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An Analysis of the Universal Home Care Program: Considerations for Implementation with the Context of Maine's Existing LTSS Programs

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An Analysis of the Universal Home Care Referendum

Considerations for Implementation within the Context of Maine's Existing LTSS Programs

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Considerations for Implementation within the Context of Maine's Existing LTSS Programs

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EXECUTIVE SUMMARY

Many would agree that there are opportunities for improving Maine’s capacity for serving older adults and persons with disabilities. In November, Maine voters will have the opportunity to decide whether the referendum Question 1, *An Act to Establish Universal Home Care for Seniors and Persons with Disabilities*, is the right strategy for addressing these needs.

This report does not constitute either support for or opposition to the referendum but is intended as an independent assessment of how the Universal Home Care Program (the “UHC Program”) could be implemented.

This analysis focuses on the implications of implementing key elements of the UHC Program (*e.g.*, the eligibility determination process or service coordination function) using different implementation strategies (*i.e.*, minimal or close coordination with the existing long-term services and support [LTSS] system currently administered by the Maine Department of Health and Human Services [the Department]).

Our analysis assumes implementation would be guided by three goals: that the UHC program be implemented in a way that would 1) avoid a negative impact on Maine’s existing LTSS programs; 2) optimize the use of public resources; and 3) advance a “community first” model of care that promotes living at home when appropriate and preferred.

Certain elements of the proposed legislation are not considered because they are outside our areas of expertise. These include the proposed funding mechanism for the UHC Program, the establishment of the UHC Trust Fund, and certain elements relating to the UHC Board. In addition, for the purpose of this analysis, we have excluded children under age 18.^{1,2}

UHC Program

If the legislation is implemented as proposed, the UHC Program would provide a range of in-home and community support to eligible individuals and family members. Eligibility for the UHC Program would include any individual sixty-five years and older, and any individual with a disability, if they live in Maine and need assistance with at least one activity of daily living (ADL). An ADL, as defined in the legislation, includes “tasks routinely performed by a person to maintain bodily functions, including bed mobility, transfers, locomotion, dressing, eating, toileting, bathing and personal hygiene.” Income may not be considered when determining eligibility and cost-sharing is not permitted.

Based on our estimates, using 2016 population estimates, approximately 27,000 people could be eligible for the UHC Program.³ In 2016, just over 5,600 people were already accessing publicly-

¹ The analysis for implementing this program for children is likely to be similar to the analysis presented here, except that the existing programs for children are very different from those considered here.

² Further detail on the scope of our analysis and our assumptions can be found in PREFACE of the full report.

³ It should be noted that these estimates do not exactly replicate the eligibility criteria established under the proposed legislation. In particular, in identifying those potentially eligible we could not replicate the definition of disability identified under the proposed legislation; under the Survey of Income and Program Participation (SIPP), the survey

funded community-based LTSS. See TABLE 1. We assume those 5,600 people would be counted among the estimated 27,000 eligible individuals. Because the UHC Program can supplement but not supplant existing services, we assume this group would not be able to access duplicative services through the UHC Program (although, as discussed in the full report, depending on program design they might access different services through the UHC Program).

TABLE 1. Number of People in Maine (Age 18 and Older) with Any ADL Need (Estimated) and Already Accessing Community-Based LTSS (Actual) (2016)

AGE GROUP	WITH ANY ADL NEED	ALREADY ACCESSING COMMUNITY-BASED LTSS
18-64	14,000	2642
65+	13,100	2980
TOTAL	27,100	5622

SOURCES: Based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine (See APPENDIX for detail); and Snow *et al.* 2018.

The UHC Program may not incur expenses in excess of available funds. The proposed legislation contemplates different service levels based on individual need. The Board may create a waiting list if the demand for services exceeds available funds.

Under the UHC Program, providers of in-home and community supports would be required to expend 77 percent of their reimbursement on direct care costs. It would also establish “individual providers,”⁴ as state employees for the purpose of the State Employees Labor Relations Act. The UHC Board is permitted to use UHC funds on workforce development, training and quality improvement reports.

The proposed legislation requires, at a minimum, that the Department work with the UHC Board to create a simple, unified process for enrollment. In addition, the UHC Board is authorized to partner with the Department to provide supplementary funding to existing LTSS programs to expand eligibility, increase payments to providers, raise quality standards, and maintain a high-quality workforce.⁵

participants self-report on their need for assistance with an ADL, while under Maine’s existing LTSS programs, the need for assistance with an ADL is determined by an independent assessor; the American Community Survey (ACS) does not include people who reside in nursing facilities but our count of those potentially eligible could include people in residential care settings who would not be eligible for the UHC Program.

