explore this option as well.

Aside from the insufficiency of the current rates to account for minimum wage increases, Commission members stress that direct care workers do hard physical and emotional work and deserve to be paid more than the minimum wage. These workers provide critical services that ensure that older adults and individuals with disabilities remain safe in their homes and residential and nursing facilities, ensure consistent and quality care and offer choice. Building off the concepts contained in LD 399, An Act To Align Wages for Direct Care Workers for Persons with Intellectual Disabilities or Autism with the Minimum Wage, a bill that has been carried over on the Appropriations table, the Commission determined that direct care workers should be paid at least 125% of the minimum wage (regardless of the level of the minimum wage) to attract workers to this sector of employment.

Increasing wages for entry-level employees will have a ripple effect on wages as employees who have higher levels of qualification or more experience and are currently paid at a higher level than those entry-level employees will expect a similar increase in pay. All members of the Commission stressed the importance of a necessary increase in direct care worker pay and the need to increase reimbursement rates to allow for a similar increase at the same time. The

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[22] Public Law 2015, chapter 299.

[23] Testimony from Department of Health and Human Services for LD 45. Located at: http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=122958.

[24] https://www.mass.gov/doc/101-cmr-345-rates-for-temporary-nursing-services/download.

Commission members are aware of the significant costs of such an increase and acknowledge it will require an appropriation through the legislative process.

The Commission wrote to the Health and Human Services Commissioner Lambrew requesting the department immediately increase reimbursement rates, including any requests for appropriations to ensure the quality of care provided and to prevent providers from going out of business. This letter is attached as Appendix D. Commissioner Lambrew responded to the Commission by letter suggesting the Commission direct its request to the Legislature for appropriations. The letter also states that the department is conducting an evaluation of MaineCare rate setting, and that the Governor recently supported LD 1758, An Act To Clarify and Amend MaineCare Reimbursement Provisions for Nursing and Residential Care Facilities, increasing funding for nursing facilities. Commissioner Lambrew's letter is attached as Appendix E.

Recommendations (immediate):

1. Increase wages for starting direct care workers to no less than 125% of the minimum wage.

2. Direct the Department of Health and Human Services to explore limiting reimbursement rates for temporary staffing agencies that provide direct care worker services for long-term services and supports.

3. Increase reimbursement rates to reflect current and future structural additions to provider costs, including increases in minimum wage, paid time off, electronic visit verification requirements, background checks and potentially fingerprinting.

Legislation to increase reimbursement rates is included in Appendix C.

Alternative Rate Reimbursement Methodologies

The recommendations above relating to starting direct care worker pay and current and future structural additions related to federal or state laws and rules are recommendations for immediate action. However, Commission members recommended that the Department of Health and Human Services consider alternative reimbursement methods that would directly and indirectly impact the workforce shortage and reimburse for quality and additional service provision. For example, current reimbursement for home and community-based services does not recognize the acuity level of clients, pay increased levels for specialized care, account for a worker's skill level or longevity, pay training costs or pay for the direct care worker to be part of the care planning team. The current rate methodologies also prevent efficiencies in work assignment.

Direct care workers and the organizations that employ them often find that individual workers are not able to perform certain tasks for clients because they are outside of their scope of practice resulting in more than one worker present in the home at one time. Commission members understand that there are complicated regulatory issues in terms of allowable tasks for certain credentialled workers, services that relate to activities of daily living versus instrumental activities of daily living, and program integrity. Providers and clients would like to be able to have blended workers that can provide care in the moment rather than one direct care worker

providing higher level medical tasks while waiting for an additional PSS or similar direct care worker to arrive to provide another service even though it might have been more efficient to provide all the tasks at once and be adequately reimbursed for them.

Recommendations (intermediate/long-term):

4. Direct the Department of Health and Human Services to identify ways to consolidate tasks currently performed by multiple staff in both home and community-based and residential settings.

5. Direct the Department of Health and Human Services to explore options to develop alternative reimbursement methodology that includes the following:

    - Accounts for acuity level of clients of home and community-based services, for both older adults and individuals with an intellectual disability or autism similar to the way case-mix is used in nursing facilities;
    - Allows additional reimbursement for merit or longevity pay increases for direct care workers;
    - Allows for increased reimbursement for specialized care including dementia care, bariatric care or behavioral needs;
    - Reimburses for ongoing training including for agency or nursing facility personnel taken off-line to conduct training of employees; and
    - Includes direct care workers as paid staff in any multi-disciplinary care planning team with a reimbursement rate to recognize the value of that work.

Rate Review

Commission members discussed the need for reimbursement rates for MaineCare and state-funded long-term services and supports to be reviewed and adjusted on a regular basis for two important reasons. First, the current system encourages providers to appeal to the Legislature for rate increases and therefore the Legislature reviews multiple bills each session requesting increases to reimbursement for a myriad of MaineCare and state-funded program rates. Providers of different services (not only long-term care rates) feel pitted against each other competing for scarce resources. Second, the increases to rates for home and community-based services provided to older adults as a result of the Burns & Associates study and corresponding legislation illustrate the non-dynamic nature of the current system of rate review – rates have already fallen short of increases to the minimum wage. Even services that do receive COLAs, such as nursing facilities, are still facing structural shortfalls because of arbitrary peer groupings used to set caps and upper limits, restrictions on allowable costs and time-lags in cost-reports.

The Commission recommends that a rate setting commission be established outside of the department to undertake the task of reviewing rate methodologies, including interested parties in those deliberations and making recommendations to the department for all long-term services and supports. At the time the Commission was meeting, the Joint Standing Committee on Health and Human Services had carried over from the first session to the second session LD 1052, An Act to Require Regular and Transparent Review of MaineCare Reimbursement Rates, and requested a presentation from the Department of Health and Human Services outlining its activities around rate review. Although the Commission recognizes that this recommendation is

at the intermediate level, that does not mean that this recommendation is of a secondary importance but that it recognizes that it will take more time to complete.

Recommendation (intermediate):

6. Support legislation to enact a Rate Setting Commission that is independent of the Department of Health and Human Services that evaluates reimbursement rates for all long-term services and supports.

