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Commission to Study the Level of Services for Maine's Elderly Citizens

Maine State Legislature

Office of Policy and Legal Analysis

Paul J. Saucier
Maine State Legislature

Jill Ippoliti
Maine State Legislature

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Final Report of the COMMISSION TO STUDY THE LEVEL OF SERVICES FOR MAINE'S ELDERLY CITIZENS

December 1990

Members:
Sen. Nancy Randall Clark

*Rep. Virginia Constantine
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Ernest Marriner
Myron McIntire
Woodrow Page
Edward F. Reed
Belle Rush
Margaret Russell
Ronald Thurston

*Denotes Chair

Staff:
Paul J. Saucier, Legislative Analyst
Jill Ipolliti, Research Assistant

Office of Policy and Legal Analysis
Room 101, State House–Sta. 13
Augusta, Maine 04333
(207) 289-1670

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Executive Summary

Origin and Purpose

The Commission to Study the Level of Services for Maine's Elderly Citizens was created by Resolves 1989, c. 58, during the First Regular Session of the 114th Legislature. The Commission was charged with analyzing data regarding the following aspects of services for older Maine citizens:

- Medicaid and Private Long-Term Care Insurance;
- Individualized Treatment Planning for Long-Term Care Clients;
- Financing and Delivery of Long-Term Care Services;
- Mental Health Services;
- Food Stamps and Supplemental Security Income (SSI);
- Transportation;
- Household Tax and Rent Refund Program; and
- Low-Cost Drug Program.

The Commission was directed to review each of these areas and make recommendations to the Legislature by December 5, 1990.

Priority Conclusions and Recommendations

The Commission arrived at many conclusions and made several recommendations. All of the conclusions and recommendations are included in the relevant topical sections of the report. Although all of the recommendations are important to the well-being of Maine's older citizens and their families, the Commission identified the following as the most pressing among the several items in the report:

1. **Expand and Index the In-Home and Community-Based Services Program.**

   Conclusion: Present appropriations for the In-Home and Community-Based Services program do not meet the existing need. While nursing home reimbursement principles allow for annual inflation adjustments, no such mechanism exists for the In-Home and Community-Based Services program.

   Recommendation: Funding for the In-Home and Community-Based Services program should be expanded to meet the need and adjusted annually based on an inflation index, such as a nationally-recognized home health market basket.

   (See pages 10 and 31.)

2. **Create a Long-Term Care Policy Committee.**

Conclusion: Financing and delivery of long-term care are incremental and lack vision. When resources are scarce, different interests within the long-term care system compete against one another rather than working cooperatively on the development of a comprehensive range of services. Many data are being collected, but many bits of information are collected in response to specific mandates and serve no greater planning purposes.

Recommendation: A Long-Term Care Policy Committee should be established under the administrative umbrella of the Maine Health Policy Advisory Council to oversee the development of long-term care policy and services in the State. The Committee would address the development of data systems and the level of funding needed for informal care, nursing homes, boarding homes, home-based care, congregate housing services and units, adult day care, assisted living, respite care and adult foster homes. The Committee would report to both the Governor and the Legislature.

(See pages 29-32.)

3. **Provide Medicaid reimbursement for eye glasses and hearing aids.**

Conclusion: Medicaid recipients who live in institutional settings are eligible for Medicaid-funded eye glasses and hearing aids while Medicaid recipients living at home are not. This inequity is one important example of the incentive to institutionalize which persists in the Medicaid program.

Recommendation: Medicaid coverage should be expanded to include coverage for eye glasses and hearing aids for recipients who are not institutionalized.

(See page 15.)

4. **Resolve liability issues for volunteer drivers.**

Conclusion: The transportation system relies heavily on volunteer drivers who are expressing increasing concerns about unresolved liability issues. Reportedly, carriers are refusing to cover them for their volunteer driving and, in some instances, have threatened to terminate coverage. Failure to resolve these liability questions threatens to diminish an important transportation resource.

Recommendation: The Department of Transportation, in consultation with the Bureau of Insurance, should assist transportation providers in resolving volunteer driver liability issues.

(See page 51.)

5. **Consider capitation of the Medicaid program.**

Conclusion: Capitation of state Medicaid programs and long-term care services offers potential advantages in the areas of cost containment, access to services, emphasis on prevention, delivery of services in the least restrictive environment, and consumer satisfaction. Special attention must be paid to quality assurance, since capitation may offer the temptation to scrimp on services.

Recommendation: The Bureau of Medical Services should investigate the costs and benefits of partially or fully capitating the State Medicaid program and offer its recommendations regarding a demonstration project to the Legislature in 1992.

(See pages 32-35.)

6. **Expand public awareness of the need for long-range financial planning.**

Conclusion: Although it is well known among health professionals that Medicare pays for only 2 to 3% of long-term care, many older people and their families are surprised and financially unprepared when faced with this reality.

Recommendation: The Department of Human Services and the Bureau of Insurance should develop a far-reaching public education campaign which makes people of all ages aware of the limits of Medicare coverage and encourages individuals to engage in financial planning and learn about long-term care insurance early in their lives.

(See pages 18-19.)

7. **Establish a Senior Health Insurance Benefits Advisors (SHIBA) program.**

Conclusion: Maine has done a good job in welcoming providers of long-term care insurance who offer products of a reasonable quality. The quality of long-term care insurance is improving rapidly, but consumers still need to be wary of substandard products. The Maine Committee on Aging reports that the majority of the calls it receives on its "800" number are related to long-term care insurance.

Recommendation: The Bureau of Insurance should establish a volunteer Senior Health Insurance Benefits Advisors (SHIBA) program to advise elderly consumers regarding health insurance, including long-term care insurance. The program could be implemented with one paid professional position at the Bureau and a network of volunteers, perhaps working out of the Area Agencies on Aging. In addition, the Bureau should establish an "800" number to receive inquiries from all consumers.

(See pages 18-19.)

8. **Index the Supplemental Security Income (SSI) State Supplement.**

Conclusion: Although Social Security retirement benefits and federal SSI payments have had periodic cost-of-living increases, the SSI State Supplement for people living at home ($8-15 per month) has not been increased since 1973. It has declined in value by more than 50% since then.

Recommendation: The SSI State supplement for people living at home should be indexed to receive the same cost-of-living increases as Social Security retirement benefits and federal SSI payments.

(See pages 46-47.)

9. **Offer a mail order option in the low-cost drug program.**

Conclusion: Most common conditions and diseases of the elderly which require life-sustaining drugs are currently covered by the program, but eligibility cutoffs keep the program from reaching everyone who could benefit from it.

Recommendation: An optional mail order service demonstration with participation incentives should be incorporated into the program. If savings result, they should be used to increase eligibility levels. Sliding co-payments should be considered if eligibility levels rise.

(See page 57.)

10. **Increase community spouse allowances.**

Conclusion: Maine has not increased spouses' Medicaid income and resource allowances to the maximum allowed by spousal impoverishment provisions of the federal Medicare Catastrophic Coverage Act.

Recommendation: Maine should increase the Medicaid income and resource allowances for spouses of people receiving care in nursing homes or through the community-based services waiver to the maximum allowed by the federal Medicare Catastrophic Coverage Act.

(See page 14.)

11. **Increase transportation funds for volunteer reimbursement.**

Conclusion: The transportation system relies heavily on volunteer drivers, some of whom are reimbursed for mileage and others of whom are not, depending on availability of funding. The willingness of volunteers to continue without reimbursement decreases as fuel prices rise.

Recommendation: Additional transportation funds should be made available to reimburse volunteer drivers.

(See page 51.)

12. **Implement a universal assessment system for all long-term care recipients.**

Conclusion: Despite efforts to introduce a universal assessment instrument for Maine's long-term care system, gaps exist in the system which make it far from universal. While the present system does serve as a "gatekeeper" for publicly-funded clients, it does not provide the system-wide data that a universal system could. Making the system universal is a manageable and worthy goal.

Recommendation: Maine should develop a universal assessment process for entry into the long-term care system.

(See pages 29-31.)

13. **Determine why Maine has no continuing care retirement communities (CCRCs).**

Conclusion: Despite their attractiveness to more affluent older people, continuing care retirement communities (CCRCs) have not been developed in Maine. State regulation of CCRCs and a general downturn in the economy may offer explanations for the lack of interest on the part of developers.

Recommendation: The Maine State Housing Authority should study the stalled development of continuing care retirement communities (CCRCs) in Maine, and recommend to the Legislature ways in which development could be encouraged, including amendments to the continuing care retirement community laws. The recommendations should specifically note any dangers for consumers which might come with facilitated development.

(See pages 35-36.)

Proposed Legislation

Recognizing the present fiscal strain, the Commission does not propose legislation for full implementation of its recommendations. Rather, it proposes legislation, attached as Appendix A, which would implement recommendations 1 through 8 above, and a number of additional recommendations from the report which would have no fiscal impact.

Introduction

Maine's Demographic Imperative

"Maine's population is aging as fewer children are born, as older Mainers live healthier, extended lives and as the bulging baby boom generation matures."
Commission on Maine's Future

The Commission on Maine's Future has aptly described Maine's version of what has been called a national "demographic imperative." The rapid aging of Maine's population threatens to overwhelm services to the elderly in the coming decades, but chaos can be avoided. The aging phenomenon is a predictable one which can be addressed in an orderly fashion if we accept the future and begin planning for it immediately.

The future is right around the corner. The "baby boomers," who make up more than one-third of the total Maine population, will begin to retire about the year 2010, and they will need an unprecedented level of health and social services. In addition, greater longevity will result in twice as many "very old" people (age 85 and up) by the year 2010. (See Appendix B for population projections.) Although the baby boomers will bring more assets to their retirement than today's elderly, observers predict that they will be faced with increased medical costs which far offset their assets advantage. Having had fewer children than their parents, they will also enjoy less informal care from relatives. These demographic trends have served as a backdrop for the Commission to Study the Level of Services for Maine's Elderly Citizens.

Commission History and Charge

The Commission to Study the Level of Services for Maine's Elderly Citizens was created by Resolves 1989, c. 58 during the First Regular Session of the 114th Legislature. (See Appendix C) It was comprised of Legislators, consumers, advocacy group representatives, service providers and State officials. The Commission was directed to analyze data regarding a broad range of subjects relating to older Maine citizens and to submit a report with any recommended legislation to the 115th Legislature by December 5, 1990.

The Commission held 13 meetings, at which it heard from experts in various fields, talked with State and private agency officials and reviewed its own research. (See Appendix D for a list of Commission guests.) Various subcommittees were convened, including one on long-term care financing and another on individual treatment planning.

The Commission found its charge difficult. On the one hand, it was directed to address an extremely broad array of topics which are not directly related (i.e., property tax refunds and private long-term care insurance). On the other hand, several important components of Maine's elder care system were not within the Commission's purview. These include services ranging from universal health care to heating fuel assistance to retirement benefits. (For an outline of

Maine's elder care system, see Appendix E.) The Commission wishes to emphasize that its failure to address particular services does not suggest that all is well in those areas. The Commission identified several areas outside of its charge which it would have liked to study, but given its constraints, it chose to spend its time and energy on those items identified in its charge.

For the sake of clarity, the report has been organized to follow the order of the enabling legislation. Chapter titles refer to specific parts of the charge as follows:

I. Medicaid and Private Long-Term Care Insurance;

II. Individualized Treatment Planning for Long-Term Care Clients;

III. Financing and Delivery of Long-Term Care Services;

IV. Mental Health Services;

V. Food Stamps and SSI Participation;

VI. Transportation;

VII. Household Tax and Rent Refund Program; and

VIII. The Elderly Low-Cost Drug Program.

I. Medicaid and Private Long-Term Care Insurance

"The Commission shall analyze data concerning...the level of services provided by and participation in Medicaid, including the effects of federal SOBRA legislation and options for redesign of the State's Medicaid programs to stimulate and complement the development of long-term care insurance;"
Resolves 1989, c. 58

A. Medicaid and the Elderly in Maine

1. Background

Maine's Medicaid program is among the most comprehensive in the country. With combined State and federal expenditures of about $384 million in FY 89, it comprised 16% of the State's total State and federal expenditures of $2.4 billion.

The Medicaid program is a federal-state partnership which is optional for the states, but all 50 states and the District of Columbia participate. This universal participation is undoubtedly due to the wide program discretion allowed the states, and the federal funding match, which is based upon each state's per capita income compared to other states. Currently, the match ranges from 50% to about 80%, with Maine's falling at 63.92%. Varying match rates and broad program discretion result in Medicaid programs which differ greatly from state to state.

All states which participate in the Medicaid program must include "mandatory coverage groups." These include people who have been deemed "categorically needy," that is, needy because they fit into a particular category. The major categories are Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) recipients, children under 5 years of age, and pregnant women. The pregnant women and children must meet certain financial requirements to be covered. By definition, AFDC and SSI recipients have already been determined to be financially needy.

2. Participation Among the Elderly and the Effect of SOBRA

For the purposes of Medicaid eligibility, "aged" or "elderly" refers to people who are 65 years of age or older. According to the Bureau of Medical Services, 23,557 elderly people participated in the general Medicaid program in FY 89. That represented a significant increase in elderly participation, attributable in large part to expanded eligibility options which Maine excercised in accordance with the Sixth Omnibus Budget Reconciliation Act (SOBRA).

SOBRA authorized optional expanded Medicaid eligibility for the aged, pregnant women, infants, children and the disabled. Maine exercised the "aged" option as far as allowed and now covers elderly people whose income falls below 100% of the federal poverty threshold. (The elderly were previously covered up to 76% of poverty.) According to the Bureau of Medical Services, elderly coverage under the SOBRA option has steadily increased since its inception in October, 1988, with 2,023 people covered by June, 1990, at a cost of about $2 million for FY 90. The number of elderly covered under SOBRA represents roughly 9% of the 23,557 elderly covered under Medicaid in FY 89.

3. Maine Exercises Nearly all State Options

In addition to the mandatory coverage groups (categorically needy), Maine is one of 36 states which covers the "medically needy," groups of people who meet eligibility standards when their medical expenses are considered.

In addition to the medically needy option, the Health Care Financing Administration lists 33 additional program options (see Appendix F) and reports that Maine exercises 27 of the 33, placing it near the top in relation to the other states. Following is a summary of Medicaid-funded programs which are particularly important to Maine's older citizens and some of the issues facing those programs.

Home and Community-Based Waiver Program for the Elderly

The Home and Community-Based Waiver program provides case management, day health, personal care, homemaker services, home health, transportation, emergency response systems, and mental health services to people age 60 and older who are at risk of institutionalization. The federal government agrees to waive certain Medicaid rules in order to provide services in a more cost-effective manner. In this case, for instance, Medicaid eligibility is based upon individual rather than household income. The program served nearly 800 people in FY 89 at a total cost of $2.2 million. By agreement with the federal government, the total number of participants is capped, and the cost per participant must be less than or equal to the Intermediate Care Facility (ICF) rate (presently around $22,000).

The cap on the number of people served will rise to 1,500 over the next three years, making this program one of potentially significant growth in services. Because of the Medicaid match, this program offers an opportunity to increase sorely needed community-based programs for a relatively small investment of State dollars, and it would be in the State's interest to appropriate sufficient State matching funds to operate the program up to the cap, and to increase the cap if possible in future negotiations with the federal government.

Home Health Services

Maine offers comprehensive home health services under its Medicaid program, broken down into the general areas of home health, private duty nursing and personal care services. Total expenditures in FY 89 (for all age groups) were over $7 million. In 1989, the Legislature, seeking to "promote the availability and accessibility of home health services," established the Advisory Committee on Home Health. (see 22 MRSA §2150) In its first report, the Advisory Committee identified four areas worthy of review: identification of gaps in the system, development of consumer education regarding access to Medicaid home health, monitoring of budgetary considerations, and review of Bureau of Medical Services rules and policies in this area. The Advisory Committee is concerned that, while service coverage is comprehensive, prior authorization requirements and other policies may unduly limit access. The Advisory Committee is mandated to report annually to the Legislature; it is scheduled to run through February 1, 1992.

Nursing Home Coverage

Approximately 75% of general Intermediate Care Facility (ICF) beds in Maine are occupied by Medicaid recipients. (This equals 6,853 of the State's 9,137 beds.) Medicaid expenditures for general ICFs were just over $123 million in FY 89, representing the largest single item in the Medicaid budget (32% of the total). When Skilled Nursing Facility (SNF) expenditures of about $5 million are added in, Medicaid expenditures for nursing homes totaled over $128 million, or about 34% of the Medicaid budget. In FY 90, the total was $142 million, or about 35% of the Medicaid budget.

Because the State is obligated by federal law to pay nursing home providers for their "reasonable costs" under the Medicaid program, the nursing home principles of reimbursement provide for an annual inflation factor. As a result, appropriations for nursing homes increase from year to year.

Case Mix Demonstration

Maine has been chosen by the federal Health Care Financing Administration to develop a case mix reimbursement and quality assurance demonstration for Medicaid and Medicare payments to nursing homes. Under a case mix system, providers are paid based upon resident characteristics and needs rather than on a flat rate basis. This provides a financial incentive to admit people who require heavy care; one goal of the project is to increase nursing home access for people with high medical needs who are in hospitals awaiting placement.

One possible result may be a shift in where a system backlog occurs. Whereas people may now be waiting in hospitals for nursing home placements, shortages in supply may shift to boarding homes or other settings as nursing homes admit heavier care patients from hospitals. Because case mix will not create new services, net shortages are not likely to be reduced, but they are likely to be moved to different parts of the system. Another possible outcome (as evidenced in New York) is increased specialization of nursing homes, which may mean that families need to travel farther if certain types of care are not available in their areas.

Boarding Home Program

On March 1, 1990, Maine began to use Medicaid to fund rehabilitation services in its cost-reimbursed boarding home program. Through Medicaid reimbursement, the federal government will now pay for a share of rehabilitation services, which were previously paid for with State dollars through SSI supplements paid to residents and additional fees paid to providers through the rate setting process. While General Fund dollars will still be needed in the program, the Medicaid initiative will reduce the amount of State funds.

During the Second Session of the 114th Legislature, the Department of Human Services proposed passage of LD 2285. In anticipation of the Medicaid initiative, the bill would have authorized the Department to deny public funds to people who failed to meet certain assessment standards set by the Department. If a person failed to meet the medical need standard to qualify for boarding home care, the Department could deny them funding. The Joint Standing Committee on Human Resources, concerned that such a policy could displace people from boarding homes, asked the Commission to review assessment data and include its review in this report. (See Appendix G)

According to the Department's Bureau of Medical Services, nearly 75% of boarding home residents are 55 years old or older, so the potential impact upon older citizens is clear. As of August 15, 1990, the Bureau had completed 700 of an expected 2300 screenings, or about 30% of the total. All 700 people screened met the medical need standard to qualify for Medicaid. The Department has, however, been targeting homes in which it expects people to meet the standard, enabling it to maximize Medicaid dollars as soon as possible. Nonetheless, it expects the vast majority of current residents to meet the medical need standard.

Who are the people, then, who would be displaced from the boarding home program if LD 2285 became law? Those identified as most vulnerable to such a policy are residents who may be physically and mentally quite well but who have no family close by and need minimal assistance to function well. In terms of their needs, they fall into a miscellaneous category ("other") and represent 2.9% of the boarding home population. One option for them might be Single Room Occupancy buildings (SROs), which tend to be available in urban areas and are often less than desirable. A more attractive option may be congregate housing, but such units are in short supply.

At the heart of the policy debate is the role of the boarding home program. The Commission believes that the program offers a degree of flexibility which is important not only to older people, but to a variety of people who may not fit into a specialized category of care or may not qualify for Medicaid or some other client-based funding source.

In terms of the financial issue, the Commission does not believe that the State would enjoy any savings by implementing LD 2285. The Department estimates (and the Commission concurs) that a very small number of people would actually be screened out of the program, and the Commission believes that they would end up receiving other public funds, most likely in the form of general assistance. For an illusory financial gain, the quality of life could be significantly diminished for those few unlucky people who were displaced or diverted from the program.

Drug Program

Maine's Medicaid program covers a comprehensive list of prescription drugs. Recipients are asked to make a co-payment of $.75 per prescription, but may not be refused a drug for inability to make the co-payment. People have been refused drugs or have chosen not to seek them because of the co-payment issue, and recent litigation has resulted in a consent order which includes education of recipients and pharmacists. Other than the co-payment issue, the drug program is generally well regarded.

Medicare A and B

Maine's Medicaid program covers deductibles and co-payments associated with both Medicare A and B, and pays the Part B premiums. In other words, for Medicaid recipients who are 65 or older, Medicaid supplements Medicare coverage and is the payor of last resort.

Hospice Services

State rules are being drafted and hospice services will soon be covered under Medicaid.

Maine Health Program

Although it is not a Medicaid service, the Maine Health Program should be mentioned for its potential impact on the elderly. The program has been designed as a Medicaid-like program for those who do not qualify for Medicaid, although it does not offer such comprehensive services. It focuses on acute services and does not, for instance, cover long-term care in an Intermediate Care Facility .

Adults with income up to 95% of the federal poverty level are eligible. As mentioned above, Maine has exercised the SOBRA option of covering the elderly up to 100% of poverty, so the Maine Health Program does not increase elderly health care access on the income side. However, the program's asset limit of $20,000 is considerably higher than Medicaid limits ($2,000 for an individual, $3,000 for a couple). This should expand health coverage to those elderly with low incomes whose assets are too high for Medicaid eligibility. The program began on October 1, 1990.

4. Medicaid Shortcomings in Maine

There are a few notable exceptions to Maine's otherwise generous Medicaid policy. They include:

Medicaid Reimbursement for People Age 65 or Older in Institutes for Mental Disease (IMDs)

An Institute for Mental Disease (IMD) is a facility of 16 or more beds in which more than half of the residents are primarily mentally ill. Federal Medicaid regulations specifically prohibit coverage for residents of IMDs who are between the ages of 22 and 64. Therefore, in order to cover the elderly (65 or older) in an IMD, a state must exercise this option.

The Bureau of Medical Services notes that Maine has covered people with mental illness in other ways, and the IMD option is not needed. For instance, residents of the nursing home at the Augusta Mental Health Institute qualify for Medicaid funding because they are primarily physically needy rather than mentally ill and, therefore, the IMD designation does not apply.