⁴ *I.e.*, those direct care workers who are not employed by a home care agency but are selected and managed to provide direct care by the person in need of services.

⁵ More detail relating to the proposed legislation can be found in the full report. The full text of the proposed bill for Question 1 can be found on Maine Department of the Secretary of State’s website for Citizen Initiatives: <https://www.maine.gov/sos/cec/elec/citizens/index.html>.

Implementation Strategies

While the proposed legislation limits the UHC Board’s discretion in some areas, it gives the Board some latitude in others. Given this latitude, the Board has the authority to develop a flexible and person-centered program that can provide individualized services aimed at helping people live at home. At the same time, the UHC Program cannot be implemented in a vacuum – how it relates to existing LTSS programs must be taken into account, partly to prevent any negative impact on the existing LTSS programs, partly to leverage existing systems and resources to avoid redundant and wasteful expense, and partly to consider opportunities for improving services in order to improve outcomes for those persons served. We considered four implementation strategies, although we did not evaluate two of these strategies in detail.⁶

Minimal Coordination

To avoid unintended, negative consequences, implementation of the UHC Program would require, at a minimum, a certain level of coordination with existing LTSS programs. In particular, the UHC Program would need to be designed to:

- Ensure that those who qualify for Medicaid access those services first, to maximize the contribution of federal matching funds.
- Avoid potential inequities between the UHC Program, which does not permit the UHC Program to require eligible persons to share in the cost of services, cost-sharing and the state-funded LTSS programs, which require persons receiving services to share in the cost of services.
- Coordinate the eligibility determination process to ensure that people eligible for Medicaid-funded LTSS are referred to that program.
- Make sure that its reimbursement policy and provider qualification standards are closely coordinated to prevent any inconsistencies and lack of parity. A lack of parity in wages could exacerbate the critical workforce shortage now facing the existing LTSS programs serving those with the greatest needs.

Close Coordination

Maine’s existing LTSS programs face a number of significant challenges, including a dire shortage of direct care workers and fragmented access to services. The UHC Program could partner with the Maine Department of Health and Human Services to:

- Strengthen and stabilize the direct care workforce;
- Use UHC funds to provide certain important “wraparound” LTSS services not allowable under the Medicaid state plan LTSS program to persons receiving services under that program;

⁶ See the ANALYSIS section for a description of the two implementations strategies not discussed in detail (i.e., converting the UHC Program to a cash voucher program, and integrating the UHC Program into a reform of the existing LTSS programs).

- Coordinate systems and supports for helping people understand their service options and how to access them;
- Promote the increased use of the self-directed services (e.g., by developing a statewide worker registry, a single model of self-direction with consistent requirements; and a common training program); and
- Leverage the systems the Department already has in place (e.g., for determining eligibility, case management, provider payment; qualifying providers; and monitoring and improving quality) to streamline access, create greater consistency and minimize duplicative investments in infrastructure.

Coordinating existing LTSS programs with the UHC Program would require some reconciliation between the laws governing each. For example, any level of integration with Medicaid-funded services would need to be consistent with federal regulation governing the State Medicaid Agency's⁷ permissible delegation of authority and otherwise meet applicable federal requirements.⁸ Federal regulation would restrict the ability of the State Medicaid Agency to delegate certain responsibilities to the Board. In addition, if the UHC Fund were used to support the existing programs, the policies of the existing LTSS programs might need to meet the requirements of the UHC Program (e.g., reimbursement pass-through requirements, and the status of individual providers related to the State Employees Labor Relations Act).

The UHC Board and Stakeholder Engagement

Significant responsibilities have been placed on the UHC Board. The Board must be able to account for the efficient and effective use of public resources, compliance with statutory requirements and the quality of services delivered. The UHC Board will need adequate oversight capability and meaningful measures of quality outcomes.

As the UHC Board moves forward with implementation, establishing a robust infrastructure to solicit stakeholder feedback is critical to the UHC Program's viability and success. The proposed legislation establishes both mandated responsibilities and discretionary powers for the UHC Board. However, even when a responsibility is mandated, in many instances the UHC Board will have discretion on how to fulfill its responsibilities. To develop a thoughtful program design that both leverages the opportunities and accounts for the challenges of implementing the UHC Program, it will need the ongoing input of Department representatives; eligible individuals and family members, providers, advocates, community organizations and others. While our analysis describes how the UHC program might be implemented in the context of Maine's existing LTSS programs, input from key stakeholders could provide more detail and identify both more issues and opportunities.