Direct Care Workforce Recruitment and Retention

A key component of addressing workforce shortages in the long-term services and support continuum is attracting more workers to the direct care field and retaining those workers and elevating the importance of the work to society. The Commission stressed the need to attract additional workers to the direct care field including new Mainers, men, younger people including students, older people and individuals with disabilities. Campaigns to attract new workers need to include all populations in the marketing materials. For example, Commission members pointed out that it is important to de-gender the workforce to both attract men to the direct care field and to have clients accept male caregivers. In Maine, six out of seven direct care workers are female.[25] Adults with disabilities are an untapped resource for the workforce. Adults with disabilities want to work but are much less likely to be employed than adults with no disability. From 2013 to 2017, 33% of working-age Mainers with disabilities were employed compared to 80% of those without a disability.[26]

The Commission spent considerable time discussing employee turnover and retention. As stated above, providers are experiencing turnover rates of 50% and above in a single year in all long-term care settings in the State. Turnover is expensive, resulting in increased recruitment and training costs to the provider. The Commission sought examples from other states that have been implemented and evaluated with presentations from Stephen Campbell, Data and Policy Analyst from PHI and Samantha Scotti from the National Conference of State Legislatures. Mr. Campbell and Ms. Scotti stated that increasing recruitment and retention in this field requires a multipronged approach that includes raising the public profile of direct care jobs, increasing their worth and emotional value, strengthening the career ladder for direct care workers beyond entry-level jobs, creating additional rungs on the career ladder such as including direct care workers as part of a care team and creating peer mentors, and creating a unified entry-level training program for the variety of specific direct care worker positions found across programs and setting.[27]

With respect to improving the public profile of a career as a caregiver, the perception and the reality is that direct care jobs are physically and emotionally draining with relatively low pay, few benefits and limited career advancement opportunities. Yet every direct care worker who spoke to the Commission described a rewarding job that they did not want to leave. They also described, as did the providers on the Commission and those who provided information to the Commission a related issue, lack of easily accessible information on open positions or potential candidates for employment.

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[25] http://legislature.maine.gov/doc/3430, pp. 7-8.
[26] https://www.maine.gov/labor/cwri/disabilities/index.html.
[27] http://legislature.maine.gov/doc/3430 and https://phinational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/.

Recommendations (immediate):

7. Direct the Department of Labor, in coordination with the Department of Economic and Community Development and the Department of Health and Human Services, to develop and implement a multimedia public service campaign that promotes direct care worker jobs as a career choice. Ensure that the campaign materials include new Mainers, men, younger people including high school students, older people and individuals with disabilities.

8. Direct the Department of Labor to conduct job fairs through the State focused on direct care workers for all long-term care settings.

Recommendations (long-term):

9. Direct the Department of Health and Human Services to offer direct care training programs in languages other than English and for ESL individuals.

10. Direct the Department of Health and Human Services to explore options, including those models outlined by PHI and NCSL, for supportive supervision and mentoring for direct care workers.

Workforce Development Initiatives

Maine has a number of initiatives around workforce development, employee training, and quality jobs. Direct care work is often left out of these initiatives because of the low pay and status. If caregiving jobs were recognized financially and professionally for their value to the State and the individuals that caregivers serve, workforce and educational initiatives might include or focus on the direct care sector of the economy. Therefore, in addition to recommendations to increase wages, improve the public perception of direct care work, and develop a career ladder, the Commission has recommendations related to creating new opportunities and avenues for entry into the direct care field and providing additional training.

The Commission learned about the State Workforce Development Board, a statutorily created entity[28] responsible for assisting the Governor to perform the duties required by the federal Workforce Innovation and Opportunity Act of 2014 and the State Plan that it creates every four years. The plan focuses on the development and implementation of a systemic approach to engaging and responding to the workforce and business service needs of employers to develop a pipeline of workers in high growth, high demand fields.[29] The next four-year plan begins in 2020. Direct care work is a high growth field with high demand and it is essential to include it in the new state plan.

Another workforce training initiative is the Maine Quality Center and its Put ME To Work Program. The Center, established by statute in 1993[30] and located at the Maine Community

[28] 26 MRSA §2006.
[29] https://www.maine.gov/swb/reports/state_plan/2016-2020_state_plan/FINAL_Maines_2016-2020_WIOA_Unified_Plan.pdf p. 7.
[30] 5 MRSA §12727.

College System Office, is required to work in close coordination with the Department of Economic and Community Development, the Office of the Governor and other state and local education and economic development agencies. The Center offers workforce training grants to Maine employers interested in providing training for new or current employees. The training provided under these grants is free of charge. The Center's Put ME to Work Program supports employers with 50% of the start-up costs to create new training programs or enhance existing ones for high paying jobs (at least $2.50 above minimum wage or at or above the median wage for the occupation). If direct care workers were paid what they were worth, providers of these services could participate.

The Commission also heard about two carry over bills aimed at reducing the cost of and debt from higher education: LD 394, An Act to Authorize a General Fund Bond Issue to Provide for Student Loan Debt Relief is carried over on the Appropriations Table; and LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program carried over by the Joint Standing Committee on Innovation, Development and Economic Advancement and Business. LD 799[31] is focused on persons who enter the health care profession, but direct care workers are not considered eligible health care providers as the bill is currently drafted.

There are numerous opportunities for healthcare training programs at all levels and for community colleges or high schools to be involved as avenues for entry into the direct care profession. Providing funding to the institutions and financial incentives to individuals to enter the field or financial reimbursement or loan repayments to defray training expenses could attract people to the profession. Requiring students in healthcare degree programs to have practicum requirements or rotations in the long-term services and support sector could broaden a student's awareness and understanding, reduce stigma and attract students to the field. In addition, students at secondary school or in tertiary education could gain experience in direct care as well as providing a flexible, part-time job for a student.

Recommendations (intermediate/long-term):

11. Direct the Department of Labor to work with the Department of Education, Maine's institutes of higher education, and Maine's Career and Technical Education Centers to develop and target education and certification programs for direct care workers, including high school vocational education programs including the following:

    - Apprenticeship programs for direct care workers;
    - "Earn as you learn" programs for direct care workers; and
    - Pre-apprenticeship program for Maine's Career and Technical Education Centers.

12. Recommend to the Joint Standing Committee on Innovation, Development, Economic Advancement and Business that it amends LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program, to specify that direct care workers be considered eligible health care providers and direct care occupations be included for priority consideration by the Maine Health Care Provider Loan Repayment Program Advisory Committee that is proposed in the bill.

[31] http://legislature.maine.gov/LawMakerWeb/summary.asp?paper=HP0587&SessionID=13.

13. Direct the Department of Health and Human Services to work with Maine's institutions of higher education and Career and Technical Education Centers to develop worker pools of students, including students with disabilities, interested in working as a direct care worker on a part-time and/or flexible schedule basis.

14. Require all healthcare degree programs that require practicum experience to include practicum requirements and rotations in the long-term services and support sector.

Qualifications and Training

The Commission had numerous discussions about the different entry qualifications and training requirements for different job titles under the direct care worker umbrella and for different sections of MaineCare or state-funded programs. For example, both a home health aide and a personal support specialist provides assistance with activities of daily living but a PSS must be at least 17 years of age and complete a 50-hour PSS training program while an HHA must be 16 years of age and may be required to complete a 180-hour certified nursing assistance training.[32] Although each type of direct care worker may have different responsibilities, the absence of a common entry-level training curriculum was considered an unnecessary obstacle to portability of qualifications and training within the direct care field. Both providers and workers argued that efficiencies could be gained if entry-level training was uniform across most or all direct care worker positions, with specialized trainings and advanced level trainings available as needed or desired as part of a career ladder. Improved availability of these trainings, both in-person and electronically was also mentioned frequently as an important step to remedy the workforce shortage.