The IMD designation may become important as people move out of the Augusta Mental Health Institute in the wake of the newly-signed consent decree, which calls for a significant reduction in the number of patients there. Placements will add to the number of people with mental illness who are already in various community settings. In the course of completing 700 boarding home resident screenings this year (see Boarding Home Program in section 3, above) the Bureau of Medical Services has identified 60 people who fall within the IMD category; Maine will not be able to claim Medicaid funds for those residents.

Spousal Impoverishment Provisions

Among the few pieces which survived repeal of the federal Medicare Catastrophic Coverage Act were provisions to prevent the impoverishment of a community spouse when a Medicaid recipient goes to a medical institution or nursing facility for at least 30 consecutive days. (See 42 USC §1396r-5) Each state may decide whether to also apply the provisions to spouses of those receiving long-term care services through the home and community-based waiver.

The amendments require the states to recognize a needs allowance for the community spouse; if the spouse's income is not as high as the needs allowance, the spouse may keep income which would otherwise be available to the institutionalized spouse. The federal law set a minimum amount for the needs allowance. That amount is presently 122% of the federal poverty threshold, which equals $856 per month. This means that, if the community spouse's income is less than $856, and if the institutionalized spouse has income to contribute, income from the institutionalized spouse will be shifted to the community spouse to bring his or her income up to $856. If the community spouse's shelter expenses are more than 30% of his or her income, he or she is entitled to an additional allowance.

States may recognize a higher needs allowance, up to a cap of $1500 per month, as adjusted for inflation. (The present cap is about $1565.) Maine has chosen to abide by the minimum requirements of the law in nursing home cases ($856 plus shelter allowance for community spouse) and it has not extended the allowance provisions to spouses of waiver clients. (The maximum allowance for spouses of waiver clients is presently $396. If a community spouse has more than $396, he or she does not lose any; $396 is the maximum income allowed when the community spouse has less than $396 and income is shifted from the institutionalized spouse.) This has created an incentive to institutionalize, since spouses of institutionalized Medicaid clients can enjoy more income than spouses of waiver clients.

Some have expressed concern over the fact that if the State applies the catastrophic income allowance to waiver clients, it must also apply the catastrophic resource allowance, and some spouses of waiver clients could end up with fewer resources (assets) than they enjoy under present rules. Others argue that the new provisions would allow spouses to claim resources if they were needed to make up the higher income allowance, and many more people would be helped than would be hurt by the change.

Eye Glasses and Hearing Aids for Non-Institutionalized Elderly

Presently, Medicaid will pay for hearing aids and eye glasses if an elderly person resides in a nursing home, but will not pay if the person lives at home. This offers one more incentive to choose nursing home care over home care.

B. Private Long-Term Care Insurance

At first glance, one might wonder how Medicaid and long-term care insurance are related. The Commission was charged with looking at ways in which the Medicaid program can be changed to stimulate and complement the development of long-term care insurance. The implicit suggestion is that long-term care insurance offers a mechanism by which private dollars can replace Medicaid dollars. That suggestion will be discussed in part C below; this part will describe long-term care insurance, how it is regulated in Maine, and how other states are trying to develop it under the auspices of the Robert Wood Johnson Foundation.

1. What is Long-Term Care Insurance?

Long-term care insurance provides benefits to policy holders who require long-term care services. When initially marketed, such policies were often called nursing home insurance, but policies which cover only nursing home care are now considered outdated. Long-term care policies generally cover home-based services as well as nursing home services. They are designed to compensate for the shortcomings of traditional acute care insurance and, in particular, Medicare, which pays for only 2 to 3% of long-term care nationally. The primary benefits offered by long-term care policies are protection of assets and preservation of personal control when long-term care is needed.

Current policies have eliminated many restrictions of earlier versions, such as prior hospitalization requirements, and are usually triggered by some measurable loss of functional ability. Most policies pay for services approved in a care plan, but recent innovations include policies which pay a cash benefit to the insured, regardless of how the insured wishes to use it.

Long-term care policies have been offered primarily to older people, but marketing efforts are being made with younger workers, particularly through workplace group plans. The move to group policies promises to decrease consumer protection issues which are of greater concern when policies are marketed directly to individuals. Consumer protection concerns have included selling policies which are not affordable to the buyers in the long-run, selling unneeded coverage, selling inadequate coverage, and selling coverage which decreases in value over time.

Marketing to younger workers also makes long-term care insurance more affordable, since it is less expensive the earlier one buys it. While the present cost of long-term care insurance makes it unaffordable to most older Maine citizens, it may offer an attractive alternative to younger citizens and to those who have significant assets to protect or who expect to have significant assets in the future. One rule of thumb suggests that those who have or expect to have income with a present value of $18,000 per year and assets (excluding the home) with a present value of $60,000 may benefit from long-term care insurance.

2. Long-Term Care Insurance in Maine

Present Law

Long-term care insurance and nursing home insurance are regulated by Chapter 68 of the insurance code (24-A MRSA §5051 et seq.), first passed in 1985 and amended in 1989. The law essentially adheres to the recommendations of the National Association of Insurance Commissioners in setting standards for policies offered in the State. The law protects consumers by establishing minimum benefits which must be offered in any policy sold in Maine.

The original legislation excluded employer-offered group policies. In an effort to stimulate the market, the 1989 amendments included employer group policies as of October 1, 1990. It also established tax incentives for insurance companies, employers, and consumers who sell or purchase policies which are certified by the Superintendent of Insurance. These incentives should increase demand for long-term care insurance in Maine, but it is too early to tell what their effect will be.

Consumer Education Efforts

In response to an increasing number of inquiries from consumers, the Maine Committee on Aging, in cooperation with the Bureau of Insurance, has developed a comparison chart to assist people who are choosing a policy. First published 4 years ago, it is periodically revised to reflect changes in the law and in the products offered. (See Appendix H) The Maine Committee on Aging speculates that it gets the bulk of the calls in this area because of its toll-free "800" number, but the calls would be more appropriately directed to the Bureau of Insurance, which does not have an "800" number.

Along with its 1989 amendments to the long-term care insurance statute, the Legislature directed the Bureau of Insurance to investigate the feasibility of establishing a Senior Health Insurance Benefits Advisors (SHIBA) program in Maine. Such a program would be directed by a paid professional and staffed by a network of volunteers throughout the State. They would advise older consumers on a variety of insurance matters, including

medi-gap and long-term care policies. The Bureau estimated that it would need 2 trainers and a clerical person to establish such a program, but the Commission believes it could be done with one professional position. The volunteer mediation program administered by the Attorney General's Office uses volunteers in a similar way, and has one professional position for staffing.

3. Initiatives in Other States: The Robert Wood Johnson Grants

With assistance from the Robert Wood Johnson Foundation, 8 states have initiated public-private proposals designed to increase the demand for long-term care insurance. (The states are California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon and Wisconsin.) Each proposal has one or more of the following features: waiver of Medicaid asset rules, state reinsurance program, consumer education, and provision of long-term care insurance to state employees. With the exception of Oregon's proposal, all of the initiatives are awaiting Congressional action before proceeding.

Waiver of Medicaid Asset Rules

All of the proposals except Oregon's have some variation on this feature. People are allowed to shelter assets in some relation to the amount of insurance they buy. For example, an individual purchases $50,000 worth of coverage, which the insurance company pays out. Medicaid eligibility excludes consideration of $50,000 of assets. Some states offer a state subsidy, on a sliding scale, to those who cannot afford the premium. California offers a choice of purchasing insurance or joining a health maintenance organization (HMO), with subsidies available for either option on a sliding scale. The asset waiver feature seeks to prevent impoverishment of people in the middle class by providing an incentive to plan for their long-term care needs. It requires extensive federal waivers which the Health Care Financing Administration (HCFA) presently does not have authority to grant. Legislation granting such authority to HCFA failed to pass during the 101st Congress.

State Reinsurance

Wisconsin seeks to establish a state reinsurance pool for insurance companies. The companies would voluntarily pay premiums to the pool if they wanted protection against unanticipated losses in their long-term care insurance funds. This feature seeks to encourage companies to market the product by offering them a risk reduction mechanism.

Consumer Education and Protection

All states seek to protect consumers by requiring counseling prior to purchase of a policy, certifying policies, and/or establishing minimum benefits which must be offered.

Coverage to State Employees

Oregon seeks to offer insurance to its state employees. The state will provide case management and marketing as its part of the partnership with private carriers. This feature seeks to stimulate the market by providing a large group of consumers for the product, thereby adding to the limited experience that exists presently. Oregon's agreement to provide the case management component reduces the carriers' risk, since the costs of the case management are difficult to predict.

C. The Interaction of Medicaid and Long-Term Care Insurance

1. Long-Term Care and the Risk of Impoverishment

The question which everyone is asking but which no one can answer very well is: "To what extent will long-term care insurance prevent impoverishment of the middle class?" To whatever extent that it does so, Medicaid expenditures will be avoided. Because Medicare pays for only 2 to 3% of long-term care, many older people and their families find themselves financially unprepared when significant long-term care costs are before them. (Private pay rates for nursing homes in Maine range from $24,000 to $34,000 per year.) Often, the only option is to spend the few resources which are available until the person qualifies for Medicaid.

At one end of the spectrum are those people who have the resources to pay for their care and, if they choose, to purchase long-term care insurance. At the other end of the spectrum are people living in poverty who clearly qualify for Medicaid. In between lies a group of people who have some resources but not enough to pay for care over a sustained period of time; they are the ones who are at risk of becoming impoverished and needing Medicaid. Those at the upper end of this middle group can afford long-term care insurance and, with adequate planning, can avoid impoverishment. It is those at the lower end of this middle group who are the most vulnerable. They have too much to qualify for Medicaid but not enough to afford private insurance, and they are faced with certain impoverishment if significant long-term care is required. Since more than half of the older people who enter nursing homes stay for 90 days or less, short-term catastrophic assistance which would pay for care at the commencement of institutionalization would significantly reduce the incidence of impoverishment.

2. National Debate Over the Robert Wood Johnson Approach

The thrust of the Robert Wood Johnson projects is to address the issue of impoverishment of the middle class by offering people an incentive to purchase insurance. The proposed incentive, a Medicaid asset waiver, is the most contentious aspect of the projects. (For a description of the asset waiver, see section B.3., above.)

At issue is the long-term effect on the Medicaid program. Proponents argue that, by encouraging the middle class to plan for their long-term care needs, many who would have become impoverished and received Medicaid will instead cover their needs with private insurance, thereby saving scarce Medicaid resources for the poor. Opponents counter that the asset waiver makes an implicit policy statement that Medicaid will serve the middle class, and pulls the program away from its mission. Proponents counter that the middle class is accessing Medicaid anyway, through impoverishment or clever estate planning, and the asset waiver would be enough of an incentive for individuals to plan for their own needs.

The debate is tied to another national controversy: whether national health insurance or some kind of national long-term care insurance should be enacted. Robert Wood Johnson proponents argue that a national program is unrealistic in the short-run; they also argue that solutions must build upon the public-private system already in place for acute care coverage. Opponents counter that the Robert Wood Johnson projects are not targeted at those who need help the most, will not offer significant relief, and will draw attention away from the need for national coverage. They also argue that the acute care system is fatally flawed and should not be replicated in the area of long-term care.

3. Options for Maine

Long-term care insurance does offer the promise of reduced public expenditures, but it is too early to know how significant that reduction will be. Long-term care insurance does not, by any means, offer a panacea to the growing need for long-term care, nor will it replace Medicaid, but any infusion of private money into the system is welcome, and Maine should do everything it can to encourage the development of long-term care insurance. Understanding that Medicaid will continue to be a significant source of long-term care financing for citizens, Maine should also continue to improve the Medicaid program, paying particular attention to reducing incentives to institutionalization.

In encouraging the development of private insurance, Maine must not lose sight of the very real consumer protection issues which exist in the marketing of long-term care insurance. Encouragement of private insurance must be coupled with enhanced consumer education, to ensure that citizens get their money's worth when they plan responsibly for their future needs.

Options include the following:

• *Establish a Senior Health Insurance Benefits Advisor (SHIBA) Program:* Such a program would serve a needed consumer education role in long-term care insurance and in other types of insurance, such as medi-gap policies.

• *Establish a Public-Private Insurance Program:* A public-private long-term care insurance program with sliding-scale premiums would enable people who are not eligible for Medicaid but can not afford long-term care insurance to avoid impoverishment. Such a program would be targeted at those most likely to end up needing Medicaid.

• *Initiate a Demonstration Based on the Medicaid Asset Waiver:* If such an approach is approved by Congress, a demonstration would give the State a sense of what the actual impact on the Medicaid program would be.

• *Offer Long-Term Care Insurance to State Employees and Retirees:* A 1990 study commissioned by the Department of Administration estimated that the administrative costs of offering an employee-pay-all policy to 15,050 employees and 5,400 retirees would total $260,000 over the first 5 years and $10,000 to $30,000 each year thereafter. An employer-pay-all program would cost an additional $73 million over 5 years.

• *Establish a Reinsurance Pool:* Such a pool could be funded in whole or in part through premiums paid by participating companies.

D. Conclusions and Recommendations: Medicaid and Private Long-Term Care Insurance

Conclusions

Medicaid recipients who live in institutional settings are eligible for Medicaid-funded eye glasses and hearing aids while Medicare recipients living at home are not. This inequity is one important example of the incentive to institutionalize which persists in the Medicaid program.

Although it is well known among health professionals that Medicare pays for only 2 to 3% of long-term care, many older people and their families are surprised and financially unprepared when faced with this reality.

Maine has done a good job in welcoming providers of long-term care insurance who offer products of a reasonable quality. The quality of long-term care insurance is improving rapidly, but consumers still need to be wary of substandard products.

Maine has not increased spouses' Medicaid income and resource allowances to the maximum allowed by spousal impoverishment provisions of the federal Medicare Catastrophic Coverage Act.

Long-term care insurance will reduce Medicaid expenditures for those middle income policy holders who would otherwise have become impoverished and relied on Medicaid, but it is not clear at this early stage who those people are or how much of a potential Medicaid savings they represent.

Although long-term care insurance is not affordable to most of today's older Maine citizens, it may offer an attractive alternative to younger citizens and to those who have significant assets to protect or who expect to have significant assets in the future. One rule of thumb suggests that those who have or expect to have income with a present value of $18,000 per year and assets (excluding the home) with a present value of $60,000 may benefit from long-term care insurance.

Maine's Medicaid program is among the most comprehensive in the country. With a few notable exceptions, it takes full advantage of optional coverage for the elderly, including the waiver program for home-based care services and the extended eligibility options under the Sixth Omnibus Budget Reconciliation Act (SOBRA).

Those who have too much to qualify for Medicaid but not enough to afford private insurance are faced with the prospect of impoverishment if significant long-term care is required.

The Home and Community-Based Care Medicaid waiver program for the elderly may be expanded for a relatively small State investment.

75% of general Intermediate Care Facility beds in Maine are occupied by Medicaid recipients. Medicaid expenditures for general Intermediate Care Facility and Skilled Nursing Facility beds comprised 34% ($128 million) of the Medicaid budget in FY 89 and 35% ($142 million) in FY 90.

Although the case mix reimbursement demonstration offers the promise of greater access to nursing homes for heavy care patients, it could push lighter care patients into a vacuum of nonexistent services. It could also result in specialization among nursing homes, forcing some clients to receive care farther away from their families and home communities.

To date, no publicly supported elderly residents of cost-reimbursed boarding homes have failed to meet the "medically needy" Medicaid standard. As assessments are completed over the next year, very few, if any, elderly residents are expected to fail to meet the standard.

Recommendations

1. Medicaid coverage should be expanded to include coverage for eye glasses and hearing aids for recipients who are not institutionalized. Cost: Slightly over $1 million in the first year, $384,000 in the second year (Bureau of Medical Services estimate).

2. The Department of Human Services and the Bureau of Insurance should develop a far-reaching public education campaign which makes people of all ages aware of the limits of Medicare coverage and encourages individuals to engage in financial planning and learn about long-term care insurance early in their lives.

3. The Bureau of Insurance should establish a volunteer Senior Health Insurance Benefits Advisors (SHIBA) program to advise elderly consumers regarding health insurance, including long-term care insurance. The program could be implemented with one paid professional position at the Bureau and a network of volunteers, perhaps working out of the Area Agencies on Aging. In addition, the Bureau should establish an "800" number to receive inquiries from all consumers. Cost: $50,000 per year for the SHIBA program (based on experience in the Attorney General's Consumer Mediation Program) and $6,000 per year for an "800" number (based on the cost of the Committee on Aging's "800" number).

4. Maine should increase the Medicaid income and resource allowances for spouses of people receiving care in nursing homes or through the community-based services waiver to the maximum allowed by the federal Medicare Catastrophic Coverage Act. Cost: $3.6 million in the first year (Bureau of Income Maintenance estimate).

5. In order to stimulate the demand for long-term care insurance and reduce future Medicaid expenditures, the State should explore all ways and means of encouraging citizens to obtain private coverage when appropriate, particularly at younger ages when coverage is more affordable. Special attention should be paid to those who have too many resources to qualify for Medicaid but not enough resources to afford private insurance. As resources permit, the State should consider:

   • A public-private long-term care insurance program with sliding scale premium assistance for those who cannot afford full premiums for private long-term care insurance. Such a program should target those who have too many resources to qualify for Medicaid but not enough resources to fully afford insurance;

   • A long-term care insurance demonstration based on a Medicaid asset waiver, if and when federal law allows such an approach;

   • The provision of long-term care insurance to State employees; and

   • A reinsurance pool for long-term care insurance providers, to be funded through premiums paid by participating companies.

6. At this early stage, the Bureau of Insurance should watch the continuing development of long-term care insurance in Maine and report to the Legislature in 1992. As the Bureau proposes new legislation or rules in this area, it should weigh enhanced consumer protection against potential restraint of product development.

7. Maine should take advantage of any opportunity to increase the number of people served in the Home and Community-Based Care Medicaid waiver program by providing the State Medicaid match needed to serve the maximum number of people allowed under the State's agreement with the federal government.

8. The nursing home case mix demonstration should be carefully monitored for its impact at all levels of care, including hospitals, boarding homes, foster homes and home-based care.

9. Laws regarding eligibility for public funding of cost-reimbursed boarding homes should not be changed. Any such changes would have little or no impact on general fund expenditures within the program.

10. The Bureau of Medical Services should review the Medicaid program and, wherever it makes sense, establish a competitive bidding process to purchase Medicaid services. In making such a decision, the Bureau should weigh potential cost savings against access and quality of care issues.

II. Individualized Treatment Planning for Long-Term Care Clients

"The Commission shall analyze data concerning...the need for improved individualized treatment planning procedures for long-term care clients which can be used to identify gaps between client needs and available services and which are based upon principles of maximum feasible restoration of functional capacity in the least restrictive setting;"
Resolves 1989, c. 58

Individualized treatment planning refers to the development and coordination of individually-tailored packages of health and social services for those requiring long-term care. In the literature, this type of service is often referred to as care management. It is important not to confuse individualized treatment planning with pre-admission screening or assessment. Screening determines what part of the long-term care system one is appropriately served in; it will be discussed as an overall service delivery issue in Chapter III. Individualized treatment planning refers to the specific plan which is developed for a person once that person is in the long-term care system.

This part of the Commission's charge arose from a bill proposed during the First Regular Session of the 114th Legislature, LD 1141, which the Joint Standing Committee on Human Resources chose not to recommend, finding that the issue needed further study. (See Appendix I) Proponents of LD 1141 argued that individualized treatment planning was either not done or done poorly in many parts of the long-term care system, and that the Department of Human Services had no way of collecting uniform client-based unmet needs data. LD 1141 would have established an elaborate system of treatment plan coordinators which would superimpose a uniform planning requirement upon all parts of the long-term care system. Opponents of the bill argued that individualized treatment planning is already carried out, and that to create a threatening, bureaucratic structure would be counter to the concepts of consumer control and flexibility in services.

The Commission reviewed the existing individual treatment planning requirements and found that improvements are needed, but LD 1141 goes too far.

A. Individualized Treatment Planning Mandates

Following are some of the existing individual planning mandates which the Commission reviewed. The list is by no means exhaustive, but it does include the major long-term care system elements.

• *Federal Medicaid Rules for Intermediate Care Facilities (42 CFR § 442.343):* Federal rules require Intermediate Care Facilities to provide rehabilitative services which will "maintain and improve the resident's ability to function independently." Such services must be specified in a plan of care developed in consultation with the attending physician.

• *State Rules for Home and Community-Based Medicaid Waiver Program (Maine Medical Assistance Manual, § 19):* The waiver program requires that an individual plan of care be prepared by a multi-disciplinary team. The plan outlines the medical and other services needed to reside in the least restrictive setting.

• *Maine In-Home and Community-Based Services Program Statute and Rules (22 MRSA § 7323 and Rules):* State statute and the rules adopted in accordance with the statute require an individual plan of care to be developed by a multi-disciplinary team, as coordinated by a care manager. The plan must be directed at assisting "individuals to maintain optimal independence."

• *Personal Care Assistance for Severely Physically Disabled Adults Statute (22 MRSA § 7343):* State statute requires a team to evaluate needs and reevaluate them periodically.

• *Boarding Home Services Statute (22 MRSA § 7910):* State statute requires that plans of care be developed for residents who need State funding.

B. Individualized Treatment Planning Delivery

Major deliverers of individualized treatment planning for publicly-assisted long-term care clients are the Area Agencies on Aging, hospitals, nursing homes and home health agencies. An individual plan is required for anyone who obtains long-term care services through one of the Area Agencies on Aging. Each Agency has care managers on staff who conduct assessments, convene multi-disciplinary teams, write care plans and coordinate service delivery. In theory, individual plans should be a ready source of unmet needs data, but in practice, the plans tend to focus on needs which can be readily met with existing funds and services. Nursing homes and home health agencies develop individualized treatment plans for the people under their care. These plans focus on the specific services which the home or agency will deliver to the client, and they generally do not list unmet needs.

Within particular service delivery settings, such as nursing homes or home health agencies, private pay clients enjoy the same individualized treatment planning as publicly-assisted clients, but overall case management as a discrete service is difficult to find for the private payor in Maine. This has been a source of frustration to many families who have the resources to pay for services but need the assistance of a professional case manager to help them identify and access the services they need. The National Association of Private Care Managers lists one entity in Maine, Elder Health, owned and operated by one person as a "very part-time" concern. The

owner/operator is uncertain if the Maine market will support a full-time business. Efforts on the part of at least one home health agency to develop private, for profit care management have failed. Observers suggest that private care management requires a large number of relatively affluent elderly people, and is successful in states such as New York, Illinois and California. Some of the Area Agencies on Aging are reportedly interested in developing private care management in order to provide a needed service and generate additional revenue for their programs, but they are prohibited from using public funds to capitalize such ventures.

