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Final Report Joint Standing Committee on Health and Human Services

Chapter 1622-A (LD 683)

An Act to Enhance Long Term Care Services for Maine Citizens

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INTRODUCTION

With the aging of Maine's population and its status as the "oldest" state in the nation, the use of long term services and supports surfaces as a key issue of public policy. In 2007, this State ranked fourth in the nation with the percent of people over age 65 (14.8%) and by 2030, Maine will have the second highest percentage (26.5%) of people age 65 or over. Using the median age of the population as a measure, Maine is already considered the oldest State in the nation. In the near term, the largest growth in population is expected to be for ages 55-65 and 65-74. The population over the age of 85 is expected to increase by almost a third.¹ The demographics of Maine's population will continue to drive the use of long term care services.

In conjunction with the Long Term Care Ombudsman's Program (LTCOP), the Department has recently participated in Community Forums across the state to better understand the desired model for long term care services. These Forums brought together providers, caregivers, advocates and consumers in an effort to begin a collaborative working relationship that will lead to the development of a plan for long term care services that is CMS compliant, cost effective and respects consumer choice with the goal of allowing people to receive the care they need in their homes and communities.

This report is being written at a time when there are significant initiatives that could directly affect this legislation and the contents of this report, specifically on-going analysis around the funding of Maine's Private Non-Medical Institutions (PNMIs).

At the request of the Centers for Medicare and Medicaid Services (CMS), the Department is in the process of reviewing its long standing system of reimbursement for PNMIs and exploring alternate ways of funding and service provision for that setting. Any changes to the PNMI system will affect the long term care system as a whole, including home and community based services, and it is against this backdrop that work on LD 683 is occurring. As part of the PNMI initiative, DHHS has organized multiple stakeholder groups to include providers and advocates in a collaborative process of the development of a model that is both compliant with CMS and in the best interest of the people served.

CHAPTER 1622-A (LD 683)

Chapter 1622-A (LD 683) directs the Department of Health and Human Services to consolidate all long term care services that are provided directly or indirectly through MaineCare or other state funded programs into one program. This program will contain a single set of rules, coordinated criteria for assessment and qualifications as well as a single budget.

The specific initiatives to be incorporated into this plan include, but are not limited to the following:

- ❖ In home, community support services and nursing facility services must be provided under one program with priority given to expenditures that serve those consumers with the greatest needs and lowest service costs.

¹ The Lewin Group and the Muskie School of Public Service. 2008. *Projections of State and County Level Long Term Care Need and Use in Maine, 2006-2015*

- ❖ Development of a standard single system for eligibility determination for all consumers regardless of diagnosis, type of disability, age or other demographic factors. This system will use the multidisciplinary teams designated by the Commissioner under Section 7323.
- ❖ The Department will periodically assess consumers for benefit determination as is appropriate to the consumer. The determination of the timeframe will be based on assessments of functional, health care and financial needs. This assessment will be conducted by an agency that is available to the consumer for case management services but does not directly or indirectly provide in-home, community support services or nursing facility services. The assessment must include a medical evaluation conducted by the consumer's Primary Care Provider or Health Care Specialist and an evaluation by the Department of the requirements for personal care assistant services and the hours of service necessary to maintain the consumer in a home-based or community-based setting.
- ❖ Upon completion of the needs assessment the Department will determine available benefits for the consumer and the consumer will choose which services to purchase. The consumer may select service delivery through any of the following models:
 - Consumer Directed: The consumer directs their care and employs the person who will provide their care, with or without a surrogate or unpaid representative to assist the consumer.
 - Agency Model: An agency directs the consumer's care and employs the persons who provide the care.
 - Residential Care/Nursing Facility Model: The consumer resides in a residential care or nursing facility and the consumer's care is provided by employees of that facility.
- ❖ If a consumer does not indicate a preference of service delivery model, the Department will place the consumer in the Consumer Directed model unless the assessment determines such placement would be inappropriate for the consumer.
- ❖ The Department will develop and authorize a plan of care based on the needs assessment for each consumer determined eligible under this chapter or Title 34-B, Chapter 5, Subchapter 3, Article 2. The plan of care must be designed to meet the consumer's needs with consideration of the consumer's living arrangement, other private or public funding sources and informal supports in order to avoid duplication of services.
- ❖ The program developed must provide for transitional facilities and/or services to assist with altering functional and health care needs.
- ❖ The program must include a nursing facility diversion component to encourage the use of facilities and services consistent with the consumer's needs assessment and as chosen by the consumer.
- ❖ The program must provide reimbursement for skilled nursing care, in-home and community support services based on a uniform rate setting process that is consistent across types of care and services, reduces administrative costs and is realistic regarding access to care and services. This process must set aside a fixed percentage of the rate for wages and benefits of the direct care workers.
- ❖ The Department shall establish best practices training standards in a common module-based format with standard designations for direct-care workers.