The Commission discussed options for improving efficiency in training direct care workers. During the presentation by Stephen Campbell from PHI, the Commission learned about uniform training programs in other states. Most notable to PHI was the condensed training started in Washington in 2012, and the uniform statewide and state-funded training curriculum started in Arizona in 2011.[33] In addition, the Maine Direct Service Worker Training Program developed by Department of Health and Human Services and the Muskie School under the Health Resources and Services Administration grant has been evaluated as a proven pathway and has been successfully piloted but never fully implemented.

The Commission understands the need for updating the PSS training curriculum as it had not been updated since 2003 and training materials are no longer in print. However, providers who train in-house are faced with additional costs to implement the new program and the new curriculum requirement was required as of January 1, 2020. The Commission wrote to Health and Human Services Commissioner Lambrew on December 17 requesting that the department suspend implementation of the new PSS training requirement until the Health and Human Services Committee has an opportunity to consider and potentially act upon the Commission's recommendation to reconstitute the Maine Direct Service Worker Training Program. This letter is attached as Appendix F. Commissioner Lambrew responded to the Commission by letter dated December 20, 2019, agreeing to delay the end date for utilization of the old curriculum from January 1 until April 1. The letter stated that the department could not suspend use of the

[32] http://legislature.maine.gov/doc/3181, pp. 12-13.
[33] http://legislature.maine.gov/doc/3430, p. 26.

updated curriculum because training has already begun. An April 1st deadline would allow the Committee and the Legislature time to review the Commission's recommendations. Commissioner Lambrew's letter is attached as Appendix G.

Recommendations (immediate):

15. Direct the Department of Health and Human Services to examine qualification requirements for entry-level direct care workers to align qualifications across settings wherever possible without compromising consumer safety.

16. Direct the Department of Health and Human Services to immediately reconstitute, update and implement the Maine Direct Service Worker Training Program.

Expanding Use of Existing Support Systems

Making the most of existing support systems was often mentioned as a component of the solution that should not be overlooked. The Commission made a number of recommendations that do not directly impact the recruitment and retention of direct care workers but may impact demand by making the most of existing support systems. Finding ways to delay or prevent the need for higher levels of care and allowing individuals to remain at home when that is their desire is a component of the solution to the workforce challenge.

Family members as caregivers

Many older adults, adults with disabilities and individuals with intellectual disabilities or autism receive care in the home from family members. Most often, family members are unpaid and also must leave the paid workforce in order to provide care. Commission members determined that family members are a critical piece of the workforce puzzle and that it is important to provide supports, including an income, to those caregivers. Not only does it improve quality and satisfaction of the individual receiving care, it is critically important to the financial and emotional well-being of the caregiver. The Commission heard testimony from Representative Riley who had to left the workforce to take care of her disabled son when he was a minor but could be employed as a PSS only after her son became an adult.

In the first session, the Health and Human Services Committee voted and subsequently the Legislature, enacted Resolve 2019, chapter 102, requiring the Department of Health and Human Services to request an amendment to the State's 1915(c) waiver from the Centers for Medicare and Medicaid Services by January 1, 2020, to allow members receiving home and community-based services under Section 19 to employ their spouse as a personal support specialist (PSS). In addition, the resolve also requires the department to determine whether employing spouses could be expanded to other sections of MaineCare and report findings to the committee by January 1, 2021. This model should be extended as much as possible to the home and community-based care spectrum.

Recommendation (intermediate):

17. Direct the Department of Health and Human Services to remove as many barriers to family members and guardians being paid caregivers as possible and allowable under federal law and regulations.

Adult day services

Adult day health services and respite services relieve pressure on family caregivers preventing or delaying the need for higher level residential services. Adult day health services are provided to eligible MaineCare members who are also medically eligible for the service. MaineCare members who are medically eligible for a nursing home qualify for up to 40 hours a week of adult day health services. Individuals not nursing home eligible but with dementia and meeting certain thresholds of cognitive loss and/or need for assistance with activities of daily living qualify for 16 or 24 hours a week. Respite services are also available as part of the supports waiver services for adults with developmental disabilities or autism (Section 29 of MaineCare). Commission members recognize the importance of quality adult day and respite services to caregivers – both financially, allowing a caregiver to remain in the paid workforce, and psychologically – as well as to the individuals attending these programs.

Recommendation (intermediate):

18. Direct the Department of Health and Human Services to review the hours allowable for adult day health services, respite services and other similar programs for adequacy in allowing individuals to remain at home with family members as long as desired by both the caregivers and the individuals receiving services.

Assistive technology and environmental modifications

Although assistive technology and environmental modifications do not directly impact the workforce challenges for direct care, these types of services can reduce the number of face-to-face or hands-on worker hours. Assistive technology refers to devices and services used to increase, maintain or improve a member's capabilities to perform activities of daily living such as motion-activated devices, remote-monitoring cameras, iPads or laptops, and electronic medication dispensers. Environmental modifications relate to physical modifications to the person's residence, such as building ramps or lifts or widening doorways. Assistive technology and environmental modifications must be approved and are subject to monthly or annual caps as well as overall spending caps within MaineCare services.[34] The concern of Commission members is that the caps are too low given the cost of technology as well as continual innovation, and it would be helpful for consumers of services if the funding were more flexible, for example combining annual caps to allow for a more expensive technology or modification to be provided. Commission members understand that the Aging and LTSS Advisory Group which convened beginning in May 2019 by the Department of Health and Human Services is likely to recommend amending cost models in such a way (bundling service over three years or moving them outside of the current program caps), as well as increasing access to occupation or assistive technology assessments.

Recommendation (immediate):

[34] http://legislature.maine.gov/doc/3429.

19. Direct the Department of Health and Human Services to raise the caps and create more flexible cost models for assistive technology and environmental modifications for members receiving home and community-based services.

Other Recommendations

Consumer-directed services

Older adults eligible for home and community-based services under the MaineCare program or state-funded programs can choose to self-direct their services by acting as an employer who manages their own services including hiring and firing their own caregivers. The Commission received presentations from Tom Newman, the Executive Director of Alpha One, a participant in the consumer-directed program, and from GT Independence, a fiscal intermediary, at the October 24, 2019, meeting. Individuals self-directing their care are required to use a fiscal intermediary to conduct administrative and payroll services, including preparing taxes, making payments and ensuring compliance with state and federal labor laws and regulations on behalf of members. The fiscal intermediary organization has a contract with the department to provide these services. The self-directed option began in the 1990s as part of the self-determination movement for individuals with disabilities.