Clearly, individualized treatment planning is required and carried out in many settings in Maine, but the requirements vary, lacking a common philosophical base, and they are carried out with varying degrees of consistency and quality. Unmet needs are generally not recorded in treatment plans, and statewide unmet needs data are not available or retrievable from the present system.

C. Conclusions and Recommendations: Individualized Treatment Planning

Conclusions

Individualized treatment planning (also referred to as case management or care management) is generally available to publicly-assisted clients but the quality and availability are not uniform across settings and need improvement.

Private individualized treatment planning is virtually not available as a discrete service in Maine.

Data which measure the unmet needs of long-term care recipients are not available.

Recommendations

1. The Department of Human Services should, through its licensing processes, assure that adults who require long-term care receive an individual treatment plan which addresses medical and social needs and is developed in accordance with the following principles:

    • An interdisciplinary process, which includes the adult, family members, and representatives from all appropriate disciplines, is followed. Representatives from appropriate disciplines have equal standing and may include social workers, mental health professionals, nurses, doctors, health aides, physical therapists and nutrition specialists;

• The adult exercises as much control over the process and outcomes as possible. This may include deciding not to participate in the process, participating selectively, or rejecting the recommended outcomes;

• The plan is directed toward maximum feasible independence for the adult, with services delivered in the least restrictive manner possible;

• The plan is directed toward maximum feasible restoration of the adult's functional capacity; and

• The plan lists unmet needs in a manner which enables the Department of Human Services to compile them periodically.

2. The Department of Human Services should periodically compile unmet needs of long-term care recipients.

3. The Department of Human Services should explore ways of making individualized treatment planning available to private-pay individuals.

III. Financing and Delivery of Long-Term Care Services

"The Commission shall analyze data concerning...the financing of long-term care needs and alternate delivery systems; methods to develop more innovative financing strategies such as capitation and prepayment for services for elderly persons, including the benefits and risks of these alternative financial arrangements; and the possible effects of restructuring the financing and delivery systems on the current medicare and medicaid shortfalls;"
Resolves 1989, c. 58

This far-reaching piece of the Commission's charge goes to the heart of most people's concerns regarding services for the elderly. Whether pursuing long-term care for one's self or on behalf of a parent or friend, Maine citizens learn quickly that long-term care services are expensive and are delivered through a complex and often mystifying maze of administrative structures. In addition, delivery of specific services varies geographically, so needed assistance may not be available close to home. This chapter will discuss ways in which Maine's long-term care system can be improved generally, and will examine specific innovations which may complement or offer some advantages over the present system. Because data management and planning emerged as significant issues in long-term care, the chapter will begin with an examination of those topics.

First, long-term care should be defined. A quick review of the literature points out that long-term care means many things to many people. As used by the Commission:

> Long-term care consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals, elderly and non-elderly, who have physical or mental functional impairments. The services may be provided in a variety of institutional and non-institutional care settings, including the home. Regardless of the setting, the goal of long-term care is to promote the optimum level of physical, social and psychological functioning in the least restrictive setting possible. The care, either continuous or intermittent, is required for an extended period of time.

The Commission specifically decided to include people of all ages in its definition. It felt that separating the elderly would perpetuate the fragmentation which is already too present in the delivery and financing of health care.

A. Data Management and System Planning

1. Describing the Needs of People Inside the System

As the Commission began accumulating information about Maine's long-term care system, it quickly became apparent that the State does not have a standardized long-term care data base. No single information system can be called upon to aggregate client-specific information and generate summaries of long-term care needs. As a result, we have no accurate sense of how well services fit the needs of service recipients. The overall effectiveness of the present service system can not be evaluated.

The Department of Human Services has considered setting up a standardized long-term care data base. A preliminary work plan was developed for this project by the Human Services Development Institute (HSDI), and the Department's 1990 Action Plan on Long-Term Care called for the plan to be developed, but the initiative has not moved forward. The plan involves entering information from the Bureau of Medical Services' Client Assessment Referral Form, BMS-85, into a computer data base. The BMS-85 form is currently used to determine the appropriate level of care for prospective nursing home residents who need public funding, and for clients of the Medicaid Waiver Program, the Medicaid Private Duty Nursing/Personal Care Services Program, the Home-Based Care Program, and the Congregate Services program. The BMS-85 is not, however, used universally, and it is criticized for its focus on medical diagnoses rather than functional impairments.

A logical place to begin collecting uniform client-based data is at each client's point of entry into the system. Despite its shortcomings, the BMS-85 does bring Maine close to having a uniform assessment instrument, but it is possible to get into the system without having that particular assessment done. Private-pay clients need not have the assessment; they represent a significant gap in the system. Non-medicaid clients who go directly to home health agencies for services may also bypass the assessment. Some of the various routes into the long-term care system are:

1. Home→→→→Area Agency→→→→→→→→→→→→Home Services
2. Home→→→→Area Agency→→→→→→→→→→→→Nursing Home
3. Home→→→→Hospital→→→→→→→→→→→→→→→Nursing Home
4. Home→→→→Home Health Agency→→→→→→Home Services
5. Home→→→→Hospital→→→→→→→→→→→→→→→Home Services

Again, if any of the above scenarios involve private pay clients, the BMS-85 need not be done at all. Maine considers the BMS-85 to be its "uniform assessment instrument," but its use is not universal, and it is used only as an assessment; data from the forms are not aggregated to get a composite of client needs which could then be compared to present services to assess the degree to which services are actually meeting needs.

Many other client-based data are collected in Maine, but they all serve specific purposes and are not useful for the broader purpose of describing the long-term care population in Maine. Other efforts include the following:

- The Medicaid Management Information System (MMIS) is essentially an accounting system for Medicaid, but it also provides information on services provided to clients of all Maine's medical assistance programs. Counts by type of service, client age group, provider, geographic area, etc. can be generated by MMIS. Individual client profiles of service can be produced. This information is valuable in describing service delivery to publicly-assisted clients, but it does not capture private services or offer an assessment of unmet need. Reportedly, technical computer problems have limited the range of information which can be generated from the data;

- Hospital discharge data maintained by the Maine Health Care Finance Commission yield reports on days awaiting placement and average length of hospital stay by age group;

- Certain programs which provide long-term care services maintain databases to support evaluation and planning efforts. One example of this is the Geriatric Mental Health Resource Program's contract with the Human Services Development Institute (HSDI) to provide client and program profiles;

- HSDI is focusing on the elderly population in its evaluation of three publicly-funded home care programs. Data collection on a sample of 800 clients began in 1988 for the 2 year study funded by the Department of Human Services; and

- The Bureau of Medical Services conducts an annual survey of licensed home health agencies. The survey contains questions on waiting lists, payors, number of clients, types of services, referral sources, etc. Responses are entered into a computer data base and reports are generated by the Office of Data, Research, and Vital Statistics. Preliminary information from the 1988 survey is now available.

2. Describing the Needs of People Outside the System

A standardized data base which describes the people within the system would be extremely valuable for allocating resources and measuring effectiveness, but it would not capture the present and future needs of those who have yet to enter the system. The need to predict the use of services will be especially critical as the system tries to prepare for the demographic shift of the next few decades. Because such population-wide information is not available in Maine, the Bureau of Elder and Adult Services conducted a needs survey of its own in 1989 (published January, 1990). It was limited to the needs of Maine citizens ages 60 and over. Survey participants were asked a range of questions designed to measure the need for long-term care services. By design, it did not include those living in institutions.

The Department of Human Services, Division of Health Planning is currently developing a model to predict the need for long term care. The model updates and refines the "Weissert" method used in 1986 to estimate the need for long-term care in Maine. This estimation method is based on national survey data and a functional dependency definition of the long-term care population. Percentages of persons with a functional dependency are determined and applied to regional demographic data to obtain estimates of persons needing all types of long-term care in Maine. This update, expected by January of 1991, will attempt to address the major criticism of the Weissert model, which is that national data do not necessarily apply to the unique characteristics of Maine citizens.

B. Incremental Financing and Delivery

The lack of comprehensive data and the inability to establish system plans which are based on data have contributed to the incremental development of the long-term care system. Existing services become institutionalized and advocate for themselves, often to the exclusion of innovations. Needs are expressed anecdotally or are collected through unreliable methods, such as the compilation of waiting list information from several service providers.

Within this incremental system, nursing homes are at least allowed to cover their increasing costs, since the Medicaid principles of reimbursement allow for annual inflation adjustments. (See "Nursing Home Coverage" in Chapter I, Part A.) No such adjustment occurs in the home-based care program, unless more funding is specifically requested and approved. When resources are scarce, nursing home providers, home-based care providers and various others who have an interest in long-term care, find themselves in the uncomfortable position of competing for funds rather than working together to develop a rational system which responds to actual needs.

As Maine faces the challenges of an unprecedented increase in the demand for long-term care, flexibility within the service system will become paramount. Funding for a broad range of needs, such as informal care, boarding homes, home-based care programs, congregate housing units and services, adult day care, assisted living, respite care and adult foster homes will become increasingly important. The system will need to respond creatively to a broad range of needs, and it will not be able to afford to use resources on services which do not actually fit the need. The system will be most efficient if it responds precisely to the need; unfortunately, incremental systems support existing efforts regardless of their continuing relevance.

In order to vest oversight responsibility for data and system planning into a single entity, a Long-Term Care Policy Committee could be established and operated under the administrative umbrella of the Maine Health Policy Advisory Council. The Committee would be comprised of legislators, service providers, state officials, consumers and advocates. It would oversee the development of long-term care policy and the development of long-range plans and short-range implementation strategies for the long-term care system. It would make recommendations regarding the level of funding needed for informal care, nursing homes, boarding homes, home-based care, congregate housing units and services, adult day care, assisted living, respite care and adult foster homes. It would make its recommendations for funding to both the Governor and to the Legislature. Perhaps most importantly, it would review the system's data needs and make recommendations regarding the development of data systems.

C. Innovations

The Commission examined several innovations in the financing and delivery of long-term care. While some of these models (particularly capitation) have the potential of providing Medicaid and Medicare services more cost-effectively, they will not significantly address shortfalls in those programs. The Medicare hospital shortfall, estimated by the Maine Health Care Finance Commission to be over $40 million, is largely the result of federal reimbursement policies which were established during the 1980s. While Maine policy makers can and must find ways to address the shortfall, such policy initiatives are outside the charge of this Commission.

This section will examine some capitation models and will describe other innovations in the financing and delivery of long-term care.

1. Capitation Models

Capitation refers to a system in which people must enroll as members and are guaranteed certain services in return for a prepaid, per capita fee. Members may only receive services from approved service providers. Every member pays the same

amount, and the provider assumes the financial risk of not knowing what services will be needed. In Medicaid and Medicare capitated programs, the per capita rate is negotiated or bid by the providers and paid by the appropriate government agency. The Commission looked at several capitation models, including the following:

Social/Health Maintenance Organizations (S/HMOs)

Dr. Walter Luetz presented a preliminary report to the Commission regarding the national S/HMO demonstrations authorized by Congress in 1984. S/HMOs provide an array of long-term care services not normally covered by Medicare on a pre-paid membership basis. Like HMOs, S/HMOs offer the promise of cost-effective care, because the providers assume financial risks. Also, S/HMOs are expected to deliver care which is better coordinated, since members' care is case managed within the organization. As of 1988, all 4 demonstrations were failing to break even, with low enrollment cited as a major concern.

On Lok Senior Health Services

On the other hand, On Lok Senior Health Services has operated a successful capitated long-term care organization for nearly two decades. The program, located in San Francisco's Chinatown district, was an early experiment in capitated community-based care when it was started 18 years ago. Its enrollees have enjoyed home-based care at a lower cost than traditional programs, and have been hospitalized for fewer days.

On Lok receives a capitated amount from Medicaid ($1,420/month), Medicare ($790/month), or both, depending on the eligibility of the enrollee. In return, it assumes full financial responsibility for all needed health care, including hospital care, nursing home care and community-based long term care.

On Lok pioneered the concept of adult day care; over half of its 315 enrollees attend one of 4 centers, where medical teams can conduct preventive screening programs. Transportation to centers is provided. On Lok also provides respite care beds, over 500 meals per day from a centralized kitchen, social and recreational activities, and subsidized apartments.

In addition to documented cost savings and reductions in hospitalization rates, On Lok is cited for the coordinated care which it offers, since most services are provided directly, as coordinated by its own assessment team.

With the assistance of four national foundations and federal legislation authorizing Medicaid and Medicare waivers, On Lok has launched a national replication project called the Program of All-Inclusive Care for the Elderly (PACE). Some of the ten sites

selected are Boston, Portland, Oregon, Denver, and the Bronx. On Lok estimates that, in order to break even, a program will need a minimum of 120 enrollees.

Oregon's Assisted Living Program

Oregon offers a capitated Assisted Living Program, which offers Intermediate Care Facility-level services in an apartment complex setting for 80% of the cost of an ICF. Oregon officials attribute the cost savings to a reduced regulatory burden.

Arizona Long-Term Care System (ALTCS)

Started on January 1, 1989, ALTCS is a prepaid, capitated long-term care program for people with low income and assets. It has been modeled on Arizona's capitated Medicaid system, which has been in operation since 1981. The system required extensive waivers from the Health Care Financing Administration.

Under ALTCS, local contractors receive a fixed, predetermined amount (adjusted annually) for each person enrolled in the system. Contractors assume financial responsibility for hospital and other medical needs and for the long-term care needs of all enrollees. If a contractor is not able to provide a needed service directly, it may subcontract through a competitive bidding process.

ALTCS covers Intermediate Care Facilities (ICFs), Skilled Nursing Facilities (SNFs) and other less structured residential alternatives (for which a waiver was required). It also provides home and community-based services for enrollees who would otherwise be institutionalized, but the Health Care Financing Administration required that total expenditures for home and community-based care be capped at 5% of total program costs. Preadmission screening is done by a registered nurse and social worker, using a standardized assessment instrument. Physician certification is also required.

Because Arizona did not previously cover long-term care services through Medicaid, ALTCS is thought to be a significant improvement for those who are able to enter the system. Coordination of services is improved, and those within the system report satisfaction with it. Some question, though, if eligible people are being turned away to cut costs. Because of the bidding process and the financial risk of the contractors, such systems are thought to encourage efficiencies in the system, but they also provide an incentive to cut services. Because the financial risks of such systems are largely unknown, very few bidders emerged in Arizona, and what was envisioned as a competitive bid process has evolved into a negotiated contract system.

Medicaid Capitation

Several states (including Alaska, California, Illinois, Kansas, Massachusetts, Minnesota, New Hampshire and Oregon) have converted all or part of their Medicaid programs to case-managed, capitated systems. The following advantages are reported:

- *Cost containment:* per client costs are often reduced, but initial costs can be greater than regular Medicaid, especially if dual systems are operated. Moving from a reimbursement program to a prepaid program also creates initial cash-flow problems;

- *Predictable costs:* the per capita rate remains constant, regardless of the specific services needed;

- *Anonymity for recipients:* programs often mix Medicaid and non-Medicaid members, and the service providers do not know if a member is Medicaid-funded;

- *Emphasis on prevention:* because contractors are financially at risk, they have incentive to offer good prevention services;

- *Continuity of care:* an HMO-type setting offers the advantage of long-term relationships for members; and

- *Established route for access:* unlike traditional Medicaid programs, members of a capitated program know where to go for services and cannot be turned away.

The chief disadvantage which is reported relates to quality control measures. Because of the financial risks which the contractors take on, corners may be cut in cost-saving attempts. The U.S. General Accounting Office recently issued a report regarding quality of care in capitated Medicaid programs in the Chicago area. It found that contractors had passed much of the risk on to medical groups and individual physicians with whom they had subcontracted for services. The subcontractors, it was found, were not always financially strong, and they had incentive to scrimp on services and were not adequately monitored.

Some concern has been expressed that Maine, suffering from a health care provider shortage in many areas, does not have the provider base to support wide-scale capitated programs, particularly in rural areas.

2. Continuing Care Retirement Communities (CCRCs)

CCRCs offer life-long care at various residential levels as needed. They offer older people who have considerable assets the opportunity to "age in place," since they can receive enhanced services as they need them. Typically, a CCRC will include housing and services which range from independent apartment living to nursing care.

A large lump sum payment is required upon entry (ranging from $40,000 to $70,000 for a one bedroom apartment in 1987) and a monthly fee is assessed, depending on the size and type of living unit and services required. Many CCRCs require that residents maintain long-term care insurance.

In 1987, Maine enacted a comprehensive law which regulates CCRCs in the State. (See 24-A MRSA § 6201 et seq.) To date, no organization has applied to the Superintendent of Insurance to be certified as a CCRC. Maine does have several retirement communities which offer various levels of service on a pay-as-you-go basis. The CCRC law prohibits the use of the name "continuing care retirement community" or "life care community" by any organization which has not been so certified by the Superintendent.

Observers have speculated that the CCRC law may be too restrictive, and that developers are getting around the law by developing various pay-as-you-go options which are not regulated.

3. Individual Medical Accounts (IMAs)

Similar to Individual Retirement Accounts (IRAs), IMA's would offer tax incentives to individuals who save for their long-term care expenses. Proponents argue that such incentives would encourage individuals to plan for their expenses and, as a secondary benefit, would increase the national rate of saving. Although generally discussed as a federal initiative, Maine could create an IMA incentive within its State tax code.

4. Home Equity Conversions

Often described as "reverse mortgages," home equity conversions offer older people an opportunity to tap into the equity in their homes without having to move. Because a significant proportion of older people own their homes outright, this is considered a potentially large source of funding for long-term care, but older people have been cool to the idea of "cashing in" on their houses. Because primary dwellings are exempted when counting assets for many public programs, the incentive to obtain a home equity conversion is not great.

As part of a federal Housing and Urban Development (HUD) demonstration, the Maine State Housing Authority and the Bureau of Elder and Adult Services are coordinating the execution of 50 federally-guaranteed conversions in Maine. The demonstration generated much initial interest, but many people decided against a conversion when the significant closing costs were explained to them. At this writing, 12 of the federally-guaranteed conversions are in progress and 38 are still available.

5. Oregon's Health Care Priorities Project

Oregon is seeking to cover more people under Medicaid but provide fewer services under a system of prioritized services. Income limits would be raised to cover more people, and an ordered list of services would be developed. Depending on available funding, a line would be drawn through the list and everything over the line would be covered.

The plan, approved by the Oregon Legislature, requires extensive federal waivers, and faces opposition from those who see it as establishing a substandard medical plan for the poor. The aged, blind and disabled have been exempted from the Oregon plan, and will continue to receive medical assistance as they have in the past.

D. Conclusions and Recommendations: Financing and Delivery

Conclusions

Present appropriations for the In-Home and Community-Based Services program do not meet the existing need. While nursing home reimbursement principles allow for annual inflation adjustments; no such mechanism exists for home and community-based services.

Financing and delivery of long-term care are incremental and lack vision. When resources are scarce, different interests within the long-term care system compete against one another rather than working cooperatively on the development of a comprehensive range of services.

We have no accurate picture of long-term care needs in Maine. Many data are being collected, but many bits of information are collected in response to specific mandates and serve no greater planning purposes. Many more questions could be answered if data were collected in a goal-oriented manner.

Capitation of state Medicaid programs and long-term care services offers potential advantages in the areas of cost containment, access to services, emphasis on prevention, delivery of services in the least restrictive environment, and consumer satisfaction. Special attention must be paid to quality assurance, since capitation may offer the temptation to scrimp on services.

Despite efforts to introduce a universal assessment instrument for Maine's long-term care system, gaps exist in the system which make it far from universal. While the present system does serve as a "gatekeeper" for publicly-funded clients, it does not provide the system-wide data that a universal system could. Making the system universal is a manageable and worthy goal.

Despite their attractiveness to more affluent older people, continuing care retirement communities (CCRCs) have not been developed in Maine. State regulation of CCRCs and a general downturn in the economy may offer explanations for the lack of interest on the part of developers.

While home equity is a potential source of long-term care financing for many Maine citizens, home equity conversions have not developed as a significant financing mechanism.

Recommendations

1. Funding for the Home-Based Care program should be expanded to meet the need and adjusted annually based on an inflation index, such as a nationally-recognized home health market basket.

2. A Long-Term Care Policy Committee should be established under the administrative umbrella of the Maine Health Policy Advisory Council to oversee the development of long-term care policy and services in the State. The Committee would address the development of data systems and the level of funding needed for informal care, nursing homes, boarding homes, home-based care, congregate housing units and services, adult day care, assisted living, respite care and adult foster homes. The Committee should report to both the Governor and the Legislature.

3. The Bureau of Medical Services should investigate the costs and benefits of partially or fully capitating the State Medicaid program and offer its recommendations regarding a demonstration project to the Legislature in 1992.

4. Maine should develop a universal assessment system for entry into the long-term care system.

5. The Maine State Housing Authority should study the stalled development of continuing care retirement communities (CCRCs) in Maine, and recommend to the Legislature ways in which development could be encouraged, including amendments to the continuing care retirement community laws. The recommendations should specifically note any dangers for consumers which might come with facilitated development.

6. The Maine Committee on Aging should monitor the home equity conversion program being administered by Maine State Housing Authority and the Bureau of Elder and Adult Services and make recommendations to the Legislature in 1992.

IV. Mental Health Services

"The Commission shall analyze data concerning... mental health services for older people;"
Resolves 1989, c. 58

Once again, the Commission found no data which provides a comprehensive picture of mental health needs among the elderly. Although the State has complied with the mental health screening requirements of the 1987 Omnibus Budget Reconciliation Act (OBRA 87), it has not compiled data from those screenings. OBRA 87 required that all persons applying to a Medicaid-certified nursing facility be screened for mental health needs. A compilation of those individual screenings would provide a useful picture of the mental health needs of nursing home patients in Maine. Outside of nursing homes, mental health data is not available at all. Community needs are expressed anecdotally and demonstrated through long waiting lists for services.

While the Commission offers recommendations in this area in response to its charge, it defers to the Legislature's Mental Health Services Subcommittee, the Systems Assessment Commission, and other bodies which are taking a more focused look at mental health services.