⁷ As a condition of participating in Medicaid, each state designates a state Medicaid agency with responsibility for administering the state's Medicaid program. In Maine the State Medicaid Agency is the Maine Department of Health and Human Services.

⁸ See, e.g., 42 CFR 431.10: "The Medicaid agency may not delegate, other than to its own officials the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters."

PREFACE

This November, Maine citizens will vote on Question 1, *An Act to Establish Universal Home Care for Seniors and Persons with Disabilities*, a citizen initiative petition appearing on the referendum ballot which would create the Universal Home Care Program.⁹ The proposed legislation underlying the referendum defines key elements of the Universal Home Care Program (the “UHC Program”) including the establishment and governance of a Universal Home Care Trust Fund and a tax that will fund the Trust. In addition, the proposed legislation defines basic parameters for the UHC Program related to program eligibility, covered services, direct care worker payment, and other programmatic elements.

SEIU has retained the Muskie School of Public Service to provide analysis on elements of the referendum related to operationalizing and implementing delivery of benefits as defined in the proposed legislation. The scope of our analysis is limited to consideration of how and to what extent implementation of the UHC Program might impact the existing publicly-funded delivery system for long term services and supports (LTSS) and potential options for implementing the UHC Program assuming varying degrees of integration with the existing State system.

Excluded from the scope of analysis are the following items:

- The proposed funding mechanism for the UHC Program as set forth in Section 4 of the referendum.
- Establishment of the Universal Home Care Trust Fund (UHC Fund), including the underlying authority of the Trust to receive tax and other revenue.
- Selection, election, terms, compensation and underlying authority of the Universal Home Care Trust Fund Board.

The parameters of our analysis are as follows:

- Our analysis is guided by three goals: avoiding unintended consequences, optimizing the use of public resources and advancing a “community first” model of care that promotes living at home when appropriate and preferred.
- As discussed in greater detail in the ANALYSIS section, starting on page 22, our review considers the implications for implementing key elements of the UHC Program (*e.g.*, the eligibility determination process or service coordination function) using different implementation strategies (*i.e.*, a minimal or close coordination with the existing LTSS system).
- For purposes of this analysis, we assume that, if approved, the proposed legislation will be implemented as proposed. We also assume that the legislation mandates some elements of

⁹ The full text of the proposed bill for Question 1 can be found on Maine Department of the Secretary of State’s website for Citizen Initiatives: <https://www.maine.gov/sos/cec/elec/citizens/index.html>.

the UHC Program while leaving the Board discretion as to how other elements will be designed and implemented.

- We assume that the existing design of publicly-funded LTSS programs and services will continue as it is, and that the State will maintain the current level of funding for existing publicly-funded LTSS programs.
- Although the proposed legislation does not exclude participants based on age, this analysis focuses only on eligible adults 18 years and older.¹⁰
- Eligibility for the UHC Program is based on functional criteria (*e.g.*, the need for assistance with a certain activity of daily living), not a diagnosis. The Maine Department of Health and Human Services (Department) has several programs targeted to groups of people with a particular diagnosis (*e.g.*, a brain injury, or an intellectual disability). While persons participating in those other programs might be eligible for the UHC Program, when we discuss coordination between the UHC Program and the Department, we focus primarily on programs that apply functional eligibility criteria (*e.g.*, home and community-based services for older adults and adults with disabilities).