IMPLEMENTATION

The elements of LD 683 are discussed below.

1. Consolidation

Long-term care services provided directly or indirectly under the MaineCare program or other state-funded programs by the department under this Title must be combined into one program, referred to in this chapter as "the program," with a single set of rules, coordinated criteria for assessment and qualifications and a single budget. In-home and community support services and nursing facility services must be provided under the program, giving priority to expenditures that serve first those consumers with the greatest needs and the lowest service costs in accordance with the provisions of this section.

Status: This directive relates to and is part of LD 1461(Resolve 2011, Chapter 71). As required by LD 1461, work is ongoing to consolidate two Medicaid waivers together into one waiver, to consolidate the Medicaid State plan optional personal care services for adults together into one program, and to combine three state funded home and community based programs together.² This consolidation will be facilitated by the proposed merger of the Office of Elder Services and the Office of Adults with Cognitive and Physical Disabilities into a single office, the Office of Aging and Disability Services.

Developing community options as an alternative to more expensive institutional placement has been, and continues to be, a priority in long term care planning and development. As work on the PNMI system progresses, there will likely be changes to other community programs, especially if changes are made to the current nursing facility eligibility criteria. The Department has also formed a work group to review the Program for All-Inclusive Care for the Elderly (PACE) model. PACE is a model of fully integrated acute, primary, specialty and long term supportive and institutional care for individuals 55 and older. Under PACE, the provider pools capitated payments from Medicare and Medicaid to provide all needed services on a per member per month basis and the provider assumes full financial risk. PACE utilizes an interdisciplinary team approach to provide and manage a full spectrum of services, including preventative, primary, acute and long term support services, regardless of type or location of care.

2. Intake and eligibility assessment.

The Department shall develop for the program a single system for intake and eligibility determination for all consumers, regardless of diagnosis, type of disability or age or other demographic factors, using the multidisciplinary teams designated by the commissioner pursuant to section 7323. The intake process, application and forms must be standardized despite differences in the criteria for eligibility for services under different provisions of the MaineCare program state plan or federally approved waiver under Medicaid or under state-funded services.

² These programs include: Section 19 and 22 of the MaineCare Benefits Manual (MBM) (waiver); Sections 12 and Section 96 of the MBM (Medicaid State plan optional services); OES State funded Home based care and ISS/Homemaker Programs (Sections 63 and 69 of the OES Policy manual) and OACPDS State funded consumer directed program (Chapter 11 of the OACPDS Policy Manual).

Status: The Department has developed a single system for intake and eligibility determination for a number of different programs, both MaineCare and state funded programs.³ This medical/functional assessment is completed by an independent statewide assessing services agency and includes an evaluation of demographic characteristics, clinical and functional needs, and caregiver and environmental information. It is based on what people can do independently and how much assistance they need in order to perform activities of daily living (ADLs) as well as other tasks such as grocery shopping and routine house work. The assessment also looks at the need for skilled services, including nursing and therapies and there are supplemental screenings for those with cognitive and behavioral problems and those with brain injuries who may need to access nursing facility services.