The Commission learned that the Department of Health and Human Services had developed a one-page document outlining options available for every assessment level to ensure that eligible individuals are aware of the consumer-directed option that was about to go live at the time of the Commission's final meeting. It is unclear to Commission members whether there is a need for publicizing the consumer-directed option for older adults with disabilities or if eligible individuals are already fully aware of its availability. However, there was consensus on the Commission that the consumer-directed option should be available to individuals with developmental disabilities or autism on the waiver and currently receiving services under Sections 21 or 29.

Recommendation (intermediate):

20. Direct the Office of Aging and Disability Services within the Department of Health and Human Services to convene a work group of stakeholders within the department that includes providers, advocates and consumers, to determine how to expand the consumer-directed options to individuals with developmental disabilities or autism and examine if consumer-directed options are fully utilized for all populations eligible for home and community-based services.

Digital Platforms for matching workers and clients and pooling workers

Direct care workers often have multiple clients and work for more than one agency in an effort to accrue their desired number of hours. Workers also experience cancellations often unexpectedly cutting their hours and reducing income, for example when a client is in the hospital or has another appointment. At the same time, individuals approved for a certain number of hours of services are unable to find providers for those services. Commission members are interested in the idea of providers pooling workers including the provision of benefits. Members are also

interested in systems to match workers to clients and employers to more efficiently reassign workers with unwanted gaps in their schedule due to cancellations of clients for whatever reason. This could provide more hours of services for individuals who need them and it could potentially prevent the unexpected cuts in earnings for direct care workers.

During the PHI presentation in October, Stephen Campbell briefly discussed the idea of matching service registries which primarily exist in the consumer-directed field. Mr. Campbell stated that Alpha One provides this service through its website.[35] Mr. Campbell also discussed the positive impact of the Direct Support Connect program in Minnesota. The Minnesota website, created in response to that state's workforce shortage, allows direct care workers and employers of direct care workers to register and then matches them up so that they can contact each other directly.[36] Consumers who self-direct but do not chose Alpha One as the fiscal intermediatry would also benefit from such a system in this State. However, it is unclear whether such a system could be extended beyond the consumer-directed programs, but it is important to explore ways to more efficiently fill direct care workers' available hours in light of unfilled hours.

Recommendation (long-term):

21. Direct the Department of Health and Human Services to convene a stakeholder group of providers to explore methods to pool workers across providers and care settings or programs, including developing a method to provide benefits to the workers.

22. Direct the Department of Health and Human Services to explore creating a HIPAA-compliant digital platform to connect direct care workers, providers, self-directing consumers and family members. The department must include providers in its exploratory effort.

Public assistance programs

Direct care workers often have high rates of reliance on public assistance programs such as SNAP, TANF, Medicaid, child care, housing assistance, and the Medicare Savings Program.[37] Commission members who are providers often hear that direct care workers are concerned about how much income they are allowed to earn before losing benefits; they want to ensure that these workers are fully informed and able to work as many hours as allowable. There are multiple federal and state laws and regulations that govern allowable income levels for various programs. For example, SNAP income levels are set at the federal level but there is flexibility within the TANF program for states to develop programs to encourage people into the workforce. To that end, the Legislature made changes to the TANF income cliffs in the first regular session of the 129th Legislature (Public Law 2019, chapter 484). Several members of the commission also mentioned that direct care workers would benefit from ready access to information on the income and asset limits of these programs. According to Commission member, Karen Fraser from the Department of Labor, the Social Security Administration addresses a similar concern from recipient of SSDI benefits through benefit counsellors who provide individual information for each person regarding their benefit and their working life.

[35] http://www.alphaonenow.org/pa_registry.htm.
[36] https://directsupportconnect.com/dsc/.
[37] https://phinational.org/wp-content/uploads/legacy/phi-facts-3.pdf.

Recommendation (intermediate):

23. Direct the Department of Health and Human Services to explore options for increasing income levels for direct care workers who are receiving various public assistance benefits and ensure that department's case workers communicate this information to their clients.

24. Direct the Department of Health and Human Services to study public assistance programs across the spectrum to determine where higher income levels might be allowable under federal and state laws and rules and consider developing programs that provide more flexibility of increased hours among direct care workers and report findings to the Joint Standing Committee on Health and Human Services for statutory action.

25. Improve communication and navigation of maximum income levels to individuals receiving public assistance.

Grant Opportunities

The Commission discussed opportunities for funding to attract people to the direct care field and to improve quality for recipients of services. Members discussed the Civil Money Penalty (CMP) Reinvestment Program several times. CMPs are imposed against nursing facilities for noncompliance with federal regulations. These penalties are paid to the Centers for Medicare and Medicaid Services but can be used by states to support activities that protect or improve the quality of care for residents of nursing facilities, including by improving staff training. It does not appear that Maine has fully utilized the CMP funding source.

A successful example of a CMP-funded program was the Music and Memory Program Maine Partnership to Improve Dementia Care in Nursing Homes which was created in 2016 when the state received a grant. Brenda Gallant, the Maine Long-Term Care Ombudsman (and Commission member) was involved in the program to train and certify nursing homes in the Music and Memory program, provide additional skills, tools and strategies for staff to assist in the person-centered care of residents with dementia and to decrease antipsychotic medication use.

Stephen Campbell from PHI discussed similar programs in other states such as the WisCaregiver Careers program in Wisconsin that was partly funded with CMP funds. In Wisconsin, the aim is to add 3,000 nursing assistants to the long-term care workforce in nursing homes by offering free training and testing in almost all technical colleges in the state and then use the WisCaregiver Careers program to find employment and pay a $500 bonus for nursing assistants who stay at least six months. The program includes a communications campaign that includes nursing assistants with diverse backgrounds, including men, in the videos. As of January 31, 2018, after approximately one year, 1,166 individuals had completed the training and 689 had completed the testing with 243 WisCaregivers employed in nursing facilities; most nursing facilities in Wisconsin participate in the program.[38]

[38] https://www.dhs.wisconsin.gov/caregiver-career/index.htm and https://phinational.org/wisconsin-partnership-could-transform-nursing-assistant-field/.

Another potential source of federal grant funding is the Lifespan Respite Care Program run by the Administration for Community Living (ACL) within the federal Department of Health and Human Services. This program was enacted by Congress to provide coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs. The purpose is to expand respite services and improve the delivery and quality of those services. Competitive grants have been awarded since 2009 to agencies in 37 states and DC but Maine has never been the recipient of a grant.