A. Recent History of Mental Health Services for the Elderly

Traditionally, Maine's older citizens have had access to the same community mental health services offered to people of all ages through regional mental health centers and private practitioners. These services have been available to both people with diagnosed mental illness, such as schizophrenia, and to those with emotional problems which may result from retirement, loss of independence, or the death of a spouse. Use of these sources by the elderly has been low, however. Observers suggest that the low participation is due to a number of factors, including an enhanced sense of stigma among older people, low Medicare reimbursement for outpatient mental health services (reimbursement to the client is 80% of 62.5% of the approved rate), failure of doctors to diagnose the mental health problems of their older patients, transportation problems, and a preference among some therapists for younger clients.

Short of therapy, various informal support groups have existed throughout the State for some time. These range from the social activities of senior centers to the focused group discussions of Alzheimer's support groups. They are often facilitated by volunteers and available at no cost to participants.

The need to develop mental health services geared specifically to the elderly has been recognized for some time in Maine, and several initiatives have recently been launched in this area. Because the need

for mental health services increases with age, and because Maine's population is rapidly aging, services geared to the elderly will take on increasing prominence in the coming decades. A range of services is needed to address everything from situational depression resulting from a move out of the family homestead to chronic clinical depression which renders a person unable to carry out basic daily functions.

Many of the new services being developed by the Bureau of Mental Health in cooperation with the Bureau of Elder and Adult Services and the Bureau of Medical Services are the result of a 1984 task force which outlined its findings in the Report of the Task Force on Mental Health Services to the Elderly. That report called for the development of a continuum of treatment programs in each region of the State, to include consultation for agencies which provide direct services to the elderly, outreach programs including in-home services, and residential alternatives such as group and adult foster homes. Also noted were the need for transportation to enable the elderly to avail themselves of community mental health services, enhanced advocacy to assist elderly consumers to obtain the services they need, and coordination between the Bureau of Mental Health and the Bureau of Maine's Elderly (now the Bureau of Elder and Adult Services), particularly in developing statewide service plans and gathering and analyzing data.

B. Recent Program Developments

1. Geriatric Mental Health Resource Program (GMHRP)

Authorized in 1988, the GMHRP provides in-home mental health assessments to people age 60 and over who have a range of mental health problems. Some of the participating agencies also provide treatment; others refer clients for appropriate treatment when indicated. The program addresses access issues stemming from funding problems (State dollars are available if the client can not pay or third-party reimbursement is not available), transportation issues (in-home treatment is available), hesitancy to seek assistance (referrals may be made by family members or social service providers), and lack of professional expertise (GMHRP requires Master's-level staff with geriatric experience).

Budget constraints have made it impossible to offer the program state-wide: presently, Aroostook, Kennebec and Somerset counties do not have GMHRPs. Also, one person is responsible for the GMHRP in the coastal areas of Knox, Waldo, Lincoln, Sagadahoc and northern Cumberland counties, a region which needs at least two people. The Department of Mental Health and Mental Retardation estimates that an expansion to cover all areas would cost an additional $175,000 (3 additional positions at $40,000 each and $65,000 in treatment money).

In some areas of the state, treatment money has run short, resulting in waiting lists. Also, because the GMHRP is limited to serving people in their homes, it excludes those living in various residential alternatives, notably boarding homes. Anecdotal evidence suggests a great need for a GMHRP-type service in residential facilities, and it is argued that such intervention would prevent avoidable moves to more restrictive settings.

2. Mobile Psycho-Geriatric Assessment and Consultation Team

Launched in 1986, the team provides mental health assessment and consultation for nursing home patients in Penobscot, Piscataquis, Washington and Hancock counties. The team, consisting of a licensed social worker, a psychiatric nurse and a gerontologist, is provided with weekly consultation from a psychiatrist.

The team is recognized as a highly effective and valuable resource in its area. The obvious shortcoming of the program is that it is not available outside the Eastern Area. Also, it provides services to nursing home residents only; such services are not available to boarding home residents.

3. Geriatric Education and Resource Outreach Program (GERO)

The GERO Training program provides training in elder mental health issues to staff of boarding and nursing homes in the Eastern, Central and Southern areas. It is a widely respected resource within its areas of operation, but it is not available in many parts of the State.

4. Community Support Program (CSP)

The Community Support Program provides services to residents of boarding and nursing homes in Aroostook County who have a diagnosis of mental illness, particularly those who have been discharged from a State mental health facility.

5. Planning and Coordination

The Joint Advisory Committee on Mental Health Services to Elderly Persons, a collaborative effort between the Bureau of Mental Health and the Bureau of Elder and Adult Services, is an ongoing group comprised of Bureau representatives, providers and consumers which advises the bureaus regarding mental health services to the elderly.

Commissioners Glover (Mental Health and Mental Retardation) and Ives (Human Services) have appointed a joint task group charged with outlining the entire range of services needed for elderly people with mental health needs. The group is examining everything from home-based care to institutional care, and will specify funding needs.

The Systems Assessment Commission, expected to make its final recommendations this fall, is charged with developing a long-range plan for the Augusta Mental Health Institute and the Bangor Mental Health Institute, including an assessment of the need for community-based services and alternatives to the institutions.

C. Need for Residential Options

The need for an array of residential options for elderly people with mental illness is often cited by providers, advocates and state officials. These range from the development of adult foster homes and "mental health" boarding homes to the designation of nursing homes or portions of nursing homes as "Institutes for Mental Disease" (IMDs). Such residences could offer professional mental health services on an ongoing basis. They will become increasingly important as people move out of the Augusta Mental Health Institution in accordance with the recent consent decree. Again, because Maine lacks centralized mental health data, the actual need for each type of residence is difficult to gauge.

Although the voters have approved a bond issue to fund the capital development of mental health residences, program development and operating funds have been lacking, and none of the bond money has been tapped by the Department of Mental Health and Mental Retardation to date.

D. Conclusions and Recommendations: Mental Health Services

Conclusions

There appears to be consensus regarding the types of community services needed, and many of them have been developed in recent years. The services, however, are not available in all parts of the State, and waiting lists are common in the areas which do offer them.

The need for an array of residential options with specialized mental health services, such as group homes, boarding homes, adult foster homes, and supportive apartments, has been recognized but resources are lacking. Additional pressure will be placed on these scarce services as people of all ages, including many older people, move into community programs in accordance with the Augusta Mental Health Institute (AMHI) consent decree. Although capital development funds are available from a mental health bond issue, funds for program development and operation have not been available. To date, none of the bond funds have been used.

Boarding home residents are not eligible for many of the new community mental health services which have been developed in recent years. Such services are particularly lacking in boarding homes.

Mental health contributes to physical health; good mental health services can prevent or delay the need for other health services. Good case management and individual treatment plans are as important to meeting mental health needs as they are to meeting physical health needs.

Support services for caregivers are vitally important. Respite care, adult day care and support groups can help people persevere as providers of long-term care to people with mental health needs.

Medicare reimbursement for outpatient mental health services is less than half of the actual cost of the service. The remaining cost must be paid by the client or absorbed by the service provider.

Maine does not exercise the "Institute for Mental Disease" (IMD) option under the Medicaid program. In the past, there was no financial incentive for the State to do so, but the ongoing boarding home Medicaid eligibility review has identified 60 people who fall into the IMD category. That number is likely to rise as people move into community programs in accordance with the Augusta Mental Health Institute consent decree.

Maine does not compile mental health data in any systematic way; it is therefore impossible to know exactly what the mental health needs of Maine's older citizens are.

Recommendations

1. The Geriatric Mental Health Resource Program should be expanded to provide services State-wide, and to include residents of boarding homes. Cost: $175,000. (Department of Mental Health and Mental Retardation estimate.)

2. The Mobile Psycho-Geriatric Assessment and Consultation Team should be expanded to provide State-wide services to both nursing and boarding homes. Cost: $615,000. (Department of Mental Health and Mental Retardation estimate.)

3. The Geriatric Education and Resource Outreach (GERO) program should be expanded to provide State-wide services. Cost: $104,000. (Department of Mental Health and Mental Retardation estimate.)

4. Data from the 1987 Omnibus Budget Reconciliation Act (OBRA 87) mental health screenings should be compiled to provide a picture of mental health needs in nursing homes.

5. The Bureau of Mental Health and the Bureau of Elder and Adult Services should collaborate to develop a data base of mental health needs among older citizens living in community settings.

6. Operating and program development funds should be provided to the appropriate Bureaus to allow them to take advantage of the mental health bond funds.

7. Individualized treatment planning should be provided to people with mental health needs.

V. Food Stamps and Supplemental Security Income (SSI)

"The Commission shall analyze data concerning... participation [among the elderly] in the food stamp program [and] the Supplemental Security Income program;"
Resolves 1989, c. 58

A. Food Stamps

1. Background

The food stamp program is a federally-funded, state-administered, need-based nutrition program which provides coupons for the purchase of food to households which meet income and asset limits. 100% of the benefits and 50% of the administrative costs are paid by the federal government. While states are given some administrative options (e.g., whether or not to deliver coupons by mail), eligibility standards and benefit levels are set in federal statute and rules. (See 7 CFR § 271 et seq.)

Households which include an elderly or disabled person qualify for food stamps more easily than those which do not; "elderly" is defined as being 60 years of age or older. The gross monthly income limit is 130% of poverty unless an elderly or disabled person is part of the household, in which case the limit is 165% of poverty. Household assets (which do not include the household's residence and connected land) are normally limited to $2,000, but the asset limitation increases to $3,000 if an elderly person lives in the household. The following additional special provisions apply to households which include a person who is 60 years of age or older:

- *Excess Medical Deduction:* Non-reimburseable medical expenses in excess of $35 per month may be deducted from gross income.

- *Prepared Food Exemption:* Normally, prepared food may not be purchased with food stamps, but elderly people may purchase food offered through communal dining or Meals on Wheels programs.

- *Institution Exemption:* Normally, recipients may not reside in institutions which provide a majority of meals, but an exception is made for federally-subsidized housing for the elderly.

- *Work Exemptions:* Elderly applicants are exempt from the work registration requirement, and income from RSVP, Foster Grandparents and other elderly volunteer/work programs is not counted in determining eligibility.

• *Interview Waiver:* Face-to-face office interviews may be waived for elderly applicants. A phone interview may be substituted or, if a phone interview is not possible, a home visit may be made.

2. Participation Rates

Participation in the food stamp program by Maine's elderly citizens was estimated using the poverty level as a proxy for eligibility. While the estimates may not be reliable measures of absolute participation rates, they do offer a useful relative measure of participation across regions in Maine.

The results shown in Appendix J suggest that overall participation in the food stamp program among the elderly poor is significantly less than half (24.3%), with the Aroostook Area having the highest rate (33.4%) and Southern Area having the lowest (21.2%).

These results are consistent with national trends. A 1988 study commissioned by the U.S Department of Agriculture (Beebout and Doyle, 1988) analyzed national data regarding participation in the food stamp program. The study found that, while 66% of all eligible individuals participate in the program, participation is highest among pre-school aged children (80%) and lowest among those age 60 and over who live with others (29%). The study also found that all age groups are more likely to participate as their benefit levels rise. This is consistent with the impressions of food stamp workers in Maine, who feel that many older people do not participate because they would not receive significant benefits.

Maine's food stamp program has not engaged in formal outreach efforts for several years. The program does distribute applications to Area Agencies on Aging in the hope that the agencies will refer potential beneficiaries.

B. Supplemental Security Income (SSI)

1. Background

Supplemental Security Income (SSI) is a cash income maintenance program for people with low income and assets who are aged (65 or older), blind or disabled. It is funded and administered federally through the Social Security Administration, but unlike Social Security retirement benefits, SSI recipients need not have contributed to the Social Security system through payroll taxes. Many older SSI recipients do not receive Social Security benefits, or receive payments which are below SSI income limits. The unearned monthly income limit for SSI is currently $471 for an individual and $694 for a couple;

earned monthly income limits are $987 for an individual and $1433 for a couple. Assets are limited to $2,000 for an individual and $3,000 for a couple.

States have the option of supplementing the federal SSI amount and having the state supplement included in the federal check. Maine has exercised this option in two ways. First, it supplements the SSI of people in certain residential programs, such as nursing homes, boarding homes and foster homes, to the point where their income is high enough to pay an established rate for the program and allow them $30 per month for personal needs. Second, it supplements SSI for other recipients (who are not in an approved residential program) by $8 to $12 per month for individuals and $10 to $15 per month for couples, depending on whether they live alone or with others. This latter supplement has not been increased since it was set in 1973, and it has declined in actual value by over 50% since then. Unlike federal SSI benefits, the State supplement for people living in their own homes is not indexed to the rate of inflation. (For State law governing SSI and SSI State supplement, see 22 MRSA §§ 3200-3282.)

Persons found eligible for SSI are automatically issued a Medicaid card. Because the eligibility standards are the same, SSI recipients are also eligible to receive food stamps, Low Income Home Energy Assistance (LIHEAP), and a subsidy for basic telephone service.

2. Participation Rates

Using the same method as that used for food stamps, participation rates for SSI among Maine's elderly citizens was estimated using the number of elderly below poverty as a proxy for eligibility. As with the food stamp estimates, the findings, presented in Appendix K, may not provide reliable absolute measures of participation, but they are useful for comparing relative differences across regions of the State. Participation rates were found to be very similar to those for food stamps, with the highest rate in the Aroostook Area (38.4%) and the lowest being in the Southern Area (22%).

Although data sources and measurement techniques make comparisons to national rates difficult, rough comparisons indicate that Maine's SSI participation among the elderly is consistent with national rates. A study commissioned by the U.S. Department of Health and Human Services (Lewin/ICF, 1990) found that the following factors have the greatest influence on participation: the amount of potential benefits, the health status of the eligible person, homeownership, earnings, receipt of pension income, receipt of social security or railroad retirement benefits, the presence of health insurance, and residence in a rural

area or in the South. Knowledge of the program and attitudes towards receiving public assistance were also found to impact the number of eligible participants. The Bureau of Elder and Adult Services' recent needs survey found that approximately one-quarter of the elderly in Maine would not choose to apply for benefits for which they might be eligible.

In February of 1990, the Social Security Administration announced that it would be funding SSI outreach demonstration projects in FY 90. Maine's Bureau of Elder and Adult Services has submitted proposals for funding under this program and expects a decision from Social Security this fall. The Southern Maine Area Agency on Aging received funding from the American Association of Retired Persons to conduct an SSI Outreach Demonstration Project in the Southern Area in September of 1990. Results from that project will be available soon.

C. Conclusions and Recommendations: Food Stamps and Supplemental Security Income (SSI)

Conclusions

Although Social Security retirement benefits and federal SSI payments have had periodic cost-of-living increases, the SSI State Supplement for people living at home ($8-15 per month) has not been increased since 1973. It has declined in value by more than 50% since then.

Although estimates vary, participation in the food stamp and SSI programs among the eligible elderly in Maine is not significantly different from national participation. Participation does vary within the State, with the Aroostook Area enjoying the greatest rate and the Southern Area having the lowest rate.

Outreach efforts are not undertaken in any systematic, ongoing way in either program.

SSI outreach could be a particularly effective and efficient way of increasing services to the elderly, since Medicaid is automatically included, and other programs use the same eligibility standards.

Because of eligibility cutoffs, those who are marginally ineligible can be worse off than those who are marginally eligible and enjoy the benefit.

Recommendations

1. The SSI State supplement for people living at home should be indexed to receive the same cost-of-living increases as Social Security retirement benefits and federal SSI payments. Cost: $1.9 million in the first full year (Bureau of Income Maintenance estimate).

2. The Bureau of Elder and Adult Services should monitor the SSI outreach effort sponsored by the American Association of Retired Persons (AARP) which is being undertaken by the Southern Area Agency on Aging. The Maine Committee on Aging should monitor any other outreach efforts which may be undertaken in Maine and, together with the Bureau, should make recommendations for further efforts to the Legislature in 1992.

3. The Bureau of Income Maintenance should develop and implement an ongoing outreach effort in its food stamps program. This effort should include a study of the Aroostook Area to see if lessons in outreach can be learned there.

4. The State should do everything it can to encourage federal changes which would allow the State to address equity issues related to eligibility cutoffs.

VI. Transportation

"The Commission shall analyze data concerning... transportation programs for the elderly;"
Resolves 1989, c. 58

Public transportation is provided to many groups in many different forms in Maine, but it is generally characterized in one of two ways. Area transit services operate on a fixed route, fixed schedule basis, and include providers such as Cyr Bus Lines and Portland Metro. Demand-response providers offer riders door-to-door transportation on an on-call or demand basis, and are generally offered by local non-profit organizations such as the Aroostook Regional Transportation System, Coastal Transportation, and the York County Community Action Corporation. Since the demand-response providers offer transportation in Maine's more rural areas, where transit services are generally unavailable, they are extremely important to Maine's older citizens and are the focus of the Commission's work in this area.

A. Recent History of Maine's Transportation System

In 1979, seeking to take advantage of available federal funds and improve services, the Legislature created the Bureau of Public Transportation within the Department of Transportation and charged it with coordinating regional public transportation services (Laws of Maine, 1979, c. 505). In addition to establishing transportation districts and administering new federal funds, the Department was directed to work with the Departments of Human Services and Mental Health and Mental Retardation toward "maximum feasible coordination of funds among all state agencies that sponsor transportation in [each] district." Chapter 505 also provided for State assistance "within the limits of available funding" for planning and technical services, capital purchases, and operating expenses. State appropriations have been $400,000 each year since the program's inception.

In 1985, expressing concern that transportation for various social services was inadequate and/or needed coordination, the Legislature created the Social Services Transportation Review Committee (Resolves 1985, c. 46). The Committee was comprised of legislators, advocates, providers, and officials from the Departments of Transportation, Human Services, and Mental Health and Mental Retardation. The Committee's charge was subsumed into a Department of Transportation-sponsored study of surface transportation. (Maine Tomorrow, 1986) The report's major recommendations have not been implemented for lack of funding.

B. Present Transportation Services in Maine

As mentioned above, services are characterized as either area transit services or demand-response services. In fact, the distinction is not that clear, with many so-called demand-response providers offering a variety of services, including fixed-route transit. Rather than literally offering transportation on demand, many communities have a service by which a rider requests to be picked up 24 hours prior to a scheduled run to the nearest commercial center. To the greatest extent possible, schedules are set to serve every Maine community at least one day each week in this manner, with additional "on demand" transportation provided to priority riders. Due to funding constraints, many Maine communities do not have the minimum one day each week service. In order to stretch resources as far as possible, volunteer drivers are used extensively, especially when individual transportation is needed, such as for a medical appointment in a far-away location. Many of the volunteer drivers are not reimbursed for mileage, and there is some indication that they will be more difficult to attract and retain as fuel prices rise. Also, volunteers are expressing increasing concerns about unresolved liability issues. Reportedly, carriers are refusing to cover them for their volunteer driving and, in some instances, have threatened to terminate coverage.

Generally speaking, transportation "on demand" is limited to the neediest of riders, and/or those who can tap a funding source. For instance, if a rider is eligible for Medicaid reimbursement, a provider may transport the rider to a medical appointment and bill the fare to Medicaid. If the rider is not Medicaid eligible but is at risk of institutionalization, the provider may be able to bill the fare to its Bureau of Social Services contract. If a person has no individual funding source, he or she must rely on the once-a-week transportation which, if available in his or her community, will provide transportation to the nearest commercial center. It is this discretionary transportation which is most at risk, since federal funds for general use have declined and State funds for general use have remained constant since 1985. As Appendix L demonstrates, increases in Medicaid funds for transportation have more than offset the losses from other sources, but Medicaid funds may only be used for Medicaid recipients. Thus, funding for transportation has become more strictly targeted at individuals who need medical attention. Those who have too much income or assets to qualify for Medicaid but not enough to afford private transportation are most likely to go without transportation.

C. Areas of Concern

The recent BEAS needs assessment survey did not reveal a large transportation problem among all elderly. Only 2.3% of men and 4.6% of women reported having difficulty getting to the grocery store.

Only 2.3% of men and 5.2% of women reported having difficulty getting to medical appointments. A cross tabulation of these questions with whether or not people drive reveals, however, that transportation problems are concentrated among those who do not drive. For example, 82% of those who reported having no difficulty getting to medical appointments drive automobiles, while only 36.6% of those who reported having difficulty getting to medical appointments drive.

These results are consistent with those of the Maine Tomorrow study, which concluded that people without cars are 6 times as likely to use public transportation as those with cars. That study also found that, while possession of a driver's license is nearly universal among those who are 18 to 44 years of age, the percentage drops to 66.5% among those who are 65 years of age or older.

The Maine Tomorrow study included the following conclusions:

- Many rural communities do not receive at least one day each week service. Because they are less likely to drive, this results in inadequate transportation for the elderly, disabled and low income people;

- In order to allocate public funds to those who need them most, "transportation dependency" factors should be included in the Department of Transportation's funding formula. These factors would include persons living under the poverty level, persons 60 years of age or older, persons with a disability and persons living in a household with no car; and

- In order to implement a new funding formula without harming any providers, and in order to expand and maintain services to an acceptable level, the State would need to increase funding by $1.4 million annually.

D. Conclusions and Recommendations: Transportation

Conclusions

The transportation system relies heavily on volunteer drivers who may or may not be reimbursed for mileage, depending upon available funding. The volunteers are an important resource which may dwindle as fuel prices rise and as important liability questions go unanswered.

While federal funding for transportation programs in Maine has generally declined in the past 5 years, Medicaid funding for transportation has increased dramatically in the same period. As a result, access to transportation is best for those elderly persons who have Medicaid.

The Maine Department of Transportation has a worthy goal of providing public transportation to every Maine community at least one day per week, but it falls far short of the goal.

Recommendations

1. Additional transportation funds should be made available for reimbursement of volunteer drivers, and the Department of Transportation, in consultation with the Bureau of Insurance, should assist transportation providers in resolving volunteer liability issues. Cost: $150,000. (Maine Committee on Aging estimate.)

2. Public transportation should be available in every Maine community at least one day per week.

3. In order to allocate public transportation funds to those areas which most need them, transportation dependency factors should be added into the allocation formula. These factors should include the percentage of people living below poverty, those over 60 years of age, those with disabilities, and those living in households with no cars.