The assessment process is intended to:

- Create a single state-wide point of entry for eligibility assessments and reassessments for long term care programs;
- Assure consistency and objectivity in applying eligibility criteria;
- Educate consumers about in-home long term services and supports and offer alternatives to facility care;
- Assist with the identification of caregiver needs to help address caregiver burnout and promote informal supports; and
- Increase consumer participation and control.

The long term goal is to reduce the long term cost of services by requiring greater emphasis on health promotion and independence and to reduce the number of unnecessary admissions to, increase the number of discharges from, and decrease the length of stay in nursing facilities.

As part of this process, DHHS has developed a two-step assessment and care management process for each person receiving home and community based services and has implemented Section 7323 through this process. Nurse assessors meet face to face with the consumer and his or her designated representative, along with family members or others requested by the consumer. Additional information from physicians and other sources is gathered as needed. Care coordinators then play an on-going role in assuring that the consumers' identified needs are addressed and evaluate whether any modifications to the plan of care are needed. Working with the members, family members, physicians and providers are key components of this service.

³ Currently, a single assessment process is utilized for the following MaineCare services: Section 67 Nursing Facility Care; Section 19 Home and Community Benefits for the Elders and Adults with Physical Disabilities; Section 96 Private Duty Nursing Services and Personal Care Services for adults; Section 97 Private Non-Medical Institutions (Appendix C); Section 12 Consumer Directed Personal Care Attendant Services ; and Section 22 Consumer Directed Home and Community Benefits for Adults with Disabilities; Section 26 Adult Day Services. In addition, the following state funded services are included: Section 63 OES Home Based care and Chapter 11 OACPDS Consumer Directed Attendant Home Based Care.

3. Needs assessment. The department shall assess a consumer for benefits determination periodically, as appropriate to the consumer, based on assessments of functional, health care and financial needs performed by an agency that is available to the consumer for case management services but that does not directly or indirectly provide in-home and community support services or nursing facility services. The assessment of the consumer's functional, health care and financial needs for in-home and community support services and nursing facility services must include a medical evaluation conducted by the consumer's primary care provider or health care specialist, as appropriate, and an evaluation by the department of the requirements for personal care assistant services and the hours of service necessary to maintain the consumer in a home-based or community-based setting.

Status: Currently the Department distinguishes between assessments for eligibility and authorization of services and on-going assessments conducted by the service coordination agency for ensuring that the consumer's identified needs are addressed. Care coordination helps to identify the medical, social, educational and other needs of eligible consumers, as well as the services needed to meet those needs. These assessments are completed through home visits and telephone contacts. When it is identified that long term changes to the plan of care are needed, this request and information is provided to the Assessing Services Agency for authorization. Some of the programs currently allow short term changes to be authorized by the Service Coordination Agency to address emergencies or acute episodes. The Department continues to support conflict-free case management, particularly as this is increasingly becoming a requirement of CMS for service delivery.

4. Benefits determination; service delivery model selection. Once the needs assessment under subsection 2 has been completed for a consumer, the department shall determine the benefits that are available for the consumer and the consumer may choose which services to purchase. The consumer may select service delivery through the following models: the model in which the consumer directs the consumer's care and employs the persons who provide care, with or without a surrogate or unpaid representative to assist the consumer; the agency model in which an agency directs the consumer's care and employs the persons who provide care; and the residential care model or nursing facility care model. If a consumer does not indicate a preference of service delivery model, the department shall assign the consumer to a self-directed model of in-home and community support services unless self-direction is determined to be inappropriate for the consumer.

Status: The long term care home and community based programs for elders and adults with disabilities currently offer self-direction for members who choose to remain in the community. Some of the programs allow the member to use a representative to manage the services on his or her behalf but not all have that option. As part of LD 1461, the ability to use a surrogate will be expanded to those programs where, currently, the eligibility requirement is for members to self-direct without the use of a representative.