In addition to the CMP and ACL grants, Commission members encourage the Department of Health and Human Services to investigate and apply for any grant opportunities that offer training to direct care workers or family caregivers or improve quality of care in any way. For example, Commission members have heard that the Health Resources and Services Administration will be offering grants in 2020 for direct care worker training on behavioral health.

Recommendations (intermediate):

26. Direct the Division of Licensing and Certification in the Department of Health and Human Services to convene a work group to develop proposals for projects in nursing homes focused on best practices for recruitment and retention of direct care staff using Civil Money Penalty Reinvestment Program funds and submit those proposals to the Centers for Medicare and Medicaid Services.

27. Direct the Department of Health and Human Services to consider applying for a grant under the Lifespan Respite Care program grant offered by the ACL within the federal Department of Health and Human Services, or working with any appropriate organization that is eligible.

28. Direct the Department of Health and Human Services to investigate and apply for any grant opportunities that improve the quality of long-term care services and supports.

Oversight Committee

Extensive analysis of the long-term care workforce was conducted in the past, most notably in 2009 and 2010 in response to LDs 400, 1059, 1078 and 1364 introduced in the 124th Legislature.[39] This earlier work produced two reports with many recommendations with specific steps toward implementation.[40] The Department of Health and Human Services provided the Commission with an update of work done since these reports.[41] However, Commission members expressed frustration that many of the recommendations were not acted on and there was no oversight or awareness of the inaction. To prevent that in the future, the Commission recommends the establishment of an Oversight Advisory Committee in statute with members appointed by the Commissioner of Health and Human Services that operates independent of the

[39] LD 400, An Act To Implement the Recommendations of the Blue Ribbon Commission To Study Long-term Home-based and Community-based Care; LD 1059, Resolve, To Enhance Health Care for Direct Care Workers; LD 1078, An Act To Strengthen Sustainable Long-term Supportive Services for Maine Citizens; and LD 1364, An Act To Stimulate the Economy by Expanding Opportunities for Personal Assistance Workers.
[40] http://legislature.maine.gov/doc/3169 and http://legislature.maine.gov/doc/3170.
[41] http://legislature.maine.gov/doc/3254, p. 4.

department. Members should mirror the membership of this Commission, except that there would be no legislators. The Oversight Committee would have the following duties:

- Review progress toward implementing the recommendations of this report as acted on by the Health and Human Services Committee and the Legislature;
- Address barriers to recommendations;
- Make new recommendations as needed;
- Collate data from the department on usage or home and community-based services and residential services, unmet demand including unstaffed hours, vacancies for direct care worker positions and unfilled beds due to staffing shortages;
- Collate data from the CWRI relating to current and future need for direct care workers; and
- Meet at least quarterly and submit ongoing and annual reports to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Recommendation (immediate):

29. Enact an ongoing, independent Oversight Committee to review progress in implementing the recommendations of this Commission, address barriers to implementation, and make new recommendations as needed.

Legislation to enact the oversight commission is included in Appendix C.

APPENDIX A

Authorizing Legislation: Public Law, 2019 Chapter 343
Part BBBBB, Section BBBBB-1

APPROVED
JUNE 17, 2019
BY GOVERNOR

CHAPTER
343
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

H.P. 743 - L.D. 1001

An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2019, June 30, 2020 and June 30, 2021

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

Whereas, the 90-day period may not terminate until after the beginning of the next fiscal year; and

Whereas, certain obligations and expenses incident to the operation of state departments and institutions will become due and payable immediately; and

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

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

PART BBBBB

Sec. BBBBB-1. Commission To Study Long-term Care Workforce Issues. Notwithstanding Joint Rule 353, the Commission To Study Long-term Care Workforce Issues, referred to in this section as "the commission," is established.

1. Members. The commission consists of up to 18 members as follows:

A. Two members of the Senate appointed by the President of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature;

B. Three members of the House of Representatives appointed by the Speaker of the House, including a member from each of the 2 parties holdiug the largest number of seats in the Legislature; and

C. Up to 13 members who possess expertise in the subject matter of the study as follows:

(1) A direct care worker appointed by the President of the Senate;

(2) A provider of home-based long-term care who is a member of a statewide association representing home-based long-term care providers appointed by the President of the Senate;

(3) A representative of a statewide association representing nonprofit housing and senior service programming appointed by the President of the Senate;

(4) A representative of an organization providing services to individuals with intellectual disabilities and autism including employment services and long-term home supports appointed by the President of the Senate;

(5) A provider of facility-based long-term care who is a member of a statewide association representing facility-based long-term care providers appointed by the Speaker of the House;

(6) A representative of an organization providing statewide homemaker services through the state-funded independent support services program within the Department of Health and Human Services appointed by the Speaker of the House;

(7) A representative of an institution of higher education eugaged in workforce development appointed by the Speaker of the House;

(8) A representative of a service coordination agency providing service coordination to people receiving home-based and community-based long-term care appointed by the Speaker of the House;

(9) A representative of an organization promoting independent living for individuals with disabilities appointed by the Speaker of the House;

(10) A representative of a business that acts as a labor intermediary helping unemployed and underemployed people obtain employment appointed by the Speaker of the House;

(11) The executive director of the long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;

(12) The Commissioner of Health and Human Services, or the commissioner's designee, who may be invited to participate; and

(13) The Commissioner of Labor, or the commissioner's designee, who may be invited to participate.

2. Chairs and subcommittees. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in subsection 4 and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement.

3. Appointments. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members and after adjournment of the First Regular Session of the 129th Legislature, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this Part a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

4. Directive of commission. The commission shall study and make policy recommendations in each of the following areas:

A. Measuring current demand for direct care workers and projecting future needs;

B. Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;

C. Supporting career ladders throughout various long-term care settings;

D. Identifying education needs and methods to fill education needs for direct care workers;

E. Identifying barriers to hiring and methods to overcome barriers to hiring;

F. Developing strategies to improve the quality of long-term care jobs; and

G. Increasing opportunities for shared staffing among long-term care providers.

The commission shall make policy recommendations for public and private funding mechanisms to implement the commission's recommendations.

5. Program. The commission shall make recommendations for the establishment of a program that will contribute to long-term care direct care workers' postsecondary education in related fields.

6. Pilot program. The commission shall make recommendations for the establishment of a pilot program to pool part-time home care workers' hours for purposes of providing greater employment opportunity and obtaining employee benefits.

7. Staffing. The Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

8. Administration. The Commissioner of Health and Human Services, the State Auditor and the State Budget Officer shall provide necessary information and assistance to the commission as required for the commission's duties.

9. Report. No later than November 7, 2019, the commission shall submit a report that includes its findings and recommendations pursuant to subsections 4 to 6, including suggested legislation, to the Joint Standing Committee on Health and Human Services. The joint standing committee may report out a bill regarding the subject matter of the report to the Second Regular Session of the 129th Legislature.