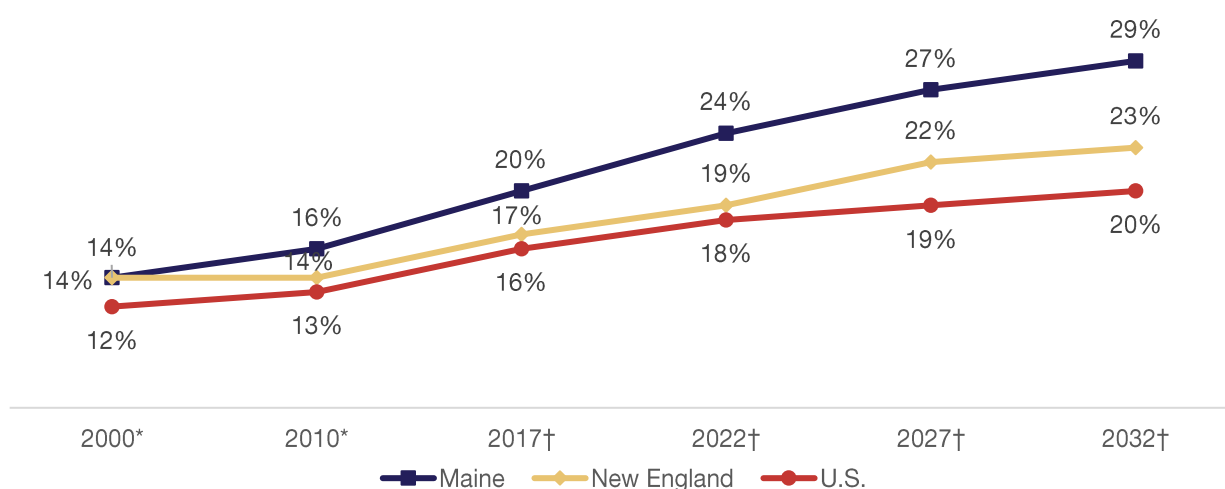
This report is intended as an independent assessment of how the UHC Program could be implemented, within the assumptions and limitations stated above. While we have considered input from the funders, the authors have retained control over the final language and analysis contained herein. This report does not constitute either support for or opposition to the referendum. Nothing contained in this report is intended as legal opinion.

¹⁰ The analysis for implementing this program for children is likely to be similar to the analysis presented here, except that the existing programs for children are very different from those considered here.

BACKGROUND

The percentage of Americans age 65 and older is increasing. In just a little over three decades, from 2000 to 2032, the percent of Americans age 65 and older is projected to almost double from 12 to 20 percent. In Maine, the rate of increase is expected to be even greater; 29 percent of Maine’s population will be age 65 and older by 2032. See FIGURE 1.

FIGURE 1. Historical and Projected Trends in the Percentage of Population 65 and Older, Maine, New England, and the United States, 2000-2032

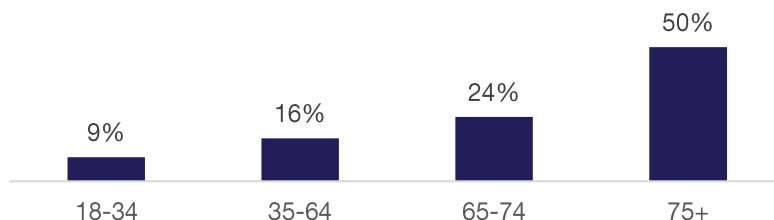


SOURCE: Snow *et al.* 2018.

NOTES: *2000 and 2010 are actual based on census data; † 2017 onward are projected.

Although only a small portion of older adults have a disability at any one time, the rate of disability increases with age. In Maine, for example, only 9 percent of people age 18 to 34 have a disability, while 50 percent of those over 75 have a disability. See FIGURE 2.

FIGURE 2. Percentage of Maine’s Adult Population with a Disability by Age Group, 2015 ACS 5-Year Estimate



SOURCE: Snow *et al.* 2018

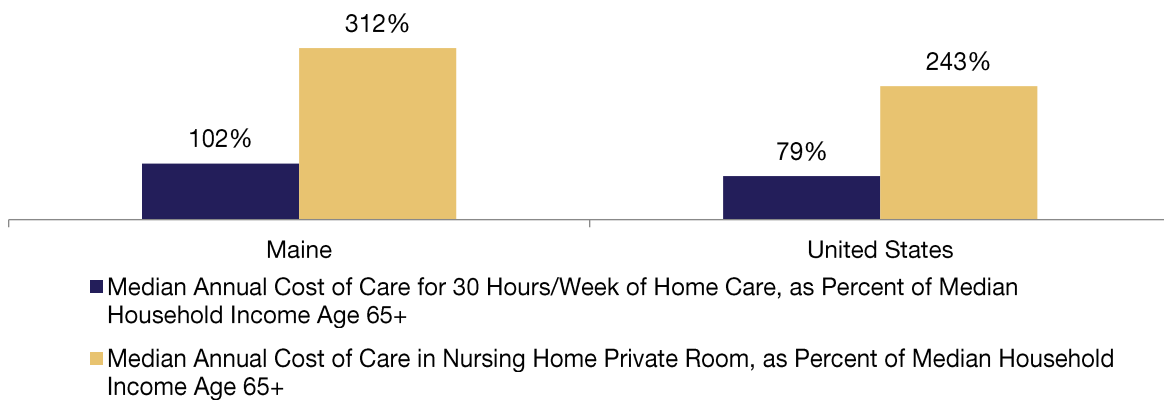
Nationally, an estimated 52 percent of individuals turning age 65 today will eventually need some assistance with an activity of daily living (ADL).¹¹ Family and friends may be able to provide some of that assistance. However, at some point in time 47 percent of this group will need paid services and supports and just under 25 percent will need paid assistance for one year or more (ASPE 2016). Those most likely to need paid supports are women and people who at age 65 have lower income, fair to poor health status and are unmarried (ASPE 2016).