VII. The Household Tax and Rent Refund Program

"The commission shall analyze data concerning... participation in the household tax and rent refund program;"
Resolves 1989, c. 58

A. Background

Maine's Elderly Householders Tax and Rent Refund Program originated in 1971 with enactment of The Elderly Householders Tax Relief Act (Laws of Maine, 1971, c. 503). Income limitations and formulas for calculating refunds have changed periodically, but the purpose and administration of the program have remained essentially the same since it became operational in 1972. The program provides a cash refund of property taxes or rent to elderly people (age 62 or older) with low income. The amount of the refund declines as income rises to an upper limit, above which refunds are not available. Beginning March 1, 1986, the statute directs the State Tax Assessor to annually determine an income adjustment factor to be applied to the limits, to ensure that inflation is taken into account. Social Security cost-of-living adjustments are used for this purpose.

In 1987 the Tax and Rent Refund Act (Laws of Maine, 1987, c. 516) created a similar program for people of all ages. The general program, designed as a "circuit breaker," differs from the elderly program in income limitations, calculation of benefit base, and in the refund formula.

Applications for either program may be submitted to the Bureau of Taxation between August 1st and December 31st. An applicant requests relief for the calender year preceding that in which the application is filed. Since the inception of the general program, applications from the elderly are processed in both programs and paid from whichever one results in a higher refund.

B. Program Participation

Table 1 in Appendix M presents information on the number of refunds issued under the elderly program since 1980, and under the general program since it began in 1988. The declining numbers in the elderly program from 1980 to 1986 probably reflect a declining number of people eligible for the program, given that income limitations were not indexed until 1987. The peak in participation for 1988 reflects substantial increases in income limitations, an $800 increase for single-member households and a $1,300 increase for multi-member households.

The severe drop from almost 25,000 refunds in 1988 to 18,817 refunds under the elderly program in 1989 is misleading. The 1989 numbers do not include elderly applicants who received refunds under the general program, and the Bureau of Taxation has been

unable to statistically separate the elderly from other people who received refunds in that program. It is felt that a significant number of elderly benefitted from the 1989 general program and that the numbers reflect a shift rather than a decline in participation among the elderly. This assumption appears to be supported by the high number of general refunds in 1989, 45,621 (up from 23,463 in 1988). The number of drug cards issued to refund program applicants continued to increase from 1988 to 1989, as indicated in Table 3. This also supports the assumption that participation among the elderly was not off in 1989, since drug card applications are on the same form as elderly refund applications.

The State Planning Office has estimated that 57,991 elderly households were eligible for the Property Tax and Rent Relief Program in 1989. Because some elderly recipients are counted in the general program, it is not possible to calculate an exact participation rate for the elderly, but it would appear that less than half of the eligible elderly applied in 1989.

The Bureau of Taxation is required by statute "to ensure that all eligible households are made aware of assistance available under the Maine Residents Property Tax Program". (36 MRSA §6219) The Bureau does this by sending representatives to meetings of the Area Agencies on Aging, by direct mailings to households such as inserts in utility bills, and by placing posters in public places.

C. Conclusions and Recommendations: Household Tax and Rent Refund Program

Conclusions

It appears that less than half of the eligible elderly are applying for refunds, but trends are impossible to track because some elderly are now receiving refunds under the new general program, and participation in that program is not stratified by age.

The Bureau of Taxation makes outreach efforts by meeting with the Area Agencies on Aging, inserting program flyers in mailings such as utility bills, and posting notices in public places.

Recommendations

1. The Bureau of Taxation should keep data in such a way that statistics can be stratified by age, regardless of which program the elderly receive refunds from.

2. The Bureau of Taxation should reassess its outreach efforts to see how it might attract more applications. Television and radio public service announcements should be considered.

VIII. The Elderly Low-Cost Drug Program

"The commission shall analyze data concerning... participation in the elderly low-cost drug program;"
Resolves 1989, c. 58

A. Background

Maine's Elderly Low Cost Drug Program helps elderly people with low income pay for prescribed and non-prescribed medicines for the treatment of certain conditions and diseases. (See 22 MRSA § 254) The Bureau of Taxation administers the application and certification of eligibility for the Elderly Low Cost Drug Program, because eligibility standards are identical to the Elderly Property Tax and Rent Refund Program (see Chapter VII). The Department of Human Services has rulemaking authority, and manages the program through its Bureau of Medical Services Pharmacy Consultant.

Drugs to treat certain conditions must be covered by statute, and others may be covered by the Department of Human Services through the rulemaking process. The categories presently covered are listed below.

Diseases & Conditions Covered	**Coverage Required By Statute**
Diabetes	Chronic Lung Disease (Laws of Maine, 1987, c. 746)
Heart Condition	Arthritis (Laws of Maine, 1987, c. 746)
High Blood Pressure	Anticoagulants (Laws of Maine, 1989, c. 563) (under heart condition)
Chronic Lung Disease	
Arthritis	

An appendix to the rules for the program lists the covered drugs by generic name and commonly known brand name. Updated copies of this list are mailed to all participating providers. Under contract with the Department, Goolds Health Systems of Augusta handles reimbursement to the providers. As of July 1, 1990 the co-payment on all program drugs is $2.00. (Laws of Maine, 1989, c. 564)

B. Adequacy of Coverage

Observers generally agree that the common conditions and diseases of the elderly requiring life-sustaining drugs are currently covered under this program. Major categories of drugs not covered by this program include "scheduled drugs," such as narcotics, and barbituates. The program's managers have made the decision not to

cover drugs which, in their opinion, lend themselves to abuse. One physician commenting on this policy suggested that pain medications be covered for the terminally ill. Also not covered are antibiotics. Drugs used to lower cholesterol are not covered. Inclusion of these drugs is frequently requested. There is some debate over their effectiveness. Drugs used to treat Parkinson's disease are not currently covered. This is considered an important drug to cover when funding permits.

C. Eligibility

Many observers feel that eligibility for the program should be increased, and that tying this program to the tax refund program is not necessarily logical. Drugs can be far more expensive and require far more income than property taxes, yet both programs have the same income limits.

A potential source of funds for expanded eligibility is savings in administrative costs and drug costs. Savings may be realized if a mail order drug service is incorporated into the existing program.

Another eligibility issue is whether individual, rather than household income, should be considered. This proposed change would address instances in which a miserly spouse refuses to use household income for drugs, so the income is not actually available to the person who needs the drugs. One possibility short of changing program eligibility rules is to develop a mechanism which would offer relief to people in the situation described. Individuals could have only their personal income counted if they could demonstrate that household income is not available to them.

D. Participation

Table 3 in Appendix M provides information on the number of people receiving drug cards since 1980. Participation mirrors that of the tax refund program. As with the tax program, income limits were not adjusted until 1986, so fewer and fewer people were eligible between 1980 and 1986, and participation declined. Since 1986, income limits have been indexed to Social Security increases, and participation has rebounded.

E. Conclusions and Recommendations: Elderly Low-Cost Drug Program

Conclusions

Most common conditions and diseases of the elderly which require life-sustaining drugs are currently covered by the program, but eligibility cutoffs keep the program from reaching everyone who could benefit from it.

Recommendations

1. An optional mail order service demonstration with participation incentives should be incorporated into the program. If savings result, they should be used to increase eligibility levels. Sliding co-payments should be considered if eligibility levels rise.

2. The program should be reviewed annually by the Bureau of Medical Services' Drug Formulary to assure that needed drugs are included and that eligibility criteria are reasonable. Drugs commonly used by the elderly which are not covered, such as those used to treat Parkinson's Disease, should be added to the list of covered drugs.

3. Eligibility should continue to be based upon household income, but an appeal process should be established which allows the program to be made available to otherwise eligible individuals who can demonstrate that household income is not available to them.

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APPENDIX A

Proposed Legislation

LR # 0354
Sponsor: Submitted by the Commission to Study the Level of Services for Maine's Elderly Citizens pursuant to Resolves 1989, c. 58.

FIRST REGULAR SESSION

ONE HUNDRED AND FIFTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

AN ACT to Enhance Medical and Social Services for Maine's Long-Term Care Consumers

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

Sec. 1. 5 MRSA §12004-I, sub-§30-A is enacted to read:

30-A. Health	Long-Term Care Policy Committee	Expenses Only	5 MRSA 19121

This subsection is repealed on October 1, 1995.

Sec. 2. 5 MRSA Chapter 436 is enacted to read:

Chapter 436

Long-Term Care Policy Committee

§19121. Establishment

The Long-Term Care Policy Committee, as established in section 12004-I, subsection 30-A, shall advise the Governor, the Legislature, the Commissioner of Human Services, the Commissioner of Mental Health and Mental Retardation, other appropriate executive branch officials, the Maine congressional delegation, and appropriate federal agency officials regarding the development of policy, long-range plans and short-range implementation strategies for the State's long-term care system.

§19122. Duties

The Committee shall:

1. Assessment of system needs. Continually assess the needs of the long-term care system, including the need for new or improved data;

2. System development. Identify how the long-term care system must develop in order to address recognized needs;

3. Resource allocation. Recommend the allocation of resources, including but not limited to the level of funding needed for informal care, nursing homes, boarding homes, home-based care, congregate housing units and services, adult day care, assisted living, respite care, foster homes, and other components of the long-term care system;

4. Advocacy. Advocate to the Governor, the Legislature, the departments and others for the development of an effective, efficient and responsive long-term care system; and

5. Self evaluation. Continually evaluate its own effectiveness in carrying out the purposes of this chapter.

§19123. Report; legislation

The committee shall prepare an annual report and submit it by December 1st to the Governor and to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, human resources, banking and insurance, and aging, retirement and veterans. A copy of the report must be submitted to the Executive Director of the Legislative Council. The report must describe the committee's activities for the year and propose specific legislation needed to implement the committee's recommendations.

§19124. Relationship to Maine Health Policy Advisory Council

The Maine Health Policy Advisory Council shall provide administrative support to the committee, including payment of bills, and may accept public and private funds on behalf of the committee to carry out the purposes of this chapter. All funds appropriated for the committee must be maintained in a separate account. The committee shall establish its office within the offices of the Maine Health Policy Advisory Council, and shall share the costs of office space, telephones, equipment and supplies.

The committee shall share ideas and information with the Maine Health Policy Advisory Council, and the two bodies shall attempt to coordinate their efforts in the area of long-term care policy. Notwithstanding these coordination efforts, the committee is independent and does not require Maine Health Policy Advisory Council approval to formulate and advocate for long-term care policy.

§19125. Membership; chair; subcommittees

1. Membership. The committee has 15 members, appointed as follows:

A. The Governor shall appoint 1 representative of a company providing health insurance in the State, 1 representative of the Department of Human Services, and 3 members of the general public from various geographic areas of the State who are at least 60 years old. The Governor's appointees shall serve for terms of 3 years, except that, for those first appointed, 2 shall serve for terms of 3 years, 2 shall serve for terms of 2 years, and 1 shall serve for a term of 1 year;

B. The President of the Senate shall appoint 1 member of the Senate and the Speaker of the House shall appoint 2 members of the House of Representatives. Legislative members shall serve during their legislative terms; and

C. The President of the Senate and the Speaker of the House shall jointly appoint 1 representative from the Maine Committee on Aging, 1 representative from an association of hospitals, 1 representative from an association of nursing homes, 1 representative from an association of home care providers, 1 representative from an association of retired persons, 1 representative of a company providing health insurance in the State, and 1 representative of area agencies on aging. The President's and Speaker's joint appointees shall serve for terms of 3 years, except that,

for those first appointed, 2 shall serve for terms of 3 years, 3 shall serve for terms of 2 years, and 2 shall serve for terms of 1 year.

2. Vacancies and reappointments. Any appointment made to fill a vacancy must be made in the same manner as the appointment of the member who vacated the position. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed must be appointed only for the remainder of that term. Members may be reappointed, but no non-legislative member may serve more than 2 consecutive full terms of 3 years each. Members may serve after the expiration of their terms until their successors have been appointed.

3. Chair. The Governor, the President of the Senate and the Speaker of the House shall jointly designate the chair from among the legislative members. The committee shall meet at the call of the chair, but not less often than 6 times a year.

4. Subcommittees. The Chair may appoint subcommittees which include persons who are not committee members to carry out the purposes of this chapter.

5. Expenses. Committee members may receive reimbursement for expenses in accordance with title 5, chapter 379.

§19126. Cooperation by departments

State departments, agencies and boards shall cooperate with the committee by providing written information when requested and by assigning representatives to meet with the committee and serve on subcommittees when invited.

§19127. Repeal

This chapter is repealed on October 1, 1995.

Sec. 3. 22 MRSA §254, second to last paragraph is amended to read:

The department may form an advisory committee which it may consult for technical information regarding the nature and operation of this particular program. The nature and composition of the advisory committee shall be at the discretion of the Governor, or at his direction, at the discretion of the Commissioner of Human Services. The members of that advisory committee shall serve without compensation; the department may disburse funds from an account created pursuant to this section to defray the reasonable costs

associated with formulation of policy and the carrying out of activities of this committee. The department may disburse funds from the account set up to carry out the purposes of this section to reimburse members of the advisory committee for their reasonable expenses incurred in carrying out their duties under this section. In no circumstance may expenditures of over $3,000 per year be incurred for the operation of this committee and all such expenditures must be approved by the Governor. The advisory committee shall review the program annually to ensure that needed drugs are covered and that eligibility standards are reasonable, and shall make recommendations, based on its review, to the Commissioner. If the department does not form an advisory committee, this annual review must be conducted by the drug formulary committee created in accordance with section 3174-J.

Sec. 4. 22 MRSA §254 is amended by adding at the end:

Beginning January 1, 1992, the department shall provide a mail order service, which recipients may participate in voluntarily. Notwithstanding other provisions of this section, financial incentives must be incorporated into the mail order option to encourage participation. The department shall keep records and compare the costs of the mail order option to the cost of other distribution methods. If the mail order option results in savings over the other distribution methods, the department shall use the savings to add new drugs to the program or shall propose to the Legislature that eligibility be expanded.

Sec. 5. 22 MRSA §3174-K is enacted to read:

§3174-K. Coverage for eye glasses and hearing aids

The department shall provide Medicaid coverage for eye glasses and hearing aids for eligible individuals without regard to type of residence.

Sec. 6. 22 MRSA §3192 is enacted to read:

§3192. Medicaid Capitation Study and Demonstration

1. Cost-Benefit Study. The department shall study the costs and benefits of fully or partially capitating the Medicaid program and submit a report to the joint standing committees of the Legislature having jurisdiction over human resources and appropriations and financial affairs by February 1, 1992. A copy of the report must be submitted to the Executive Director of the Legislative Council. The study must consider at least the following possibilities:

A. Capitation of the entire Medicaid program;

B. Capitation in discrete geographical locations; and

C. Capitation of long-term care services.

The report must include an analysis of expected cost savings and other potential benefits and of quality assurance issues and other potential costs.

2. Demonstration Project. If the department finds that the benefits of full or partial capitation outweigh the costs, it shall include in its report a proposal for a demonstration project, together with any necessary implementing legislation.

Sec. 7. 22 MRSA §7324 is enacted to read:

§7324. Maintaining effort in all regions

Beginning with fiscal year 1991-92, the department shall make available within each region funds which exceed the previous fiscal year's distribution by at least an amount calculated to allow for inflation in the cost of in-home and community support services, unless the department demonstrates, based on demographic and other relevant indicators, that a region's need for in-home and community support services has decreased from the previous fiscal year's need. The department shall use a nationally recognized index to determine the applicable rate of inflation.

Sec. 8. 23 MRSA §4209, sub-§3, ¶ A-2 is enacted to read:

A-2. In consultation with the Bureau of Insurance, advise transportation providers regarding the liability of volunteer drivers;

Sec. 9. 36 MRSA §6162-A, sub-§2 is amended to read:

2. Income. Eligibility for this program shall be determined by the same income levels as eligibility for elderly households is determined under chapter 907~~.~~, except that when an applicant demonstrates that the income of other individuals in the applicant's household is not available to the applicant, only the applicant's income may be considered.

Sec. 10. Home Equity Conversion Report. The Maine Committee on Aging shall study the home equity conversion program which is jointly administered by the Bureau of Elder

and Adult Services and the Maine State Housing Authority and shall submit a report to the Legislature's Joint Standing Committee on Human Resources by February 1, 1992. A copy of the report must be sent to the executive director of the Legislative Council. The report must present program statistics and an analysis of its success, along with any recommended legislation.

Sec. 11. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92	1992-93
HUMAN SERVICES, DEPARTMENT OF		
Long-Term Care - Human Services		
All Other	$15,000,000	$20,000,000
Provides funds to expand and index home-based care programs throughout the State to fully meet the need for the elderly.		
HUMAN SERVICES, DEPARTMENT OF		
Medical Care Administration		
All Other	$ 32,500	
Provides funds to study and report on the costs and benefits of fully or partially capitating the Medicaid program.		
HUMAN SERVICES, DEPARTMENT OF		
Medical Care Payments to Providers		
All Other	$ 776,764	$ 383,754
Provides funds for eye glasses and hearing aids for all eligible individuals.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$15,809,264	$20,383,754

	1991-92	1992-93
MAINE HEALTH POLICY ADVISORY COUNCIL		
Long-Term Care Policy Committee		
Positions	(1)	(1)
Personal Services	$ 26,951	$ 39,247
All Other	11,250	13,000
Capital Expenditures	5,000	
Provides funds for a comprehensive health planner II position to staff the Long-Term Care Policy Committee, and for committee expenses and general operating costs. Capital expenditures include funds to purchase a computer.		
MAINE HEALTH POLICY ADVISORY COUNCIL TOTAL	$ 43,201	$ 52,247
TOTAL APPROPRIATION	$15,852,465	$20,436,001

Sec. 12. Allocation. The following funds are allocated from the Federal Expenditure Fund to carry out the purposes of this Act.

	1991-92	1992-93
HUMAN SERVICES, DEPARTMENT OF MEDICAL CARE ADMINISTRATION		
All Other	$ 32,500	
Provides for the allocation of federal matching funds to study and report on the costs of capitating the Medicaid program.		

	1991-92	1992-93
Medical Care-Payments to Providers		
All Other	$1,304,040	$ 611,974
Provides for the allocation of federal matching funds for eye glasses and hearing aids for eligible individuals of all ages.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$1,336,540	$ 611,974
TOTAL ALLOCATION	$1,336,540	$ 611,974

STATEMENT OF FACT

This bill is recommended unanimously by the Commission to Study the Level of Services for Maine's Elderly Citizens. It does the following:

1. Creates a long-term care policy committee to develop and advocate for coordinated long-term care policy;

2. Requires the low-cost drug program advisory board to review the program annually to ensure that needed drugs are covered and that eligibility standards are reasonable. It also requires the Department of Human Services to establish a voluntary mail order option within the program. The bill also requires that, in cases where household income is not available to an individual applicant, only the individual's income may be considered in determining eligibility for the low-cost drug program;

3. Requires that Medicaid reimbursement be available for eye glasses and hearing aids for eligible people of all ages, regardless of where they live. Presently, eye glasses and hearing aids are only reimbursable for recipients who live in institutional settings;

4. Requires the Department of Human Services to study the costs and benefits of fully or partially capitating the Medicaid program;

5. Requires that funds for the In-Home and Community Support Services be indexed annually to ensure that effort is at least maintained in each region. The bill also appropriates funds to fully meet the need for the program;

6. Requires the Department of Transportation to consult with the Bureau of Insurance and assist transportation providers with volunteer liability issues; and

7. Requires the Maine Committee on Aging to study the home equity conversion program and report to the Legislature.

LR # 0355
Sponsor: Submitted by the Commission to Study the Level of Services for Maine's Elderly Citizens pursuant to Resolves 1989, c. 58.

FIRST REGULAR SESSION

ONE HUNDRED AND FIFTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

AN ACT to Protect Insurance Consumers and Encourage Long-Range Financial Planning

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

Sec. 1. 22 MRSA §3186-A is enacted to read:

§3186-A. Public education

The department and the Bureau of Insurance shall establish and maintain a public education campaign which makes people of all ages aware of the limits of Medicare health coverage and encourages them to engage in long-term financial planning and to learn about long-term care insurance early in their lives. The campaign may include television and radio announcements, educational seminars, production and distribution of literature, and any other efforts which are possible within available funds.

Sec. 2. 24-A MRSA §218-A is enacted to read:

§218-A. Senior Health Insurance Benefit Advisors Program

The superintendent shall establish a Senior Health Insurance Benefit Advisors Program to train and support volunteers to assist Maine citizens who are 60 years of age or older with claims and purchase of health, long-term care and life insurance. The superintendent may hire staff as necessary to implement the program.

Sec. 3. Long-term care insurance report. The Bureau of Insurance shall prepare a report regarding long-term care insurance and submit it, together with any recommended legislation, to the Legislature's Joint Standing Committee on Banking and Insurance by February 1, 1992. A copy of the report must be sent to the Executive Director of the Legislative Council. The report must assess the impact of Public Laws 1989, c. 556, Part B, on the development of long-term care insurance in Maine. The report must analyze the number of individual and group long-term care policies sold in Maine over time, and the number of insurance companies, employers and individual consumers who have received tax reductions or credits related to long-term care insurance.

Sec. 4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92	1992-93
HUMAN SERVICES, DEPARTMENT OF		
Bureau of Health		
All Other	$25,000	$25,000
Provides funds to establish and maintain a public education campaign to encourage early financial planning		
DEPARTMENT OF HUMAN SERVICES TOTAL	$25,000	$25,000

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance

Positions	(1)	(1)
Personal Services	$23,023	$33,259
All Other	43,000	49,000

Provides funds for a full-time trainer position to develop and implement a Senior Health Insurance Benefit Advisors Program, and for travel, printing and mailing. Also provides funds to establish a toll-free "800" number within the Bureau to receive inquiries from all consumers, and funds to establish and maintain a public education campaign to encourage early financial planning

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$66,023	$82,259
TOTAL APPROPRIATIONS	$ 91,023	$107,259

STATEMENT OF FACT

This bill is recommended unanimously by the Commission to Study the Level of Services for Maine's Elderly Citizens. The bill requires the Department of Human Services and the Bureau of Insurance to jointly establish and maintain a public education effort which makes citizens aware of the limits of Medicare coverage and encourages financial planning early in life. The bill also creates a Senior Health Insurance Benefits Advisors program to train volunteers to assist older citizens with insurance decisions and claims. The bill also provides funding for an "800" toll-free telephone number at the Bureau of Insurance to allow consumers of all ages to call with inquiries or complaints.

LR # 0356
Sponsor: Submitted by the Commission to Study the Level of Services for Maine's Elderly Citizens pursuant to Resolves 1989, c.58.