PART CCCCC

Sec. CCCCC-1. 25 MRSA §5101, as amended by PL 2017, c. 407, Pt. A, §104, is further amended to read:

§5101. Substance Use Disorder Assistance Program

1. Substance Use Disorder Assistance Program. The Substance Use Disorder Assistance Program~~, referred to in this chapter as "the program,"~~ is established to support persons with presumed substance use disorder by providing grants to municipalities and counties to carry out ~~projects~~ programs designed to reduce substance use, substance use-related crimes and recidivism.

2. Eligibility; program targets; programs. Grants may be awarded to:

A. Municipal or county governments or regional jails for ~~projects~~ programs designed to assist persons with presumed substance use disorder by ~~diverting~~ using liaison strategies both before and after arrest to refer alleged low-level offenders into community-based treatment and support services. ~~Projects~~ Programs may include, but are not limited to:

(1) Referral of ~~program~~ participants in the Substance Use Disorder Assistance Program under subsection 1 to evidence-based treatment programs, including medically assisted treatment; and

APPENDIX B

Membership list, Commission to Study Long-term Care Workforce Issues

Commission to Study Long-term Care Workforce Issues

MEMBERSHIP

Appointments by the President of the Senate

Senator Erin Herbig	Senate Chair
Senator Jeffrey Timberlake	Member of the Senate
Kathy Callnan	Representative of statewide association of non-profit housing and senior service programing
Jillian Jolicoeur	Representative of an organization providing services to persons with intellectual disabilities and autism
Rachel Small	Direct care worker
Michael Stair	Provider of home-based long-term care who is a member of statewide association representing home-based long-term care providers

Appointments by the Speaker of the House

Representative Jessica Fay	House Chair
Representative Abigail Griffin	Member of the House
Representative Holly B. Stover	Member of the House
Sandy Butler	Representative of an institution of higher education engaged in workforce development
Debbie Gilmer	Representative of an organization promoting independent living for individuals with disabilities
Don Harden	Representative of an organization providing statewide homemaker services through the state-funded independent support services program within DHHS
Mary Jane Richards	Provider of facility-based long-term care who is a member of a statewide association representing facility-based long-term care providers

Betsy Sawyer-Manter	Representative of a service coordination agency providing service coordination to people receiving home-based and community-based long-term care
Amy Winston	Representative of a business that acts as a labor intermediary helping unemployment and underemployed people obtain employment

Authorizing Legislation Named Members

Brenda Gallant	Executive Director of the long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C
Commissioner Jeanne Lambrew	Commissioner of Health and Human Services, or designee
Karen Fraser, Bureau Director	Commissioner of Labor, or designee

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Staff:

Anna Broome, Senior Legislative Analyst
Lynne Caswell, Legislative Analyst
Office of Policy and Legal Analysis

APPENDIX C

Suggested Legislation

Recommended Draft Legislation

An Act To Implement the Recommendations of the Commission to Study Long-term Care Workforce Issues

PART A

Sec. 1. 22 MRSA Chapter 1476 is enacted to read:

CHAPTER 1476
DIRECT CARE WORKER WAGES

§5319. Definitions

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

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

2. Direct access. "Direct access" means access to the property, personally identifiable information, financial information or resources of an individual or physical access to an individual who is receiving services from a direct care worker in an institutional setting or in a home or community setting.

3. Direct care worker. "Direct care worker" means an individual who by virtue of employment generally provides to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or has direct access to provide care and services to clients, patients or residents regardless of the setting.

4. Home or community setting. "Home or community setting" means health and social services and other assistance required to enable adults with long-term care needs to remain in their places of residence or group homes. These services include, but are not limited to, self-directed care services; home health aide services; personal care assistance services; companion and attendant services; homemaker services; respite care; and other appropriate and necessary social services.

5. Institutional setting. "Institutional setting" means residential care facilities, licensed pursuant to chapter 1664; intermediate care and skill nursing facilities and units and hospitals,

licensed pursuant to chapter 405; and state institutions for individuals who have intellectual disabilities or autism or other related conditions.

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

7. Self-directed care services. "Self-directed care services" means services procured and directed by the person receiving services or the person's surrogate that allow the person to reenter or remain in the community and to maximize independent living opportunities. "Self-directed care services" includes the hiring, firing, training and supervision of direct care workers to assist with activities of daily living and instrumental activities of daily living.

§5320. Direct care worker minimum wage

Starting, January 1, 2021, the minimum hourly wage paid to a direct care worker must be no less than 125% of the minimum wage established in Title 26, section 664, subsection 1. Increases to the minimum wage for direct care workers must begin on January 1st of each year at the same time as any increase in the minimum wage takes place.

§5321. Rulemaking

The department shall adopt rules providing reimbursement rates under this chapter that take into account the costs of providing the direct care worker minimum wage required in section 5320. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. Department of Health and Human Services adopt rules to provide reimbursement rates sufficient for structural costs. The Department of Health and Human Services shall adopt rules to increase reimbursement rates under Chapter 101 of the MaineCare Benefits Manual and any state-funded programs to take into account costs of providing care and services in conformity with applicable state and federal laws, rules, regulations, training requirements and quality and safety standards including, but not limited to: the costs of increases in wages for direct care workers pursuant to the Maine Revised Statutes, Title 22, chapter 1476; increases in minimum wages for any other workers pursuant to the Maine Revised Statutes, Title 26, section 664, subsection 1; earned paid leave pursuant to Title 26, section 637; background checks required pursuant to the Maine Revised Statutes, Title 22, chapter 1691; and electronic visit verification required under the federal 21st Century Cures Act, Public Law 114-255, Section 12006. The department shall consult with providers and other stakeholders that the department determines appropriate to determine appropriate reimbursement levels for services.

[Rulemaking authority to remain the same as in existing law, e.g. PNMI reimbursement rules are major substantive; most others are routine technical.]

PART B

Sec. 1. 5 MRSA §12004-I, sub-§47-L is enacted to read:

47-J	Long-term care workforce oversight	Not authorized	22 MRSA §5307

Sec. 2. 22 MRSA §5307 is enacted to read:

§5307. Long-term care workforce oversight advisory committee

The long-term care workforce oversight advisory committee, as established in Title 5, section 12004-I, subsection 47-J and referred to in this section as "the oversight committee," is established to provide advice and oversight to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding long-term care workforce issues.

1. Membership. The oversight committee consists of 10 members as follows:

A. Eight members, appointed by the commissioner, are employers and providers of services in the long-term care industry employing direct care workers providing assistance with activities or daily living or instrumental activities of daily living to clients, patients or residents, in institutional and home and community settings;

B. One member, appointed by the Commissioner, is a recipient of self-directed services as defined in section 5319, subsection 7; and

C. The long-term care ombudsman established in section 5107-A is a member of the oversight committee.

For the purposes of this subsection, "direct care worker" has the same meaning as in section 5319, subsection 3.