The type of help needed for a person with a disability to live successfully at home will depend on many factors specific to the individual including the type of disability a person has, their health, their economic status, their family and social network, the affordability and accessibility of their home, and the characteristics of the community around them.

Family members play a critical role in providing care nationally and in Maine: 178,000 Mainers were serving as family caregivers in 2013 and provided services worth \$2.2 billion (Houser *et al.* 2018). Family caregivers can experience a negative impact on their own physical and emotional health, financial security, social networks and employment (Reinhard *et al.* 2015). These impacts are generally magnified when caring for individuals with Alzheimer’s disease or other dementia. (Alzheimer’s Association, 2018).

Paying for LTSS out of pocket is unaffordable for most Americans. The high cost of LTSS is a particularly significant issue in Maine, which ranks in the lowest quartile in access and affordability of LTSS (Reinhard *et al.* 2017). The median cost of a private room in a Maine nursing facility is 312 percent of the median household income for Maine’s older adults, while the median cost of 30 hours per week of homecare for a year is 102 percent. See FIGURE 3.

FIGURE 3. Median Private Pay Cost for LTSS as a Percent of Median Income, Maine and US, 2015-2016



SOURCE: Adapted from *Picking Up the Pace of Change: A State Scorecard on Long-term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, by Reinhard *et al.* 2017.

¹¹ Defined as the need for assistance with at least two ADLs expected to last at least 90 days or the need for substantial supervision for health and safety threats due to severe cognitive impairment (ASPE 2016).

Few people have private Long Term Care (LTC) insurance; in 2014, only 11 percent of adults age 65 and older living in community settings were covered by LTC insurance (Johnson 2016). The cost and complexity of LTC insurance, as well as confusion about other coverage options for LTSS, are factors contributing to low utilization (Ujvari, 2018). Many mistakenly believe Medicare will cover LTSS (Benz et al. n.d.).

While federal solutions to creating new models of financing for LTSS have been proposed over the last decade, there has generally not been agreement on a financing approach.¹² The Community Living Assistance Services and Supports (CLASS) Act, originally enacted as Title VIII of the Patient Protection and Affordable Care Act, was ultimately repealed in 2013.

When paid services are needed, public financing has an important role to play. In the United States Medicaid pays for 53 percent of LTSS. See FIGURE 4.

FIGURE 4. Payment Sources for Long Term Services and Supports, United States, 2015



SOURCE: Adapted from *10 Things to Know About Medicaid: Setting the Facts Straight*, by J. Paradise, 2017

Medicaid and State-Funded LTSS

Maine’s current system of publicly-funded LTSS is provided under a fee-for-service system and relies primarily on three funding streams:

Medicaid State Plan

Within the parameters of federal law each state defines Medicaid-funded services, the qualifications of those providing the service, payment, and other program details. The federal regulations specify the range of services that may be funded under the Medicaid state plan, some of which are required and others which may be offered at the option of the State. In-home and community-based LTSS are predominantly accessed under *Consumer Directed Attendant Services* and *Private Duty Nursing and Personal Care Services*.¹³ In addition to in-home and community-based LTSS, Maine also covers nursing facility services and certain services in residential care settings under the Medicaid state plan.¹⁴

¹² See, e.g., the U.S. Senate Commission on Long-Term Care’s Report to Congress, 2013.

¹³ §§12 and 96, respectively, in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Ch.101).

¹⁴ Defined under §67 *Nursing Facility Services*, §97 *Private Non-Medical Institution Services*, and §2 *Adult Family Care Services* in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Ch.101).