FIRST REGULAR SESSION

ONE HUNDRED AND FIFTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

AN ACT To Ensure that the SSI State Supplement is not Diminished by Inflation

---

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

Sec. 1. 22 MRSA §3273, sub-§8 is enacted to read:

8. Cost-of-living adjustments. Notwithstanding any other provisions of this section, beginning January 1992 and every January thereafter, the department shall adjust the minimum state supplemental income benefit provided in subsection 1, paragraph A as follows.

A. For an individual, the minimum state supplemental income benefit for the previous month must be multiplied by one plus the most recent federal cost-of-living adjustment for Social Security retirement benefits. The result must be rounded to the nearest dollar.

B. For a couple, the minimum state supplemental income benefit must be 150% of that calculated for an individual in paragraph A.

Sec. 2. Report. The Bureau of Elder and Adult Services shall study the supplemental security income outreach project funded by the American Association of Retired Persons in the Southern Area Agency on Aging. The Maine Committee on Aging shall study any supplemental security income outreach efforts undertaken by the Bureau of Elder and Adult Services. The Bureau of Elder and Adult Services and the Maine Committee on Aging shall jointly submit a report regarding the outreach efforts, together with any recommendations and implementing legislation, to the Joint Standing Committee on Human Resources by February 1, 1992. A copy of the report must be sent to the Executive Director of the Legislative Council.

Sec. 3. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1991-92	1992-93
HUMAN SERVICES, DEPARTMENT OF		
State Supplement to Federal Supplemental Security Income		
All Other	$554,568	$1,875,946
Provides funds for cost-of-living adjustments to the state supplemental income benefit effective January 1, 1992 and January 1, 1993 in accordance with the provisions of this Act.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$554,568	$1,875,946

STATEMENT OF FACT

This bill is recommended unanimously by the Commission to Study the Level of Services for Maine's Elderly Citizens. The bill requires that the State supplement to federal Supplemental Security Income (SSI) payments receive the same cost-of-living increase as Social Security retirement benefits. The bill also requires the Bureau of Elder and Adult Services and the Maine Committee on Aging to study SSI outreach efforts and make recommendations to the Legislature.

APPENDIX B

From Maine's Changing Face, by Joseph McGonigle
Prepared for the Commission on Maine's Future, July, 1989

TABLE 7

THE MAINE POPULATION

1986 and 2000

Census Scenario

Age Cohort	1986 Population	1986-2010 Change	2010 Population
85 & +	17,000	15,000	32,000
80 - 84	20,000	5,000	25,000
75 - 79	30,000	2,000	32,000
70 - 74	40,000	0	40,000
65 - 69	49,000	7,000	56,000
60 - 64	53,000	25,000	78,000
55 - 59	56,000	36,000	92,000
50 - 54	53,000	50,000	103,000
45 - 49	56,000	51,000	107,000
40 - 44	69,000	25,000	94,000
35 - 39	93,000	-10,000	83,000
30 - 34	96,000	-16,000	80,000
25 - 29	100,000	-18,000	82,000
20 - 24	100,000	-16,000	84,000
18 - 19	38,000	-3,000	35,000
15 - 17	56,000	-2,000	54,000
10 - 14	82,000	1,000	83,000
5 - 9	81,000	-5,000	76,000
0 - 4	82,000	-9,000	73,000
Total	**1,171,000**	**138,000**	**1,308,000**

Note: Cohort populations do not sum to projected total due to rounding

APPENDIX C

APPROVED

JUL 11 '89

BY GOVERNOR

CHAPTER

58

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED AND EIGHTY-NINE

H.P. 550 - L.D. 747

Resolve, Establishing a Commission to Study the Level of Services for Maine's Elderly Citizens

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

Whereas, it is necessary for this study to begin during the summer in order to be completed; 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

Sec. 1. Commission created; purpose of commission. Resolved: That there is created the Commission to Study the Level of Services for Maine's Elderly Citizens. The commission shall analyze data concerning the following aspects of the care of Maine's elderly citizens:

1. The level of services provided by and participation in Medicaid, including the effects of federal SOBRA legislation and options for redesign of the State's Medicaid programs to stimulate and complement the development of private long-term care insurance;

2. The need for improved individualized treatment planning procedures for long-term care clients which can be used to identify the gaps between client needs and available services and which are based upon principles of maximum feasible restoration of functional capacity in the least restrictive setting;

3. The financing of long-term care needs and alternate delivery systems; methods to develop more innovative financing strategies such as capitation and prepayment for services for elderly persons, including the benefits and risks of these alternative financial arrangements; and the possible effects of restructuring the financing and delivery systems on the current Medicare and Medicaid shortfalls;

4. Mental health services for older people; and

5. Participation in the food stamp program, the Supplemental Security Income program, transportation programs for the elderly, the household tax and rent refund program and the elderly low-cost drug program; and be it further

Sec. 2. Membership of commission; appointment. Resolved: That the commission shall consist of 15 members appointed within 30 days of the effective date of this resolve as follows:

1. One member of the Senate appointed by the President of the Senate and 2 members of the House of Representatives appointed by the Speaker of the House of Representatives;

2. One representative appointed jointly by the President of the Senate and the Speaker of the House of Representatives from a list of 3 persons submitted by each of the following: the Maine Committee on Aging, the Maine Hospital Association, the Maine Health Care Association, the Home Care Alliance and the American Association of Retired Persons;

3. Two representatives of companies providing health insurance in the State appointed jointly by the President of the Senate and the Speaker of the House of Representatives;

4. Three members of the general public from various geographic areas of the State, who are at least 60 years old, to be appointed jointly by the President of the Senate and the Speaker of the House of Representatives;

5. One representative of the Department of Human Services, appointed by the commissioner; and

6. One representative of area agencies on aging to be appointed jointly by the President of the Senate and the Speaker of the House of Representatives; and be it further

Sec. 3. Selection of chair; convening of commission. Resolved: That the President of the Senate and the Speaker of the House of Representatives shall jointly appoint a chair from

among the legislative members of the commission. The Executive Director of the Legislative Council shall convene the first meeting within 30 days of appointment of all the members; and be it further

Sec. 4. Report. Resolved: That the commission shall complete its work by December 1, 1990, and present its findings, together with any recommended legislation, to the First Regular Session of the 115th Legislature by December 5, 1990; and be it further

Sec. 5. Assistance. Resolved: That the commission shall request staff assistance from the Legislative Council, except that the Legislative Council shall not provide staff assistance during the Second Regular Session of the 114th Legislature; and be it further

Sec. 6. Compensation. Resolved: That the members of the Legislature shall receive the per diem and expenses as provided in the Maine Revised Statutes, Title 3, section 2 and that all members of the commission who are not state employees shall receive reimbursement for expenses upon submission to the Executive Director of the Legislative Council; and be it further

Sec. 7. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1989-90
LEGISLATURE	
Commission to Study the Level of Services for Maine's Elderly Citizens	
Personal Services	$ 2,475
All Other	12,200
Provides funds for the per diem, meeting and related expenses of the Commission to Study the Level of Services for Maine's Elderly Citizens. These funds shall carry forward to June 30, 1991.	
LEGISLATURE TOTAL	$14,675

APPENDIX D

COMMISSION TO STUDY THE LEVEL OF SERVICES FOR MAINE'S ELDERLY CITIZENS

List of Commission Guests

October 10, 1989

Medicaid

Elaine Fuller, Director, Bureau of Medical Services
Ruth Lunn, Bureau of Income Maintenance

Medicare

Harold Hainke, Advocates for Medicare Patients

October 25, 1989

Commission on Maine's Future

Anthony Buxton, Vice Chair

Elderly Health Care Policy

Kayla Ladenheim, Health Policy Advisory Council

November 27, 1989

Bureau of Elder and Adult Services Needs Assessment

Valery Nyboe, BEAS

December 15, 1989

R.W. Johnson Home - Based Care Demonstration

Dan Crocker, Kennebec Valley Regional Health Services

Video: "The Third Step to Dignity"

Romaine Turyn, Maine Committee on Aging

January 4, 1990

Social/Health Maintenance Organizations

Professor Walter Leutz, Brandeis University

February 28, 1990

Financing Long-term Care

James Lee, State Economist

Hospital Discharge Planning

Chris Carpenter and others, Hospital Social Work Directors

Betty Hamel, Health Care Review, Inc.

May 23, 1990

Transportation

Linwood Wright, Department of Transportation

Barbara Donovan, Maine Transit Association

Mental Health

Joyce Harmon, Department of Mental Health and Mental Retardation

Priscilla Cote, Bureau of Medical Services

Romaine Turyn, Committee on Aging

June 20, 1990

Long-Term Care Insurance

Ted Reed, UNUM

Rick Diamond, Bureau of Insurance

Bruce Thomas, Maine Health Policy Advisory Council

Individualized Treatment Planning

Neville Woodruff, Legal Services for the Elderly, Inc.

August 22, 1990

Medicaid Reimbursement in the Boarding Home Program

Linda Ewing, Bureau of Medical Services

Joan Sturmthal, Long-Term Care Ombudsman

September 12, 1990

Long-Term Care Coordination Council

Sheila Comerford, Maine Committee on Aging

#1141LHS

APPENDIX E

Components of Maine's Elder Care System

Commission to Study the Level of Services
for Maine's Elderly Citizens

December, 1989

(updated September, 1990)

ABBREVIATIONS

AAA's - Area Agencies on Aging

BEAS - Bureau of Elder and Adult Services
(formally Bureau of Maine's Elderly)

CAPs - Community Action Programs

CHSP - Congregate Housing Services Program

DCS - Division of Community Services

HBC - Home-Based Care Program

HEAP - Home Energy Assistance Program

WAIVER - Home and Community-Based Medicaid Waiver Program

CONTENTS

Page

D. Housing

E. Advocacy

LHS256

COMPONENTS OF MAINE'S ELDER CARE SYSTEM

(compiled for the Commission to Study the Level of Services for Maine's Elderly, Citizens, 12/89)

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
A. Income Maintenance					
1. Social Security					
a. Old Age Pension	Employed under social security and 65 or 62 with reduction	Social Security Administration (U.S.D.H.H.S.)	federal	payroll tax while working under system	
b. Invalidity Pension	Employed under social security and unable to work due to lasting impairment	Social Security Administration	federal	payroll tax while working under system	
c. Survivor Pension	Surviving spouse or dependent of pensioner	Social Security Administration	federal	No	
2. Supplemental Security Income (SSI)	Low income and assets and 65 or blind or disabled	Social Security Administration	federal	No	SSI recipients qualify automatically for Medicaid
3. SSI State Supplement	Receiving SSI	State and Federal (supplement is issued as part of SSI check)	state	No	States may supplement federal SSI payments. Maine has opted to do so.
4. General Assistance	Resident of municipality and in need of emergency assistance.	municipalities	state and local	No	
5. Veterans Income Programs					
a. Compensation: monthly compensation based upon degree of disability.	Veteran disabled by injury incurred or aggravated during active service	Department of Veterans Affairs (federal)	federal	No	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
b. Pension	Wartime veteran and limited income and 65 (not working) or disabled for reasons not traceable to service.	Department of Veterans Affairs (federal)	federal	No	This is essentially a disability & income based benefit, but veterans who are 65 and not working are considered disabled.
c. Dependency and Indemnity Compensation (DIC)	Surviving spouse, unmarried child under 18, or certain parents of veterans who died in connection with service.	Department of Veterans Affairs (federal)	federal	No	
d. Nonservice Connected Death Pension	Income limitations and veterans surviving spouse or unmarried child under 18.	Department of Veterans Affairs	federal	No	
6. Elderly Householders Tax and Rent Refund Program: "circuit breaker" which offers cash relief when property taxes or rent equivalent exceeds a set percentage of income.	Income limitations and 62 or 55 and disabled	Bureau of Taxation (state)	state	No	Claim must be filed by October 15th each year in order to receive benefit.
7. Veterans Property Tax Exemptions: assessed valuation is reduced by $5,000 to $7,000.	State resident and veteran or surviving spouse and 62 or disabled.	Bureau of Taxation (state) and municipalities	state	No	Claim is made at municipal office and state reimburses.
8. Employment Programs					
a. Job Training Partnership ACT (JTPA): Training programs for entry into the labor force.	Income limitation	Department of Labor (state) and various local agencies	federal & state	No	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
b. Senior Community Service Employment Program: part-time employment in community service jobs.	55	Bureau of Elder and Adult Services (BEAS), AARP and others	federal, state & volunteers	No	
c. Foster Grandparent Program: part-time volunteer opportunities with disadvantaged children; stipend provided.	60 and income limitations	Various state & private organizations	federal (ACTION)	No	Although designed as a volunteer program, the stipend does provide supplemental income to participants.
d. GI Bill: education, job training and vocational counseling.	veteran	Department of Veterans Affairs approves requests and pays provider schools/agencies.	federal	maximum amount paid by DVA may not full cover cost	Educational loans are available to cover unpaid amounts.
e. Veterans Job Training Act: job training paid to employers on behalf of veterans in approved training programs.	veteran on active duty during Korean or Vietnam conflicts	Department of Veterans Affairs	federal	No	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
B. Medical Care					
1. Medicare "A" and "B":					
"A" covers hospital care, up to 150 days skilled nursing facility (SNF) or skilled rehabilitation per year. covers part-time home health if patient is home bound and physician orders, covers up to 210 days hospice.	"A": eligible for SSA or SSI or Railroad retirement and disabled 24 months. "B": eligible for "A" or 65 and makes application.	federal: Social Security Administration and Health Care Financing Administration (HCFA). Gov't. contracts with Blue Cross/Blue Shield of Mass. and BC/BS of ME to administer in Maine.	federal	"A": hospital deductible of $560 + 1st 3 pints of blood. SNF deductible of $22.50/day for 1st 8 days. "B": premium (presently $31.90/mo.) plus 20% co-pay on all charges.	Medicare assigns a maximum amount for each service. If providers do not accept Medicare's assignment, the patient may be liable for more than the standard deductions. Deductibles and co-payments are likely to rise as part of this year's federal budget reconciliation.
"B" covers physicians; medical equipment; out-patient services; speech, physical and occupational therapy; diagnostic tests; ambulance; oxygen; drugs; biologicals.					
2. MediGap Policies: refers to a variety of policies designed and marketed to supplement Medicare	varies with policy. Generally, Medicare recipients are eligible	offered by various entities	Privately funded through premiums	Premiums, which vary by policy	Maine regulations specify that Medigap policies offered in Maine must offer at least: -3 pt. blood deductible -8 day SNF deductible -all or none of the hospital deductible the 20% "B" co-pay.

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
3. Medicaid: covers "medically necessary" situations, including: hospital, outpatient, nursing home, home health when ordered by doctor, chiropractic services, mental health services and prescription drugs.	income and asset limits: categorically needy (eligible for AFDC or SSI) or medically needy	state: Bureau of Income Maintenance and Bureau of Medical Services	roughly 62% federal, 38% state	If assets are too high, "spend down" may be necessary before Medicaid benefits begin	Medicaid is the greatest single funding source of nursing home care. Additionally, general ICF care represents the greatest single item in the Maine Medicaid budget (34.2% in FY 88).
4. Medicaid Home and Community-Based Services Waiver: allows state to waive certain Medicaid rules to offer community-based services to those who would otherwise require institutional-ization. May include: case management, adult day care, homemaker, home health, personal care, habitation and respite.	60 and income and asset limits and ICF eligible	Bureau of Income Maintenance, Bureau of Medical Services, Bureau of Elder & Adult Services, and AAAs.	62% federal 38% state	No	Only individual income is considered, resulting in easier eligibility than general Medicaid which considers household income.
5. Civilian Health and Medical Program (CHAMP): comprehensive medical coverage for families of active duty military personnel and military retirees.	family of active duty military personnel or military retirees and their families or surviving spouses and families of active duty military personnel or retirees.	local CHAMP offices	federal	co-pay for hospital services and outpatient services	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
6. Maine Health Program: Medicaid-like benefits for people who are not Medicaid eligible.	income and asset limits	Bureau of Income Maintenance and Bureau of Medical Services	state	sliding scale premiums	Although this program targets the "working poor," some elderly and their dependents may qualify, since the asset limit ($20,000) is considerably higher than Medicaid's.
7. Hospice: support to terminally ill persons and their families, either in home or in hospice facility.	varies: some require Medicare eligibility, which, in turn, requires 3 mos. or less life expectancy; others expand service to 6 mos.	various hospital and community organizations	Medicare Private insurance Volunteer services	depends upon person's funding source and how well-established hospice is.	Medicaid will cover Hospice soon. (Regulations being drafted).
8. Home Health Care: in-home nurse, nurse's aid, home health aide, physical, speech or occupational therapist, medical social worker.	Medicaid eligible or Medicare eligible or CHAMP eligible or home-based care eligible (HBC eligibility 60 yrs. old)	BEAS, AAAs, and various local agencies	federal and state	co-pay for Medicare, CHAMP and HBC	
9. Private Duty Nursing, Personal Care: RN, LPN, CNA, home health aide.	Medicaid eligible and ordered by doctor	Bureau of Income Maintenance, Bureau of Medical Services and various local agencies	62% federal 38% state	Only if "spend down" has been assigned.	
10. Low-Cost Drug Program: low-cost life sustaining and chronic condition drugs.	Income limitations and 62 or 55 disabled widow/widower	Bureau of Medical Services and Bureau of Taxation	state	$2 co-payment per prescription	
C. Social Services					
1. Homemaker/Chore Services: assistance with routine household tasks.	Medicaid eligible or waiver eligible or home based care (HBC) eligible	Bureau of Elder & Adult Services, AAAs and various local agencies	state & federal	co-pay may be required for HBC	Medicaid will fund homemaker only

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
2. Respite Care: Care provided to elder as respite or break from usual care arrangement. May be provided in home or respite facility.	waiver eligible or HBC eligible	Bureau of Elder & Adult Services, AAAs and various local agencies	state & federal	co-pay may be required for HBC	
3. Adult Day Care: Various services provided in day care setting; minimum 3 days/wk, 6 hrs./day.	waiver eligible or HBC eligible	Bureau of Elder & Adult Services, AAAs and various local agencies	state & federal	co-pay may be required for HBC	
4. Nutrition					
a. Noon meals: provided at noon at designated meal sites or delivered to home if elder is home-bound	60	Bureau of Elder & Adult Services, AAAs and various local agencies	federal, state, local and volunteers	donations are encouraged	
b. Food Stamps	income and asset limitations	Bureau of Income Maintenance	federal	depending on income and assets, recipient may need to pay a percentage of the value of the stamps.	food stamps may be used to donate to the noon meals program.
5. Care Management: nurses and social workers assess individual needs and facilitate the design and implementation of a care plan which is directed at maximum independence.	waiver eligible or HBC eligible	Bureau of Elder & Adult Services, AAAs and various local agencies	federal & state	HBC may require co-payment	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
6. Transportation: a variety of group and individual transportation systems	60 or Medicaid eligible or HBC eligible	Department of Transportation, Bureau of Medical Services, Bureau of Elder & Adult Services, Bureau of Social Services, AAAs, transport agencies and various other local agencies	federal, state and local	co-pay may be required	
7. Adult Protective Services: Services designed to protect incapacitated and dependent adults who are in danger.	incapacitated or dependent and in danger of abuse, neglect or exploitation	Bureau of Elder & Adult Services	state	No	BEAS recently assumed responsibility of the Adult Protective Program.
8. Community Mental Health Services: in-home assessment and referral, with in-home services on a limited basis.	60	Department of Mental Health and Mental Retardation	state and 3rd party payments	Not currently, but co-payment may be required as demand for program increases.	Elders also have access to community mental health centers, but in-home assessment is available for the first time with funds appropriated in FY '89.
9. Support Groups/Clubs various support groups and social clubs which provide emotional support, companionship and recreation.	generally open to those 60 yrs. old or needing a particular type of support.	varies widely	local organizations and volunteers	varies; often membership fees and activity fees.	
D. Housing					
1. Congregate Services: refers to a wide range of services which supplement shelter to avoid institutionalization. Generally, includes: 1 meal/day, transportation, housekeeping and home health.	Congregate Housing Services Program (CHSP) targets those who can no longer live independently yet do not need a nursing home	Bureau of Elder & Adult Services, AAAs and various local agencies	state	co-pay may be required	"Congregate housing" is also used to describe various types of privately developed and marketed housing complexes.