2. Terms. Members of the oversight committee are appointed to staggered 2-year terms so that at least 4 members representing providers expire on July 1st of each year. If the commissioner fails to make an appointment prior to the expiration of a member's term, that member continues to serve until the commissioner makes an appointment for the remainder of that term. If a vacancy occurs prior to the expiration of a specified term, the commissioner shall appoint a person to serve the remainder of that term.

3. Duties. The oversight committee has the following duties:

A. Collect data from the department relating to the number of hours of services provided by direct care workers, the number of approved hours for which staffing cannot be provided due to staffing shortages, vacancies for direct care worker positions and the number of unfilled beds in residential care facilities licensed under chapter 1664 and nursing facilities licensed under chapter 405;

B. Collate data available from the Department of Labor relating to current and future need for direct care workers;

C. Review progress by the department in implementing recommendations provided to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters relating to long-term care workforce issues and address barriers to implementing those recommendations; and

D. Make recommendations to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters on proposals to increase the long-term care workforce and address shortages in services.

4. Meetings; report. The oversight committee must meet at least quarterly and submit an annual report to the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than January 2nd of each year describing the oversight committee's activities and recommendations.

SUMMARY

This bill implements the recommendations of the Commission to Study Long-term Care Workforce Issues which was established by Public Law 2019, chapter 343, part BBBBB. The bill does the following.

1. It requires direct care workers across the long-term care spectrum to be paid no less than 125% of the minimum wage. It requires the Department of Health and Human Services to adopt rules that take into account the cost of this increased wage in its reimbursement rates.

2. It requires the Department of Health and Human Services to adopt rules to increase reimbursement rates under Chapter 101 of the MaineCare Benefits Manual and any state-funded programs to take into account costs of providing care and services in conformity with applicable state and federal laws, rules, regulations, training requirements and quality and safety standards including, but not limited to, increases in the minimum wage, earned paid leave, electronic visit verification, background checks and other costs that are not provided for in the current reimbursement rates.

3. It establishes a long-term care workforce oversight advisory committee to collect and compile data related to workforce shortages and services provided to clients, review progress by the Department of Health and Human Services regarding recommendations provided to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters including the recommendations of the Commission to Study Long-term Care Workforce Issues, identify barriers to implementing recommendations and make recommendations on proposals to address long-term care workforce shortages. The oversight committee must submit an annual report to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

APPENDIX D

Letter to Commissioner Lambrew regarding reimbursement rates

Commission to Study Long-term Care Workforce Issues

December 17, 2019

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

We are writing to relay the concern of the Commission to Study Long-term Care Workforce Issues regarding the urgent need for the Department of Health and Human Services to increase reimbursement rates for state and MaineCare funded services for long-term service and supports including home and community-based services, PNMI and nursing facilities, and consumer-directed services for older adults and individuals with physical and developmental disabilities as soon as possible.

As you know, because you are a member, the Commission was established pursuant to Public Law 2019, chapter 343 (the biennial budget), Part BBBBB in response to the workforce shortages experienced across the spectrum of long-term service and supports, from the Homemaker program to nursing facilities. Maine is currently the oldest state in the nation with a long-term service and supports system that is in crisis. Direct care workers, including those who are committed and would prefer to remain in their caregiving professions, are unable to make a living and are leaving the field for better paying jobs. Direct care workers do hard physical work that is also emotionally taxing and they deserve to be paid more than they are currently paid. Many are working long hours at multiple jobs, often without benefits, in an attempt to make ends meet. On the other side of the equation, consumers of these services are going without care that they need, and have been approved for, due to a severe workforce shortage. Older adults and individuals with disabilities who try to take care of themselves when someone else should be there poses a serious safety risk. As a result, these individuals are likely to end up in the hospital or in a nursing home with a higher level of care that is more expensive. Older adults and individuals with disabilities in this state deserve consistent and quality care from caregivers that they trust and can build relationships with.

From the provider perspective, the current reimbursement rates are both inadequate and unsustainable. Providers are committed to providing services to people who live in this state who both need and are entitled to these services. However, from a business perspective, the system is in crisis. Several nursing facilities have recently closed and providers across the long-term supports and services spectrum are often operating at a loss. Providers also have many unfilled positions because they are unable to attract direct care workers. Reimbursement levels do not cover existing costs and future anticipated structural additions to costs will make the

situation worse. Providers will have to comply with state and federal laws and regulations including the upcoming increase in the minimum wage, the requirement to provide paid time off, insurance mandates, electronic visit verification requirements and background checks (including the possibility of finger printing) but there is insufficient funding to do that.

The Commission understands that the Department of Health and Human Services will be reporting to the Health and Human Services Committee regarding its efforts to establish a rational and regularly reviewed rate scheme. Providers need immediate relief in the form of a rate increase as well as ongoing predictability in rate review. Accordingly, we urge you to take all necessary steps to increase reimbursement rates as soon as possible, including any requests for appropriations, in order to prevent providers from going out of business, more committed direct care workers from leaving their chosen profession, and our older adults and individuals with disabilities from finding themselves in untenable and unsafe positions that lead to a higher, more expensive level of care.

We thank you for your attention to this very important matter.

Sincerely,

Erin D. Herbig
Senate Chair

Jessica L. Fay
House Chair

cc: Michelle Probert, Director of the Office of MaineCare Services
Molly Bogart, Director of Government Relations

APPENDIX E

Response from Commissioner Lambrew to the letter regarding reimbursement rates

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

December 20, 2019

Senator Erin Herbig, Chair
Representative Jessica Fay, Chair
Commission to Study Long-term Care Workforce Issues
#100 State House Station
Augusta, Maine 04333-0100

Dear Senator Herbig, Representative Fay, and Members of the Commission to Study Long-term Care Workforce Issues:

I wanted to respond in a timely way to your letter sent earlier this week that asks the Maine Department of Health and Human Services (DHHS) to provide "immediate relief in the form of a rate increase..."

The Commission's authorizing legislation directed its report to the Joint Standing Committee on Health and Human Services. The recommendations in your letter would require a legislative appropriation. Maine State Legislature has granted DHHS neither the blanket authorization nor unlimited appropriations to unilaterally increase reimbursement rates for MaineCare services. We respectfully suggest the Commission direct its request to the Legislature.

The Commission also notes a desire for "ongoing predictability in rate review," which we share. To inform the Legislature's consideration of your request among others, DHHS is conducting a comprehensive evaluation of MaineCare's rate setting system for all services, including those for long-term services and supports. This evaluation will include a comparison of what MaineCare pays to (1) five comparable state Medicaid programs; (2) Medicare; and (3) commercial health plans. The results will inform the next biennial budget. We are specifically looking to reform the complicated and outdated system of MaineCare reimbursement for nursing facility services. Governor Mills has directed DHHS to examine reforms that would promote simplicity, quality, value, transparency, and accountability.