Medicaid §1915 Home and Community-Based Services Waiver

To provide states more options for serving people with disabilities in home and community-based settings, the federal government allows states to request a “waiver” of Medicaid state plan requirements. Authorized under §1915(c) of the Social Security Act, the waiver targets home and community-based services to persons who would otherwise need nursing facility services. Maine has several different §1915(c) waivers; for this report we focus on *Home and Community Benefits for the Elderly and Adults with Disabilities*.¹⁵

State-Funded (Non-Medicaid)

Maine uses all state dollars to provide a range of community LTSS, including but not limited to in-home personal care, participant directed care, nursing, therapies, homemaker, adult day, respite and some assisted living services. The State does not receive federal matching dollars for these services.¹⁶ State-funded programs include Maine’s *Home Based Care*, *Consumer Directed Home Based Care* and the *Independent Support Services* (more commonly known as *Homemaker* services).¹⁷

Maine’s funding framework was designed over 20 years ago, early in the evolution of Medicaid-financing for home and community-based services. Although the federal government allows greater flexibility today, at that time a state had a more limited set of tools for using Medicaid to fund home and community-based services. Maine’s combination of LTSS programs were designed to leverage the options available at the time, using these three different funding streams to target those most in need, based on functional, medical and financial need. However, as discussed as part of the ANALYSIS (starting on page 22), each of these funding streams is subject to a different set of requirements, creating differences in eligibility, benefits and provider requirements that can affect individuals moving across differently funded programs when their needs or financial circumstances change.

Medicaid spending on long term services and supports for older adults and adults with physical disabilities in Maine totaled over \$427 million in 2016 (Eiken *et al.* 2018). Nationally and in Maine, the trend has been to reduce the share of LTSS expenditures spent on nursing facility services and shift those resources into the community. In the 1990s, Maine implemented a number of reforms that pushed greater investment in home and community-based services. As indicated in FIGURE 5, in recent years Maine has seen a reverse in that trend. This shift could be explained by a number of factors. For example, it could reflect an increase in nursing facility payment due to rate or case-mix¹⁸

¹⁵ §19 in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Ch.101).

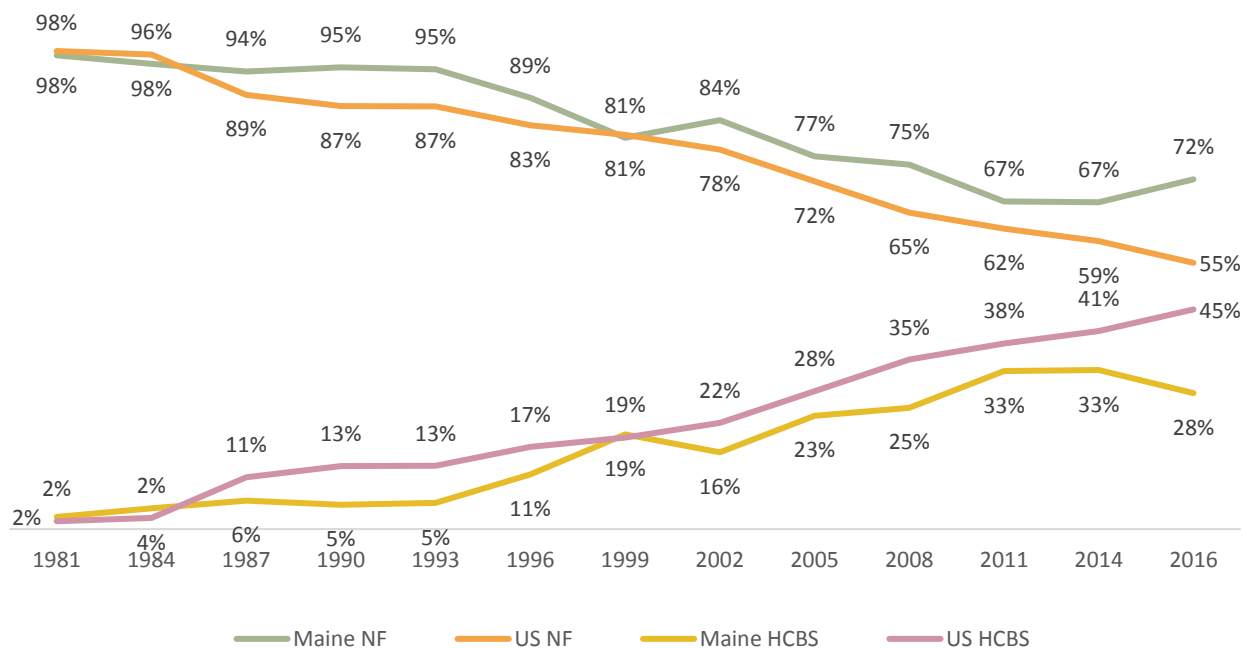
¹⁶ The federal government shares in the cost of Medicaid services. The federal share, based on the Federal Medical Assistance Percentage (FMAP), varies by state and is calculated based on a formula that takes into account a state’s average per capita income. Maine’s FMAP is 64.52 percent for fiscal year 2019. Federal Register, November 21, 2017 (Vol. 82, No. 223), pp. 55383-55386.