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
2. Board & Care Homes: represents various living arrangements, providing at least a place to live, meals and 24 hour protective oversight.	various, as established by the proprietors and non-profits which operate them.	Individuals and agencies operate; state licenses, localities zone.	various, depending on individual's eligibility	individual pays monthly fee, which often comes from SSI or other income maintenance source.	
3. Nursing Homes: Skilled Nursing Facilities (SNF) provide skilled nursing under supervision of physician or RN. Intermediate Care Facilities (ICF) provide nursing care but less supervision than SNFs.	In order to receive certain funding, must be deemed appropriate for level of care provided.	various state, municipal and private operators; state licenses	Medicare (SNF only) Medicaid, Department of Veterans Affairs, Private Insurance	If not eligible for funding, "private pay" patient pays fee. Also, Medicaid "spend down," or Medicare/insurance co-payments may apply.	
4. Alzheimer's Facilities: facilities, certified at various levels of care, which specialize in the care & treatment of people with Alzheimer's Disease.	various, depending on facility, but all require a diagnosis of Alzheimer's.	state, municipal and local agencies	federal & state	if no funding, or if privately insured, may need to co-pay or fully pay cost.	
5. State Institutions: AMHI, BMHI, Pineland Center.	categorized disability: mental illness for AMHI & BMHI; developmental disability for Pineland and no less restrictive appropriate setting available.	Department of Mental Health and Mental Retardation	Medicare Medicaid State funds	generally, residents contribute all of their income except for a spending allowance	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
6. Home Sharing/Match Up Programs: Services match those looking for home with those looking for housemates and assist with setting ground-rules.	Home provider establishes	Southern Maine AAA and Central Maine AAA operate formal programs.	privately arranged	home seeker pays home provider. Barter is often part of the arrangement.	
7. Home Equity Conversion Program: Demonstration project under which 50 federally guaranteed conversions will be executed.	62 and owns a home with sufficient equity.	Bureau of Elder & Adult Services and Maine State Housing Authority	federal (HUD)	Equity in home.	
8. Subsidized Housing: various types of "affordable" housing built or renovated with public funds.	income limitations; many are exclusively for elders, with specific age requirements varying.	state and local housing agencies	federal and state	no more than 30% of income.	
9. Rental Assistance: Rent subsidies, in the form of vouchers or certificates, allowing people to rent from private landlords.	income limitations	state and local housing agencies, in cooperation with landlords	federal (HUD)	no more than 30% of income	

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
10. Tenant Assistance Program (TAP): 5 demonstration programs, in which elderly housing managers are trained to identify and intervene with tenants who have substance abuse problems.		Bureau of Elder & Adult Services and Maine State Housing Authority	federal	No	
11. Home Energy Assistance Program (HEAP): financial assistance with energy bills.	income limitations. Higher income is allowed if an elderly individual (60) lives in the household	Division of Community Services, CAP agencies and municipalities	federal	No	The DCS anticipates a significant cut in the federal block which funds this program.
12. Weatherization: financial assistance with certain home weatherization projects.	income limitations	Division of Community Services, CAP agencies and municipalities	federal	No	
13. Misc. Private Housing Options:					
a. Retirement Communities					
b. Continuing Care Retirement Communities (CCRCs)					
c. Accessory Apartments					
d. ECHO Housing (Elder Cottage Housing Opportunities)					
e. Equity Exchange					

SERVICE	ELIGIBILITY CRITERIA	WHO ADMINISTERS?	FUNDING SOURCE(S)	INDIVIDUAL CONTRIBUTION?	COMMENTS
E. Advocacy					
1. Legal Services for the Elderly (LSE): legal services specializing in income maintenance, health and housing issues.	60	LSE is a private, non-profit	federal, state and private	No. fee-generating cases, such as social security "back payment" cases are generally referred to private attorneys	
2. Pine Tree Legal Assistance: legal services for people with little or no resources.	income limitations	private, non-profit	federal and state	No	
3. Volunteer Lawyers Project: coordination of pro bono legal representation from private firms.	income limitations	Pine Tree Legal and the Maine BAR	federal and private	generally no, although clients may be required to pay court filing fees	
4. Maine Committee on Aging: State oversight body which advocates for Maine's older citizens.			federal and state	No	
5. Long Term Care Ombudsman: receives and investigates problems related to the quality of long term care. Follows up with facilities/agencies/ families.	Recipient of long term care, in any setting	Maine Committee on Aging	federal and state	No	

APPENDIX F

TABLE 1

Optional Services In State Medicaid Programs, 1989

Basic Required Medicaid Services		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Respiratory Care Services
	ALABAMA																	
	ALASKA																	
	ARIZONA																	
	ARKANSAS																	
	CALIFORNIA																	
	COLORADO																	
	CONNECTICUT																	
	DELAWARE																	
	D.C.																	
	FLORIDA																	
	GEORGIA																	
	HAWAII																	
	IDAHO																	
	ILLINOIS																	
	INDIANA																	
	IOWA																	
	KANSAS																	
	KENTUCKY																	
	LOUISIANA																	
	MAINE																	
	MARYLAND																	
	MASSACHUSETTS																	
	MICHIGAN																	
	MINNESOTA																	
	MISSISSIPPI																	
	MISSOURI																	
	MONTANA																	
	NEBRASKA																	
	NEVADA																	
	NEW HAMPSHIRE																	
	NEW JERSEY																	
	NEW MEXICO																	
	NEW YORK																	
	NORTH CAROLINA																	
	NORTH DAKOTA																	
	OHIO																	
	OKLAHOMA																	
	OREGON																	
	PENNSYLVANIA																	
	RHODE ISLAND																	
	SOUTH CAROLINA																	
	SOUTH DAKOTA																	
	TENNESSEE																	
	TEXAS																	
	UTAH																	
	VERMONT																	
	VIRGINIA																	
	WASHINGTON																	
	WEST VIRGINIA																	
	WISCONSIN																	
	WYOMING																	
15	CN	12	15	8	11	8	15	12	10	5	7	16	8	14	13	4	3	3
36	CN and MN	32	35	21	29	18	34	32	27	22	27	35	29	34	32	17	14	6
51	TOTAL	44	50	29	40	27	49	44	37	27	34	51	37	48	45	21	17	9

1. CN: Categorically Needy – individuals receiving federally-supported financial assistance.
2. MN: Medically Needy – individuals who are eligible for medical but not for financial assistance.

Source: Health Care Financing Administration, Division of Intergovernmental Affairs, 1990.

TABLE 1 CONTINUED:

Optional Services In State Medicaid Programs, 1989

Basic Required Medicaid Services		Preventive Services	Rehabilitation Services	Services for Age 65 or Older in Mental Institutions: A. Inpatient Hospital Services	Services for Age 65 or Older in Mental Institutions: B. SNF Services	Services for Age 65 or Older in Mental Institutions: C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for under Age 21	Christian Science Nurses	Christian Science Sanitoria	SNF for under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Services	Total Additional Services
	ALABAMA																	14
	ALASKA																	18
	ARIZONA																	20
	ARKANSAS																	25
	CALIFORNIA																	27
	COLORADO																	16
	CONNECTICUT																	26
	DELAWARE																	17
	D.C.																	26
	FLORIDA																	19
	GEORGIA																	15
	HAWAII																	23
	IDAHO																	15
	ILLINOIS																	28
	INDIANA																	28
	IOWA																	22
	KANSAS																	25
	KENTUCKY																	25
	LOUISIANA																	16
	MAINE																	27
	MARYLAND																	19
	MASSACHUSETTS																	32
	MICHIGAN																	30
	MINNESOTA																	30
	MISSISSIPPI																	16
	MISSOURI																	18
	MONTANA																	28
	NEBRASKA																	24
	NEVADA																	25
	NEW HAMPSHIRE																	28
	NEW JERSEY																	28
	NEW MEXICO																	16
	NEW YORK																	28
	NORTH CAROLINA																	21
	NORTH DAKOTA																	25
	OHIO																	26
	OKLAHOMA																	18
	OREGON																	26
	PENNSYLVANIA																	20
	RHODE ISLAND																	18
	SOUTH CAROLINA																	19
	SOUTH DAKOTA																	16
	TENNESSEE																	20
	TEXAS																	18
	UTAH																	26
	VERMONT																	24
	VIRGINIA																	22
	WASHINGTON																	28
	WEST VIRGINIA																	22
	WISCONSIN																	30
	WYOMING																	11
15	CN	3	12	17	9	11	23	23	12	1	5	21	14	7	15	6	4	
36	CN and MN	16	28	24	16	19	28	27	26	4	12	29	27	19	35	25	20	
51	TOTAL	19	40	41	25	30	51	50	38	5	17	50	41	26	50	31	24	

1. CN: Categorically Needy – individuals receiving federally-supported financial assistance.
2. MN: Medically Needy – individuals who are eligible for medical but not for financial assistance.

Source: Health Care Financing Administration, Division of Intergovernmental Affairs, 1990.

STATE OF MAINE

ONE HUNDRED AND FOURTEENTH LEGISLATURE

COMMITTEE ON HUMAN RESOURCES

March 29, 1990

Honorable Virginia Constantine
RFD 1, Box 3560
Bar Harbor, ME 04609

Dear Rep. Constantine:

During the Second Regular Session of the 114th Legislature, the Human Resources Committee considered LD 2285, "AN ACT to Amend the Laws Pertaining to Preadmission Assessment." (copy attached). This bill was presented by the Department of Human Services. One of the provisions of this bill would have permitted the Department to refuse state payment for boarding home care for persons who are determined not to need that level of care.

Prior to March 1, 1990 state payment for boarding home care was made under the state supplement portion of the federal Supplemental Security Income (SSI) program. The SSI state supplemental payment is 100% state funds. The only qualification is income eligibility. There is no determination of medical or social need.

On March 1st, the State instituted Medicaid participation for boarding home care. Under Medicaid, a recipient must meet not only an income eligibility standard but also a medical standard of need. With Medicaid participation, the federal government pays approximately two-thirds of the cost.

Under the Medicaid program, the State must assess each applicant for State assistance to determine whether that person meets the standard of medical need. If the standard of need is not met, Medicaid payment is not possible. Under LD 2285 the State was seeking authority to deny SSI payment for cost reimbursed boarding homes for persons not meeting the medical standard of need.

STATE HOUSE STATION 115, AUGUSTA, MAINE 04333 TELEPHONE: 207-289-1317

The majority of the Human Resources Committee recommended "Ought Not to Pass" on LD 2285. That report was accepted in the House, and the bill was indefinitely postponed in the Senate. The majority of the committee was concerned that if reimbursement was denied, some people would not be able to obtain boarding home care and would have no other place to go. We have asked the Department to provide you and us with the number of persons who do not meet the standard of medical need. We request that you consider this issue and the availability of other living arrangements for people who would not be able to live in a boarding home and include this analysis in the report you will be submitting to us in December.

Thank you.

Sincerely,

Sen. N. Paul Gauvreau
Senate Chair

Rep. Peter J. Manning
House Chair

Enc.

#1006LHS

APPENDIX H

Bureau of Insurance
State House Station #34
Augusta, ME 04333
(207) 582-8707

Maine Committee on Aging
State House Station #127
Augusta, ME 04333
(207) 289-3658
Toll Free: 1-800-452-1912
(for Ombudsman Program)

1990 LONG-TERM CARE AND NURSING HOME CARE INSURANCE COMPARISON CHART

This chart lists all non-group long-term care and nursing home care insurance policies approved by the Maine Bureau of Insurance as of June 15, 1990. The Bureau of Insurance and the Maine Committee on Aging have developed this guide to assist consumers in comparing policies sold in Maine. Long-term care and nursing home care insurance is a rapidly growing field, with new policies entering the market monthly. Therefore, if a policy you are considering is not on the chart, call the Bureau of Insurance (582-8707) for more information.

There are two types of policies sold in Maine: a nursing home policy and a more comprehensive long-term care policy. Policies vary widely as to benefits provided, eligibility requirements and cost. The purpose of this chart is to assist you in comparing the various policies available in Maine. Companies also vary as to quality of service. While this cannot be measured, it is important to consider when shopping for a policy.

Long-Term Care Insurance

All long-term care insurance policies issued in Maine must provide at least the following benefits:

(1) coverage for skilled, intermediate or custodial care received in a skilled nursing or intermediate care facility;

(2) custodial care benefits that are at least 50% of those provided for skilled nursing care in a nursing facility;

(3) home health care coverage for at least 90 visits in any year; and,

(4) home health care per visit coverage at least 50% of the daily benefit for a skilled nursing facility confinement.

No long-term care insurance policies issued in Maine may:

(1) contain coverage for only skilled nursing facilities;

(2) require a prior hospital stay as a condition for policy benefits;

(3) require a prior skilled nursing home stay as a condition for receipt of intermediate care facility benefits; or

(4) require prior institutionalization as a condition of receipt of home health care benefits.

Nursing Home Care Insurance

A nursing home policy may be less expensive, but it offers less coverage. Home care may or may not be covered in a nursing home care policy, and when it is covered, it may require a prior nursing home stay. Also, many nursing home policies do not cover custodial care for persons who may be in a nursing home for non-medical reasons.

Tax Incentives

A certified long-term care insurance policy is eligible for a state income tax deduction for the premiums paid. Nursing home policies are not eligible.

Definitions

The following terms are commonly used in long-term care and nursing home policies:

"*Elimination period*" the number of days or visits following the start of a benefit period when no benefits are payable.

"*Benefit period*" the extent of coverage. Usually in terms of a maximum number of years or, for home health care, a maximum number of visits.

"*Preexisting conditions*" health problems you may have had when you applied for a policy. For persons 65 and over, the exclusion of coverage may be no more restrictive than excluding coverage for 6 months for a condition for which medical advice or treatment was recommended by or received within 6 months before the effective date of coverage.

"*Activities of Daily Living*" (ADLs) activities such as eating, continence, transfer, bathing, dressing, and toileting. Eligibility for benefits may be based on inability to perform activities of daily living.

Outline of Coverage and Consumer's Guide

When you complete an application to purchase a nursing home or long-term care insurance policy, the agent is required to provide you an Outline of Coverage, which describes the policy benefits, and a Consumer's Guide to Long-term Care Insurance and Nursing Home Care Insurance. The Consumer's Guide was developed to help consumers make informed decisions when considering the purchase of long-term care and nursing home care insurance.

Guaranteed Renewable

All non-group nursing home and long-term care insurance policies must be guaranteed renewable. This means that you may renew the policy each year although the premium may increase.

Waiver of Premium

The policy may include a provision which waives the payment of premiums after an insured has been disabled for a specified period of time.

Free Look

Remember you have at least 10 days for a "free look" at the nursing home or long-term care insurance policy. Many policies provide 30 days. If you are not satisfied with the policy for any reason, you can return it to the agent or the insurance company. All premium paid will be returned and the policy will be considered as if it were never issued.

Need

The chances of needing nursing home care are one in one hundred if you are age 65 to 74, rise to seven in one hundred if you are 75 to 84, and peak at twenty-three in one hundred after age 85.

Two out of five persons who are 65 or older today will need some nursing home care. However, more than half will stay less than 90 days in a nursing home, and roughly 40% will stay an average of 2 1/2 years.

Persons in need of long-term care and nursing home care insurance are those who wish to protect their assets. A general rule of thumb is that the person should have an annual income of $18,000 and assets (excluding the home and personal items) in excess of $60,000 in stocks, bond, savings, and the like. If your income and assets are in this range, you may want to consider long-term care and nursing home care insurance.

The current charge for a nursing home bed in Maine ranges from $75 - $125 per day. Call your local nursing home to determine the cost in your area.

The cost of nursing home care is likely to increase with time. Most policies provide for either automatic or optional increases in the daily benefit. Some policies provide automatic benefit increases with no increase in premium. This may be desirable if you are on a fixed income. Other policies require a premium increase when benefits increase.

Policy Comparison

The diversity and lack of standardization of long-term care policies can make choosing a policy very difficult. We hope that this chart will make comparing policies easier for you. To make premium comparisons, we selected a policy that paid $100 per day, with a benefit period as close as possible to five years and an elimination period as close as possible to 100 days, with home health care benefits if available, and an inflation

CONTINUED ON BACK

					INFLATION PROTECT			
COMPANY/ POLICY FORM (FOUND IN LOWER LEFT CORNER OF POLICY)	BENE-FIT PERIOD	ELIMINA-TION PERIOD	ELIGI-BILITY FOR BENE-FITS BASED ON ADL's	HOME CARE BENEFITS	AMOUNT & FREQUENCY OF INCREASES	MAXIMUM TOTAL INCREASE IN DAILY BENEFITS	BENE-FIT INC-REASES STOP AT AGE	DOES BENEFIT INCREASE WHILE YOU ARE RECEIVING BENEFITS
Aid Association for Lutherans 4910ME	3, 6, or 12 years	30, 90, or 180 days	3 of 6 ADL's	Home health care, adult day care, and respite care. Note A	Up to 25% every 2 years	100%	84	Note B
AMEX Life Assurance Company 50003L	2, 3, or 4 years or life	20 or 100 days	3 of 6 ADL's Home health care and adult day care 2 of 6 ADL's	Home health care, adult day care and respite care Note D	5 % annually	no limit	85	yes
Mutual of Omaha NH23, Series 15627 --- NH24, Series 15628	5 years Note E --- 2 years	30, 150 or 365 days Note F	2 of 6 ADL's or 1 of 6 for adult day care	Home health care, hospice care and adult day care Note G	10% every 4 years Note H	no limit	70	Note H
Travelers Insurance Company H-569	$ cap Note K	20, 100 or 365 days	3 of 7 ADL's Note L	Home health care, 90 visits a year, and adult day care Note M	Annual, based on CPI	100%	79	Optional
UNUM Life Insurance Company LTC-590 Note O	2 or 4 years or life	30 or 90 days	Level 1: 2 of 6 ADL's Level 2: 3 of 6 ADL's Note P	Disability triggers level 1 benefit	5% annually	no limit	no limit	yes

			PREMIUM COMPARISON INFORMATION							
			BENEFITS USED FOR PREMIUM COMPARISON		ISSUE AGE 60 1ST YEAR		ISSUE AGE 60 11TH YEAR	ISSUE AGE 70 1ST YEAR		ISSUE AGE 70 11TH YEAR
...O PREMIUMS ...NCREASE ...HEN DAILY BENEFIT ...NC- ...EASES	TAX DEDUCT- IBLE	SOLD TO PERSONS UP TO AGE	BENEFIT PERIOD	ELIMIN- ATION PERIOD	PREMIUM ($100 DAILY BENE- FIT)	DAILY BENE- FIT	PREMIUM	PREMIUM ($100 DAILY BENE- FIT)	DAILY BENE- FIT	PREMIUM
Yes	No	84	6 years	90 days	$1,982	$148 Note C	$3,341	$5,191	$148 Note C	$8,617
)	yes	79, 84 for 2 or 3 year benefit period	4 years	100 days	$1,871	$150	$1,871	$2,769	$150	$2,769
			5 years		$2,320 $773 Note J	$120	$3,057 $1,018 Note J	$4,981 $1,661 Note J	$100	$4,984 $1,991 Note J
Yes	yes	75	-------	150 days	-------	------	-------	-------	------	-------
			2 years		$1,478 $493 Note J	$120	$1,947 $650 Note J	$3,187 $1,062 Note J	$100	$3,187 $1,062 Note J
S	yes	79	Note K	100 days	$1,012	$148 Note N	$1,738	$2,421	$137 Note N	$3,921
)	yes	85	4 years	90 days	$2,708	$150	$2,708	$4,795	$150	$4,795

			HOME CARE BENEFIT			INFLATION PROTECTION			
COMPANY/ POLICY FORM (FOUND IN LOWER LEFT CORNER OF POLICY)	BENE-FIT PERIOD	ELIMINA-TION PERIOD	OPTIONAL OR INCLUDED IN POLICY	PRIOR NURSING HOME STAY REQUIRED	COVER-AGE	AMOUNT & FREQUENCY OF INCREASES	MAXIMUM TOTAL INCREASE IN DAILY BENEFITS	BENE-FIT INCR-EASES STOP AT AGE	DOES BENE INCR WHILE YOU AR RECEI ING BENEFIT
Aid Association for Lutherans 4911-ME	3, 6 or 12 years	30, 90 or 180 days			None	Up to 25% every 2 years	100%	84	Note
Amex Life Insurance Company 50000F ---------- IDS Life Insurance Company 30240 ME	2 or 4 years or life	20 or 100 days	Included	Yes	Recov-ery bene-fit Note O	5% Annually	No Limit	85	Yes
Bankers Life & Casualty Insurance Company GR-7A1-ME PLAN II ---------- Bankers Multiple Line Insurance Company D-7A1-ME PLAN II ---------- Union Bankers Insurance Company NH-GR-88 PLAN II	1, 2, 3, or 5 years or life	0, 20, 100 or 150 days			None	5% Annually for first 10 years	50%	No limit	No

INSURANCE CONTRACTS

			PREMIUM COMPARISON INFORMATION							
			BENEFITS USED FOR PREMIUM COMPARISON		ISSUE AGE 60 1st year		11th year	ISSUE AGE 70 1st year		11th year
D REMIUMS NCREASE ILY ENEFIT NC ES	TAX DEDUCT-IBLE	SOLD TO PER-SONS UP TO AGE	BENEFIT PERIOD	ELIMIN-ATION PERIOD	PREMIUM ($100 DAILY BENE-FIT)	DAILY BENE-FIT	PREMIUM	PREMIUM ($100 DAILY BENE-FIT)	DAILY BENE-FIT	PREMIUM
es	No	84	6 years	90 days	$978	$148 Note C	$1,667	$2,657	$148 Note C	$4,429
	No	84 ---- 79, 84 for 2 year bene-fit period	4 years	100 days	$745	$150	$745	$1,478	$150	$1,478
es	No	69, 79, or 84 varies with bene-fit period	5 years	100 days	$732	$150 if no claim dur-ing first ten years	$1,272	$1,548	$150 if no claim during first ten years	$2,872

			Home Care Benefit			INFLATION PROTECTION			
COMPANY/ POLICY FORM FOUND IN LOWER LEFT CORNER OF POLICY	BENE-FIT PERIOD	ELIMINA-TION PERIOD	OPTIONAL OR INCLUDED IN POLICY	PRIOR NUSRING HOME STAY REQUIRED	COVERAGE	AMOUNT & FREQUENCY OF INCREASES	MAXIMUM TOTAL INCREASE IN DAILY BENEFITS	BENE-FIT INCR-EASES STOP AT AGE	DOES BENEF INCRE WHILE Y ARE RECEIV BENEFI
Continental Casualty Company P1-59433-A18	3 or 5 years	15, 30 or 90 days	Optional	Yes	Home health care - 50% of nursing home daily benefit for up to 2 years	5% Annually	No limit	No limit	Yes
John Hancock Mutual Insurance Company LTC-88	3 or 6 years	20 or 100 days	Included	No	Home skilled care benefit Note R	Every 3 years Note S	No limit	No limit	No
Mutual Protective Insurance Company PP 3358(ME)	1 or 3 years Note U	0, 20 or 100 days	Optional	No	Covers adult day care. Home health care Note V	5% Annually for first 15 years	75%	No limit	Yes
Union Labor Life Insurance Company 2000-88-LTC-ME	1, 2, 3, 4, 5, or 6 years	20 or 100 days	Included	Yes	Home health care covered at 50% of nursing home daily benefit Note W	5% annually for first 10 years	50%	No limit	Yes
World Life & Health Insurance Company of Pennsyl-vania WL-NH-225(ME) Note X	1, 2, 3, 4, or 5 years	0, 75 or 150 days	Included	No	Private duty nurse and licensed physical therapist benefit Note Y	5% Annually for first 10 years	50%	No limit	Yes

INSURANCE CONTRACTS

			PREMIUM COMPARISON INFORMATION							
			BENEFITS USED FOR PREMIUM COMPARISON		ISSUE AGE 60 1st year		11th year	ISSUE AGE 70 1st year		11th year
EMIUMS INCREASE WITH ILY NEFIT INCREASES	TAX DE-DUCT-IBLE	SOLD TO PERSONS UP TO AGE	BENE-FIT PERIOD	ELIM-INAT-ION PERIOD	PREM-IUM ($100 DAILY BENE-FIT)	DAILY BENE-FIT	PREM-IUM	PREM-IUM ($100 DAILY BENE-FIT)	DAILY BENE-FIT	PREM-IUM
	No	79	5 years	90 days	$770	$150	$770	$1,547	$150	$1,547
ES	No	79	6 years	100 days	$650	$159 Note T	$1,337	$1,775	$159 Note T	$4,134
	No	79, 84 for 1 year bene-fit period	3 years	100 days	$803	$150	$803	$1,571	$150	$1,571
	No	79, 84 for 1 year bene-fit period	5 years	100 days	$1,319	$150	$1,319	$3,901	$150	$3,901
O	No	84, no age limit for 1 year bene-fit period	5 years	75 days	$1,191	$150	$1,191	$2,595	$150	$2,595

Note A — Home health care 50% or 75% of the nursing home daily benefit. Adult day care 25% of the nursing home daily benefit. Respite Care 50% of the nursing home daily benefit 7 days per calendar year.