Recognizing short-term challenges in institutional care settings, just last week Governor Mills announced her support for LD 1758, "An Act To Clarify and Amend MaineCare Reimbursement Provisions for Nursing and Residential Care Facilities." Combined with current rate increases, LD 1758 will increase MaineCare nursing facility rates by 5.5 percent on average for fiscal year 2020. Reimbursement to nursing facilities has increased cumulatively by 40 percent since fiscal year 2012. This is more than most other MaineCare services and should significantly bolster the ability of our nursing facilities to provide quality care.

As many witnesses at Commission meetings explained, MaineCare reimbursement rates are neither the sole cause nor the sole solution to ensuring a high-quality, accessible long-term services and supports system and the workforce to support it. Under the leadership of the Office of Aging and Disability Services (OADS), DHHS has launched a comprehensive initiative to support aging in Maine. This includes a Long-Term Services and Supports Advisory Group. Its report, which will be published early in the new year, will describe ways to better coordinate care for Medicare-Medicaid dual eligible individuals as well as pathways for more home- and community-based options. These options will affect the workforce in that they empower consumers and families, which lessens the pressure on agencies and providers. And, harnessing assisted technology and other in-home supports will alleviate the need for home care workers for some Mainers.

We also continue to support workforce training, recruitment, and retention. This includes reviewing how DHHS programs can co-locate and collaborate with those of the Department of Labor. We are working on streamlining training curriculum, and are happy to respond to concerns as they arise, as noted in our response to your letter regarding the personal support specialist (PSS) curriculum timeline. The State is also addressing credentialing. For example, recent changes to recognize other states' certified nurse assistant (CNA) training programs has resulted in 1,200 new registered CNAs in the last year. In addition, we also are working on lateral matrices for workers to be able to navigate across careers within the health sector. DHHS is hiring a health care workforce coordinator for the State who will identify the most pressing shortages and develop strategies with the private sector including, but not limited to, enhanced training programs, recruitment initiatives, and retention promotion.

In closing, DHHS views front-line workers in long-term care facilities, home, and community-based settings as the heart of the system. The hidden word in their job description is "compassion." They care for our parents as their ability to live independently declines. They support our children with intellectual or developmental disabilities as they age.

We appreciate your commitment and look forward to working with you on actionable, evidence-based solutions that support older Mainers and people with disabilities, as well as the people who care for them.

Sincerely,

Jeanne M. Lambrew, PhD
Commissioner

JML/klv

cc: Michelle Probert, Director, Office of MaineCare Services
Molly Bogart, Director of Government Relations

APPENDIX F

Letter to Commissioner Lambrew regarding PSS training

Commission to Study Long-term Care Workforce Issues

December 17, 2019

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

We are writing to relay the concern of the Commission to Study Long-term Care Workforce Issues with the upcoming launch of the new Personal Support Specialist (PSS) curriculum by the Division of Licensing and Certification (DLC). We learned during the Commission meetings, that DLC has worked hard to update the current PSS curriculum which was last amended in 2003, and we commend DLC for completing this project. However, after hearing from a wide range of consumers, workers, providers, and stakeholders, the Commission will, in its upcoming report to the Health and Human Services Committee, recommend that the Committee direct the Department to reconstitute the Maine Direct Service Worker Curriculum developed under a HRSA demonstration grant awarded to DHHS in 2010.

If implemented as currently scheduled, the new PSS training will require providers who conduct their own trainings to invest a significant amount of money to update their training programs within the first 90 days of 2020. To prevent unnecessary expense to, and to minimize confusion and disruption of providers, consumers and PSS workers, the Commission respectfully requests that the PSS curriculum launch be delayed for a few months. Such a short delay is unlikely to negatively affect workers, providers, or consumers in any significant way and will give the Health and Human Services Committee time to review, consider, and possibly act upon the Commission's recommendation during the Second Regular Session. We hope that DLC will participate in the committee's deliberation on this topic.

We thank you for your attention to this very important matter.

Sincerely,

Erin D. Herbig
Senate Chair

Jessica L. Fay
House Chair

cc: Bill Montejo, Acting Director, DHHS/DLC
Molly Bogart, Government Relations Director, DHHS

APPENDIX G

Response from Commissioner Lambrew to the letter regarding PSS training

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
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TTY: Dial 711 (Maine Relay)

December 20, 2019

Senator Erin Herbig, Chair
Representative Jessica Fay, Chair
Commission to Study Long-term Care Workforce Issues
#100 State House Station
Augusta, Maine 04333-0100

Dear Senator Herbig, Representative Fay, and Members of the Commission to Study Long-term Care Workforce Issues:

Thank you for sharing your concerns regarding the revised Personal Support Specialist (PSS) curriculum in your recent letter.

The Division of Licensing and Certification's (DLC) Workforce Development Unit was tasked with the challenge of revising the PSS curriculum in large part because the textbook associated with the program is out of print. There were also concerns regarding the scope of practice being taught in the course and potential conflicts with other relevant State Agency jurisdictions such as the Board of Nursing's (BON) Certified Nursing Assistant courses and the BON rules regarding delegation of nursing care to unlicensed assistive persons.

As part of the development of the new PSS curriculum, staff conducted a review of the draft PSS curriculum that was written in 2010 and utilized for the Direct Service Worker Training Project (DSWTP), which was funded through a grant from the Health Resources and Services Administration (HRSA). A determination was made that this draft curriculum would require revisions and updating due to content that conflicted with the BON scope of nursing delegation. DLC made the determination that it was more beneficial to start with a clean slate and the new revised PSS curriculum was shared with the BON to ensure that the curriculum did not conflict with BON rules.

The implementation of the new PSS curriculum started on October 1, 2019. Stakeholders were sent notice of the new curriculum and the roll-out plan in September and were advised that, after December 31, 2019, DLC would only issue course certificates based on the new curriculum. Since utilization of this new curriculum has been in place since October 1, 2019 and there have been several trainers and courses conducted with this new curriculum, we are unable to delay the launch of this curriculum.

However, the Department can accommodate the Commission's request for a delay in the end date for utilization of the old curriculum for an additional 90 days until April 1 to allow for further review and discussion. We will post this on the DHHS website and inform stakeholders of this extra time.

The Division of Licensing and Certification and the Office of Aging and Disability Services would welcome the opportunity to work with the Commission, Legislature, and stakeholders on the curriculum going forward.

Sincerely,

Jeanne M. Lambrew, Ph.D.
Commissioner

JML/klv

cc: William Montejo, Director, Division of Licensing and Certification
Molly Bogart, Director of Government Relations