¹⁷ These programs are governed under §63 (*In-Home and Community Support Services for Elderly and Other Adults*), §69 (*Independent Support Services*) of the Office of Aging and Disability Services (OADS) Policy Manual (found under 10-149 CMR Ch.5) and Chapter 11, (*Consumer Directed Personal Assistance Services*) of the OADS Policy Manual (found in 10-197 CMR Ch.5).

¹⁸ “Case Mix” is a system that classifies residents into distinct groups based on the resident’s condition and care needs. This classification system is used to determine the daily payment rate the facility charges for the care it provides; those facilities serving higher need residents receive a higher payment rate.

changes, a decrease in the use of home and community-based services because staff are unavailable, a change in the way Maine categorizes its expenditures, or other factors.

FIGURE 5. Nursing Facility and Home and Community-Based Services Expenditures as a Percentage of Total LTSS Expenditures Older Adults and Adults with Disabilities, Maine and US, 1981 – 2016



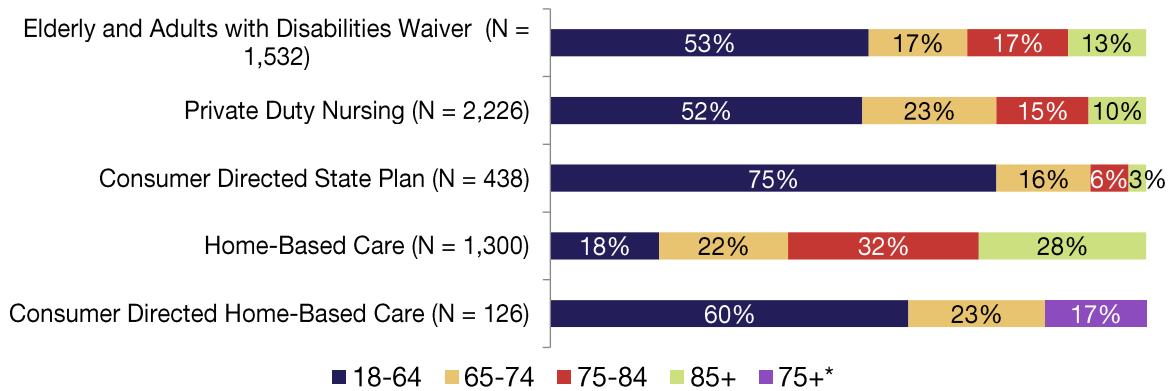
SOURCES: Authors’ analysis of historic LTSS expenditure data (CMS); Eiken *et al.* 2016; Eiken *et al.* 2017; and Eiken *et al.* 2018.

Program Participants, Publicly-Funded LTSS Programs

As discussed in greater detail in the PROGRAM ELIGIBILITY AND COVERED SERVICES section, financial, medical and functional criteria are used to determine service options and eligibility. As a result, there are differences in who is currently served by which existing LTSS program. Nearly half (47 percent) of persons served in Maine’s existing LTSS community programs tend to be younger adults, age 18-64 (Snow *et al.* 2018). Only in Maine’s state-funded *Home Based Care* program do individuals age 85 and older out-number those age 18 to 64. See FIGURE 6. In contrast, almost half of nursing facility and residential care facility¹⁹ residents are age 85 and older (Snow *et al.* 2018).

¹⁹ Residential care services funded under Appendix C in Chapter III, §97, in the MaineCare Benefits Manual (found in 10-144 CMR Ch.101).

FIGURE 6. Age Distribution of MaineCare and State-Funded LTSS Users by Program, Older Adults and Adults with Disabilities, 2016