Programs currently offering self-direction and/or direction through a representative:

- Home and Community Based Services for Elders and Adults with Disabilities (Section 19 of the MaineCare Benefits Manual (MBM))
- Private Duty Nursing and Personal Care Services (Section 96 of the MBM)

- OES State funded Home Based Care and Homemaker Services (Sections 63 and 69 of the OES Policy Manual)

Programs currently offering self-direction by member but not through a representative:

- Home and Community Based Services for Adults with Physical Disabilities (Section 22 of the MBM)
- Consumer Directed Personal Attendant Services (Section 12 of the MBM)
- OACPDS State funded Consumer Directed Attendant Services Program (Chapter 11 of the OACPDS Policy Manual)

5. Plan of care. The department shall develop and authorize a plan of care for each consumer determined to be eligible under this chapter or Title 34-B, chapter 5, subchapter 3, article 2. The plan of care must be based on the needs assessment under subsection 2 and must be designed to meet the needs of the consumer identified in the assessment, giving consideration to the consumer's living arrangement and informal supports and, to avoid duplication of services, services provided by other private and public funding sources.

Status: The Department currently authorizes a plan of care based on needs identified as part of the assessment, taking into account the consumer's living arrangement and informal supports and to avoid duplication of services, services provided by other private and public funding sources.

6. Transitional facilities and services

The program must provide a consumer with transitional facilities and services to assist with changing functional needs and health care status.

Status: Maine is currently implementing demonstration services around transitional case management under Money Follows the Person, a federal grant aimed at transitioning individuals from nursing facilities back into the community. With respect to development of facilities, this is part of a longer term vision that will be considered as part of larger reforms in the system as the PNMI issues are resolved.

7. Nursing facility diversion

The program must include a nursing facility diversion component to encourage the use of facilities and services consistent with the consumer's needs assessment under subsection 2 and as chosen by the consumer under subsection 3.

Status: The Department is implementing this in several ways.

First, the assessment process described provides community options information to anyone seeking long term services and supports. Even when a person seeks nursing home placement, a care plan is provided that describes what services an individual would be eligible to receive in the community. This is done to assure an individual has a choice of where they want to receive services. Members who meet nursing facility level of care

must sign a Choice Letter, indicating their preference to receive services in a nursing facility or in a community setting.

Second, the Aging and Disability Resource Centers (ADRCs) located at the Area Agencies on Aging provide options counseling to people seeking long term support services. This initiative, funded by the Administration on Aging, provided funds to hire staff to conduct options counseling with individuals seeking information on long term care services and supports. This counseling is targeted to individuals at risk of going into nursing facilities. The intent is that this program will be sustained within the ADRCs.

8. Reimbursement

The program must provide reimbursement for skilled nursing care and in-home and community support services based on a uniform rate-setting process that is consistent across types of care and services, that reduces administrative costs and that is realistic regarding access to care and services. The process must set aside a fixed percentage of the rate for wages and benefits of the direct-care workers.

Status: There have been several stakeholder groups over the past decade convened to study reimbursement for long term care services, including the Direct Care Worker Task Force convened in October 2009. DHHS generally supports initiatives aimed at creating a consistent rate setting methodology across programs yet must work within constraints of funding and other regulatory and legislative challenges. Some rates were made more consistent September 1, 2010 at the time MIHMS went live and the consolidation required by LD 1461 will continue this effort.

9. Best Practices Training Standards

Establish best practices training standards in a common module-based format with standard designations for direct care workers.

Status: Maine is one of six states awarded a grant through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to develop and implement a competency-based curriculum and coordinated training and credentialing system for direct care workers. The goal is to streamline training across the job titles through a common core with specialized modules that will allow more flexibility in cross training for workers. The result of this will be the ability to reshape a workforce in response to an increasingly complex population who use long term services and supports. An initial pilot using the newly developed core curriculum will begin in late April 2012.