Note B — Optional rider provides for annual increase of $5 - $15 in nursing home daily benefit during a claim period.

Note C — Assumes 8.2% increase every 2 years (4% annual rate).

Note D — Home health care and adult day care benefit is lesser of: 80% of actual expense or ½ of the nursing home daily benefit. Respite care benefit is lesser or 80% of actual expense or ½ the nursing home daily benefit 14 days per calendar year.

Note E — Benefit period increased by 365 days if no claims during the first 2 years the policy is in force.

Note F — Elimination period for home health care, adult day care, and home hospice care is 30 days.

Note G — Hospice care facility benefit same as nursing home care benefit. Adult day care, home hospice care and home health care daily benefit 50% of nursing home care benefit. Home health care 90 visits per year. Hospice care and adult day care 365 day maximum benefit.

Note H — Optional rider also includes return of premium benefit for death prior to age 70.

Note I — Policy provides that after 365 days of benefits, daily benefit in schedule increases 5%. Same increase each 365 days. After period of care ends, benefit returns to schedule.

Note J — The first rate shown applies to those living alone. The second applies to those in 2-person households. All rates are 10% less for non-smokers.

Note K — Cap is 5 years X 365 days X Daily Benefit Limit.

Note L — For benefits for skilled and intermediate nursing care and adult day care, an ADL determination is not required. For home health care and custodial nursing care, physician certification and an ADL determination is required.

Note M — Home health care and adult day care covered at 80% of charge to daily limit.

Note N — Assumes 4% annual increase in CPI.

Note O — This policy includes a reduced paid-up benefit which continues if you stop paying premiums.

Note P — Level 2 benefits require nursing home confinement.

Note Q — Pays convalescence benefit for period for which benefits were paid for nursing home confinement. Days 1 - 30 pays 70% of nursing home benefit, days 31 - 60 pays 60% of nursing home benefit, days 61 - later pays 50% of nursing home benefit.

Note R — Covers skilled nursing care received in the home if a skilled nursing home confinement would be necessary without it.

Note S — Inflation adjustment based on medical care component of CPI and is only available as long as the company offers an individual nursing home policy. Not available if you have received benefits in the prior 2 years.

Note T — Assumes the medical component of CPI increases at 8% annually and increase option is exercised on 3rd and 9th policy anniversaries. Benefit will not increase if you have received benefits in the prior 2 years, or if the company is no longer offering a nursing home policy.

Note U — Issue age to 79 benefit period 3 years, lifetime maximum 4 years. Issue age 80 - 84 benefit period 1 year, lifetime maximum 1 year.

Note V — Policy covers adult day care up to 50% of the nursing home daily benefit. Optional home health care rider covers actual charges up to 50% of the nursing home daily benefit with 0, 20 or 60 day elimination period and 2 year maximum benefit.

Note W — 24 month benefit period for policies with 24 month or longer nursing home benefit period. 90 day benefit period for policies with 1 year benefit period.

Note X — Benefits under this policy are reduced by 20% if pre-admission certification is not obtained.

Note Y — Limited to 365 days.

CONTINUED FROM PAGE 3

guard or option to increase benefits. Premiums for such a policy sold to a person 60 years old are compared to the cost of the same policy sold to a person 70 years of age. Premiums are based on age at issue. Once the policy is issued, the premium will not change to reflect increasing age, although it may change for other reasons. For some policies, the premium will increase when the daily benefit is increased to offset inflation. The chart shows the premiums both at issue and 10 years later. The premiums shown are annual premiums. Semi-annual, quarterly, and monthly premiums are also generally available. Your actual premium will depend on your age and the daily benefit, benefit period, elimination period, and optional benefits you select.

If You Have Questions

For questions about long-term care and nursing home care insurance call the Bureau of Insurance at 582-8707. If you are concerned about a resident in a long-term care facility, please call the Maine Committee on Aging/Maine Long Term Care Ombudsman Program at 1-800-452-1912.

Since 1870 the Bureau of Insurance has overseen and regulated the business activities of insurance companies, brokers, agents, consultants, and adjustors in our state.

To ensure that the marketing of insurance is lawful and honest, policies and premiums are reasonable and just, and the payment of legitimate claims is dependable and timely, the Bureau is organized into some 11 divisions. Each of these divisions is charged with its special responsibility -- Administrative, Actuarial, Legal, Research, Licensing, Property and Casualty, Life and Health, Examinations, Computer Services, Market Conduct and Consumer Services, the latter drawing upon all the others for support in responding directly to inquiries and consumer problems.

Joseph A. Edwards
Superintendent

John R. McKernan, Jr.
Governor

APPENDIX I

114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document No. 1141

S.P. 430 In Senate, April 11, 1989

Reference to the Committee on Human Resources suggested and ordered printed.

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator BUSTIN of Kennebec.
Cosponsored by Representative BURKE of Vassalboro, Representative MELENDY of Rockland and Senator TITCOMB of Cumberland.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act to Improve Individualized Treatment and Planning Procedures for Long-term Care Clients.

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

22 MRSA c. 1627 is enacted to read:

CHAPTER 1627

TREATMENT AND PLANNING PROCEDURES

FOR LONG-TERM CARE CLIENTS

§7361. Definitions.

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

1. Applicable state agency. "Applicable state agency" means:

A. The Bureau of Maine's Elderly for clients who are being discharged from a hospital or who are receiving or in need of community-based services; and

B. The Bureau of Medical Services for clients needing or receiving care in an institutional setting.

2. Appropriately constituted. "Appropriately constituted," when referring to an interdisciplinary team, means membership which includes the client's physician, primary nurse, relevant therapists, social worker, homemaker, service coordinator, involved family members and others as applicable. The client or a designated client representative shall be a member of the team. The makeup of the team shall be sufficiently broad to address each significant need of the client and in no event may consist of fewer than 3 members.

3. Client service coordinator. "Client service coordinator" means the member of the interdisciplinary team responsible for convening meetings of the team, assuring that records of meetings are kept and conducting reviews of the prescriptive program plan.

4. Community-based services. "Community-based services" means those services needed or provided in the client's home, the private home of another person, a foster, group or congregate housing site or in some other community-based setting.

5. Critical juncture. "Critical juncture" means the point at which a long-term care provider or agency observes that a client is in need of initial long-term care, a significant change in long-term care or the cessation of long-term care. A critical juncture shall be deemed to occur prior to discharge

from a hospital, admission to a nursing or boarding home, the receipt of community-based services, the termination of nursing or boarding home care or the termination of community-based services. "Critical juncture" includes a significant change in the client's condition, a planned significant change in the method or place of service delivery and the termination of services by a significant service provider.

6. Deficit list. "Deficit list" means a list of services recommended for a client's care or treatment which are currently unavailable to the client. When an appropriate service exists but a barrier prevents the client from receiving that service, that barrier shall be described in the deficit list.

7. Designated client representative. "Designated client representative" means a person designated by the client for the purpose of participation on the interdisciplinary team or, if the client is unable to designate a representative, the client's attorney-in-fact or guardian or, if there is no attorney-in-fact or guardian, an attorney, paralegal or advocate designated by the applicable state agency to represent the client.

8. Institution-based service. "Institution-based service" means a service provided in a hospital or a nursing or boarding home.

9. Interdisciplinary team. "Interdisciplinary team" means a team of persons established under this chapter whose meetings are conducted in accordance with professionally accepted standards and whose purpose is to evaluate a client's needs for long-term care services and to develop an individual prescriptive program plan to meet the client's needs for those services.

10. Least restrictive alternative. "Least restrictive alternative" means a guiding principle in the interdisciplinary team's design and implementation of a prescriptive program plan to meet a client's long-term care needs. According to this principle, a prescriptive program plan shall be designed to permit the client to function at a maximum level in the setting which imposes the least restrictions on the client's personal autonomy, individual choice, mobility and freedom of association. It is presumed that this principle is best met in or near the client's own home and that institutional placement is most restrictive.

11. Licensed long-term care service provider. "Licensed long-term care service provider" means a hospital, nursing home, boarding home, home health agency or community home health agency or any other facility or agency which provides long-term care under a license issued by the State.

12. Long-term care. "Long-term care" includes all medical, nursing, social, psychosocial, rehabilitative, therapeutic, supportive and other services required to maintain or improve the functioning of a person over an indefinite future.

13. Long-term care client. A "long-term care client" means a recipient or intended recipient of long-term care.

14. Maximum feasible restoration of functional capacity. "Maximum feasible restoration of functional capacity" means a guiding principle in the interdisciplinary team's design and implementation of a prescriptive program plan for a long-term care client. This principle requires that the prescriptive program plan be designed and implemented with the explicit purpose of restoring the long-term care client to maximum functional capacity. By way of example, a client who has lost mobility, speech, bowel or bladder control or the ability to participate in the planning of the client's own program plan will receive those services best calculated to restore the maximum feasible level of mobility, speech, bowel or bladder control or ability to participate in the planning of that program plan.

15. Normalization. "Normalization" means a guiding principle in the interdisciplinary team's design and implementation of a prescriptive program plan for a long-term care client. This principle requires that, to the extent feasible, a client's care be provided in a homelike setting and the client be allowed a variety of personal choices. To the extent possible, the client shall be allowed to maintain associations in the community, make choices necessary for daily living and select the routines and rhythms of life which the client prefers.

16. Prescriptive program plan. "Prescriptive program plan" means a written plan prepared by an interdisciplinary team in sufficient detail to provide all treatment providers and care givers the guidance necessary to carry out the plan as intended. The plan shall be designed to meet the long-term care client's needs in the least restrictive, most normal setting and manner and with the goal of maximum feasible restoration of functional capacity.

17. Private agency which receives public funding. "Private agency which receives public funding" means a private agency which receives public financing or publicly financed in-kind services. An agency does not receive public funding solely on account of its receipt of reimbursement for services to individual clients through Medicare, Medicaid or other state or federal programs.

18. Publicly assisted client. "Publicly assisted client" means a client whose care is subsidized or paid for by Medicare, Medicaid, home-based care funding, local general assistance or support from a private agency which makes funding available to private individuals based on their specific needs or place of residence.

§7362. Rules of construction

If any requirement of this chapter is less specific or less stringent than any requirement of any state or federal law, rule, regulation or policy, then the more specific or stringent requirement shall control.

§7363. Applicability

1. Prescriptive plan; interdisciplinary team. Each publicly assisted client receiving long-term care shall receive care based upon a prescriptive program plan developed in accordance with the requirements of this chapter by an appropriately constituted interdisciplinary team.

2. Licensed long-term care provider. Each licensed long-term care provider shall provide its services based upon a prescriptive program plan developed by an appropriately constituted interdisciplinary team in accordance with the requirements of this chapter.

3. Agency. Each agency which receives public funding to plan for, coordinate and deliver long-term care shall provide its services based upon a prescriptive program plan developed by an appropriately constituted interdisciplinary team in accordance with the requirements of this chapter.

§7364. Procedures

1. Convening of team. Within 3 business days after a critical juncture in a client's need for long-term care or the cessation of such need, an interdisciplinary team meeting shall be convened for the purpose of formulating a prescriptive program plan for the client. The team shall be appropriately constituted to assure that all significant care and treatment needs of the client can be professionally assessed and remedial recommendations made.

2. Meeting procedure. At the onset of an interdisciplinary team meeting a team member shall be made responsible for taking minutes of the meeting. The team shall review all information which is available to it and solicit the views of each participant. The team shall choose a client service coordinator and detail a prescriptive program plan in

accordance with the requirements of this chapter. The client or client's representative must assent to the plan before it may be implemented.

§7365. Contents of prescriptive program plan

1. Plan components. Each prescriptive program plan shall be individually tailored to the actual needs of the client, describe the nature of the client's specific needs and capabilities, including the need for further evaluation, specify treatment needs for further evaluation and specify treatment needs with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall in all cases:

A. Define the client's need for all relevant services without regard to the availability of those services;

B. Identify all services available to meet the client's needs;

C. Recommend a course of action to meet as many needs of the client as possible; and

D. Include plans for continued exploration of suitable program services within specified time frames and by specified persons.

2. Available services. The client service coordinator shall obtain assurances that all services identified under subection 1, paragraph B, are provided at the earliest possible date. The respective responsibilities of each team member for implementing the client's prescriptive program plan shall be specified.

3. Deficits. The client service coordinator shall prepare a detailed deficit list describing all relevant services under subsection 1, paragraph A, which are not currently available. The deficit list shall be updated at the conclusion of the time allowed for completion under subsection 1, paragraph D, and provided immediately to a designated agent within the applicable state agency.

4. Reconvening. The client service coordinator shall review the client's progress toward attainment of planned treatment objectives at least quarterly and shall reconvene the interdisciplinary team, in all cases, within one year of the last interdisciplinary team meeting held for a client. Any member of the interdisciplinary team, including the client or client's representative, may reconvene the team at an earlier date whenever any significant change in the client's condition requires a change in the plan for the client's care and treatment. The team, with appropriate changes in membership,

shall be reconvened at each critical juncture in the client's care and treatment.

§7366. State agency responsibilities

The applicable state agencies shall coordinate their activities in a manner calculated to assure that long-term care is provided to clients throughout the State, to the extent feasible given limited public and private resources, in accordance with prescriptive program plans developed pursuant to this chapter. Without limiting their responsibilities to assure the implementation of a comprehensive, coordinated long-term care system, the applicable state agencies shall:

1. **Rules; forms.** Adopt such rules and develop such forms as may be required by long-term care providers to fully carry out the purposes of this chapter;

2. **Training.** Provide coordinated training activities to assure that long-term care providers develop and implement long-term care services in accordance with this chapter;

3. **Deficit lists.** Designate persons within their agencies to record deficit lists of currently unavailable services needed by long-term care clients and descriptions of barriers to the receipt of existing services by clients;

4. **Develop services.** Utilitize the information obtained pursuant to subsection 3 to plan for and develop services and to overcome existing barriers to the receipt of those services; and

5. **List client representatives.** Develop and maintain a list of designated client representatives throughout the State to assist clients who are unable to designate their own representatives.

§7367. Compliance with other laws

Affected state and private agencies involved in the planning for and delivery of long-term care services shall conform to the various requirements of state and federal law deriving, without limitation, from the hospital discharge planning requirements of the United States Medicare Catastrophic Coverage Act of 1988; the nursing home reform requirements of the United States Omnibus Budget Reconciliation Act of 1987; and the various state law requirements for in-home and community support services for adults with long-term care needs, Title 22, sections 7301 to 7306; in-home and community support services for the elderly, Title 22, sections 7321 to 7323; personal care assistance services for severely physically disabled adults, Title 22, sections 7341 to 7343; placement and therapeutic services for dependent and incapacitated adults, Title 22,

sections 3488 to 3492; boarding care facilities, Title 22, sections 7901-A to 7913; licensing of hospitals and institutions, Title 22, sections 1811 to 1827; and rules, regulations and policies adopted pursuant to these laws.

STATEMENT OF FACT

This bill will make uniform throughout Maine's system of long-term care the procedures for assessing the needs of individual clients and tailoring programs to meet their needs. It will also provide the individualized treatment planning process with a set of articulated and maximum feasible restoration of functional capacity. Finally, the bill addresses the need of Maine's long-term care system to have available to it a "snapshot" of needed services which are currently unavailable to long-term care clients.

APPENDIX J

TABLE 1. – FOOD STAMP PARTICIPATION RATES FOR MAINE'S ELDERLY, 1990

Area	(1.) Population 60 Yrs & Over	(2.) Number of Elderly at or Below Poverty	(3.) Number of Food Stamp Recipients 60 & Over	(4.) Participation Rate Among All Elderly	(5.) Among Elderly Poor
Aroostook	14527	5419	1808	12.4%	33.4%
Eastern	43543	11103	2655	6.1%	23.9%
Senior Spectrum	54307	12002	2921	5.4%	24.3%
Western	35180	8197	1888	5.4%	23.0%
Southern	71842	11710	2481	3.5%	21.2%
Maine	219399	48431	11753	5.4%	24.3%

(1.) 1987 population estimates from Office of Data, Research, and Vital Statistics, Maine Dept. of Human Services.
(2.) Estimates were calculated using data from the Bureau of Elder and Adult Services 1989 Needs Assessment Survey.
(3.) From Maine Bureau of Income Maintenance Records: Total persons 60 years and over receiving food stamps as of May 1, 1990.
(4.) Calculated by dividing col. 3 by col. 1.
(5.) Calculated by dividing col. 3 by col. 2.

Prepared by: OFFICE OF POLICY AND LEGAL ANALYSIS
6/8/90

APPENDIX K

TABLE 2. – SSI PARTICIPATION RATES FOR MAINE'S ELDERLY, 1988

Area	(1.) Elderly Population	(2.) Number of Elderly at or Below Poverty	(3.) Number of SSI Recipients 65 & Over	(4.) Participation Rate Among All Elderly	(5.) Participation Rate Among Elderly Poor
Aroostook	11384	4246	1631	14.3%	38.4%
Eastern	33075	8434	2167	6.6%	25.7%
Senior Spectrum	42329	9355	2581	6.1%	27.6%
Western	27121	6319	1639	6.0%	25.9%
Southern	55064	8975	1976	3.6%	22.0%
Maine	168973	37329	9994	5.9%	26.8%
U.S.A.*				6.9%	57.6%

(1.) 1988 population estimates from Office of Data, Research, and Vital Statistics, Maine Dept. of Human Services.
(2.) Estimates for 1988 were calculated using data from the Bureau of Elder and Adult Services 1989 Needs Assessment Survey.
(3.) From SSI STATE AND COUNTY DATA: 1988, SSA Publication No. 13–11976, Table 3, p. 32 and SSI Recipients By Zip Code, December 1988, SSA Publication No. 13–117.
(4.) Calculated by dividing col. 3 by col. 1.
(5.) Calculated by dividing col. 3 by col. 2.

* U. S. A. rates were calculated using Table 11, BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, 1989, p. 695, and U.S. Bureau of Census, Current Population Reports, Series P–60, No. 166.

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APPENDIX L

MAJOR SOURCES OF PUBLIC FUNDING FOR MAINE TRANSPORTATION, 1985 - 1990

Source	FY 85-86	86-87	87-88	88-89	89-90	% Change 1985-90
1. UMTA sec.18	$705,181	$619,280	$736,706	$639,873	$652,768	-7.4%
2. UMTA sec.18(h)	$0	$0	$0	$64,229	$66,318	N/A
3. UMTA sec.16(b)(2)	$246,932	$275,708	$276,195	$275,232	$275,244	11.5%
4. UMTA sec.9	$1,729,170	$1,457,694	$1,408,802	$1,214,671	$1,106,625	-36.0%
5. UMTA sec.9b	$0	$0	$0	$47,330	$50,776	N/A
6. Title 23, sec. 4209	$400,000	$400,000	$400,000	$400,000	$400,000	0.0%
7. Older Americans Act	$279,001	$246,719	$252,495	$273,476	$244,968	-12.2%
8. Social Services Grant	$1,052,290	$1,184,095	$1,183,345	$1,168,630	$1,215,932	15.6%
9. State Social Services	$261,851	$39,220	$51,050	$50,255	$63,045	-75.9%
10. Medicaid	$448,929	$1,116,601	$1,573,732	$3,784,057	$3,982,089	787.0%
Total	**$5,123,354**	**$5,339,317**	**$5,882,325**	**$7,917,753**	**$8,057,765**	57.3%
% change from previous year		**4.2%**	**10.2%**	**34.6%**	**1.8%**	

1. Federal rural and small urban assistance for capital, administration and operating. (DOT)
2. Federal rural transit assistance for training. (DOT)
3. Federal capital assistance for nonprofit transportation of elderly and handicapped. (DOT)
4. Federal urban assistance for capital and operating. (DOT)
5. Federal urban assistance for capital and planning. (DOT)
6. State support "within the limits of available funding" for public transportation. (DOT)
7. The portion of federal Older Americans Act funds allocated by the AAAs to transportation (includes some state funds). (BEAS)
8. The portion of federal block grant funds used by DHS to purchase transportation for various "at-risk" populations, including elderly at-risk of institutionalization. (BSS)
9. State General Fund money which supplements social services block grant funds. (BSS)
10. Reimbursement for transportation to people receiving Medicaid. Includes state match of approx. 1/3. FY 89-90 figure includes estimate for last 2 months. (BMS)

Prepared by: Office of Policy and Legal Analysis, revised 5/29/90
Data provided as follows: Lines 1-6, Maine Department of Transportation; Line 7, Maine Bureau of Elder and Adult Services; Lines 8-9, Maine Bureau of Social Services; Line 10, Maine Bureau of Medical Services

APPENDIX M

Table 1: MAINE RESIDENTS TAX AND RENT REFUND PROGRAM
Number of Refunds 1980–1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Refunds–General Program									23463	45621*
Refunds–Elderly Program	24375	22788	22337	21018	20137	18979	18096	18125	24968	18817

* Contains elderly persons receiving refunds under the general program.

Table 2: MAINE RESIDENTS TAX AND RENT REFUND PROGRAM
Elderly Program Income Limitations 1980–1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Single–member household	$5,000	$5,600	$6,200	$6,200	$6,200	$6,200	$6,400	$6,600	$7,400	$7,700
Multi–member household	$6,000	$6,700	$7,400	$7,400	$7,400	$7,400	$7,700	$7,900	$9,200	$9,600

Table 3: Elderly Low Cost Drug Program
Drug Cards Issued 1980–1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Applied card only*								2021	1814	1053
Applied tax/rent refund*								12797	13615	13825
Total Drug cards issued	19787	18877	18230	17357	15929	14718	14017	14818	15429	14878

* Information readily available for 1987–1989 only.

Prepared by: Office of Policy and Legal Analysis 6/18/90
Data supplied by: Maine Bureau of Taxation