10. Assistive Technology

The Department shall promote the use of assistive technology

Status: Maine is currently implementing demonstration services for the use of assistive technology under Money Follows the Person, a federal grant aimed at transitioning individuals from nursing facilities back into the community.

11. Integration of services

The Department shall integrate skilled nursing and personal care and personal care services and support

Status: Integration of services is a primary component of long term care programs such as PACE, described above. The Department is also actively involved in initiatives for the development of Medical Homes and Accountable Communities, all of which are aimed at providing better coordinated and integrated care for members.

The assessment process described above in this report currently evaluates a person's functional needs as well as the need for skilled nursing services. In the development of the plan, resources to address skilled services may include Medicare or MaineCare as the payor of last resort, With the exception of current self-directed programs (Section 22, 12 and state funded self-directed), the service coordination agency is responsible for coordinating a member's personal care and skilled nursing services.

12. Qualified Providers

Establish a system to designate qualified providers who must:

- (1) Provide the full range of services in the self-directed and agency models under subsection 3;
- (2) Have the organizational and administrative capacity to administer and monitor a complete range of in-home and community support services, including, but not limited to, serving as a resource regarding service options, coordinating and implementing consumer services, ensuring the services are delivered, providing skills training, responding to questions and problems, performing administrative services, ensuring compliance with policies and performing utilization review functions; and
- (3) Submit proposals for coordinated in-home and community support services in response to a solicitation for proposals to qualified provider agencies from the department, in the form and manner required by the department as specified in rules. Rules adopted pursuant to this subparagraph are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A

Status: This work will be incorporated into the work required by LD 1461. Further evaluation will be needed regarding the requirement to RFP service coordination services. Generally under federal requirements for Medicaid, any willing and qualified provider may enroll to provide a MaineCare covered service. The State funded OES Home Based Care and the ISS/Homemaker Programs are currently part of an RFP process and those agencies perform many of the function outlined above.

13. Consolidation of Accounts

The Department of Health and Human Services shall combine long-term care accounts to implement the consolidation of long-term care services under the Maine Revised Statutes, Title 22, chapter 1622-A for fiscal years 2011-12 and 2012-13. The accounts that must be integrated into a single budget include the Office of Elder Services - Central Office account, the Long-term Care - Human Services account, the Nursing Facilities account and the Independent Housing with Services account.

Status: The Department is currently reviewing these accounts consistent with the overall intent of the bill and redesign of the long term care system to determine what, if any, of the consolidation as set forth is allowable or feasible. The specified accounts include some, but not all, of the long term care MaineCare accounts (including both the federal funds and associated match) and some, but not all, of the long term care state General Fund program service monies. Within the Office of Elder Services Central Office Account, the majority of the funding is federal and is used to support programs not directly related to long term care; including, Community Support Services, Alzheimer's Respite Program, Priority Social Services Program, Volunteers Program and the Aging and Disability Resource Centers. Much of the General Fund available in this account is used to support the state match and maintenance of effort requirements for the Federal Older Americans Act and overall administration of the Office of Elder Services. One of the accounts that is not included is the state funded OACPDS self-directed attendant program. The complexity of this has made implementation of this provision challenging and the Department is still in the process of this review to determine what funds can be consolidated and which, for compliance reasons, cannot be combined.

SUMMARY

The Department is committed to the review, analysis, development and implementation of a system of long term care services that meet the requirements as set forth in LD 683. To that end there are currently multiple initiatives underway to meet these requirements. This transformation of the long term care system is undertaken by the Department with the purpose of improving outcomes, improving the quality of care, meeting the needs of MaineCare members and increasing the availability and accessibility of home based community services. This work is undertaken in full collaboration with providers, advocates and consumers with the goal of a resultant system that will allow the delivery of quality services in a cost effective manner in full compliance with all state and federal mandates, directives and laws.