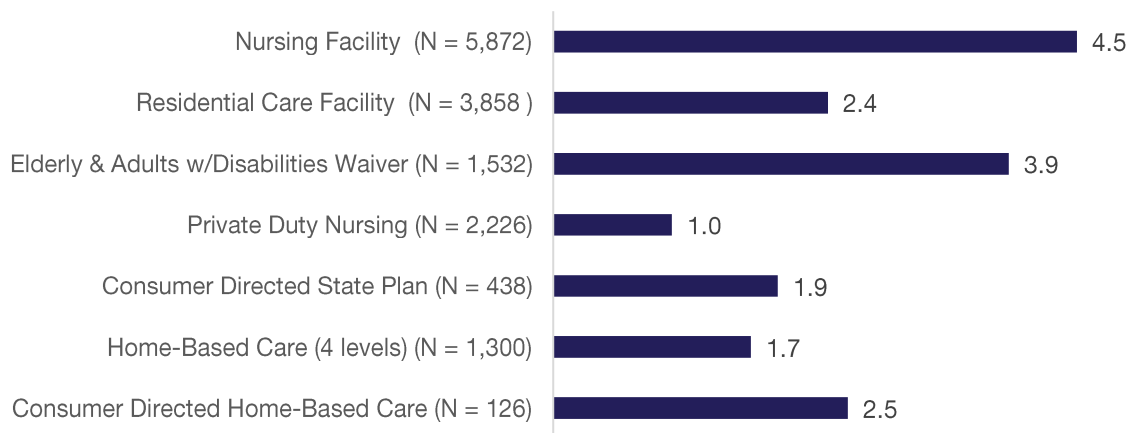


SOURCE: Snow *et al.* 2018.

NOTE: *The 75-84 and the 85+ age groups have been consolidated for the *Consumer Directed Home Based Care* program because there are too few people falling into those age groups; privacy protections prohibit presentation of “small cell sizes.”

Consistent with program eligibility criteria, the need for assistance with ADLs varies by program, with those in nursing facilities requiring the greatest level of assistance; those in the *Elderly and Adults* waiver program also having the highest level of need. See FIGURE 7.

FIGURE 7. Average Number out of Five Activities of Daily Living (ADLs) Requiring Supervision or Greater Levels of Assistance, among Maine Adults Using LTSS, 2016

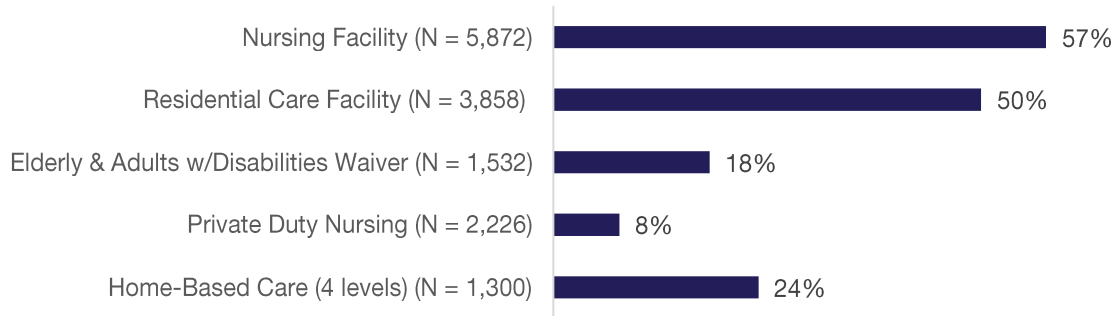


SOURCE: Snow *et al.* 2018.

NOTE: The five ADLs measured include bed mobility, transferring, locomotion, eating, and toileting.

Those using Private Duty Nursing had the lowest reportable percentage of dementia at 8 percent, while those using nursing facility services had the highest at 57 percent. Comparing these settings, persons accessing services at home are far less likely to have dementia. See FIGURE 8.

FIGURE 8. Percentage of Maine LTSS Users who have Dementia by Setting, Older Adults and Adults with Disabilities, 2016

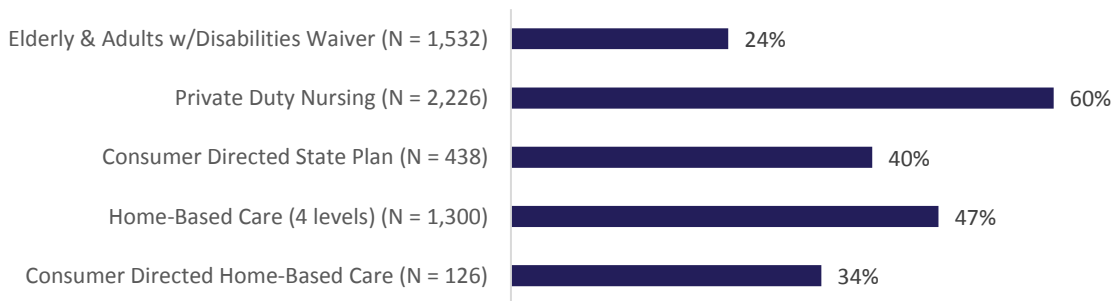


SOURCE: Snow *et al.* 2018.

NOTE: Self-directed programs are omitted; eligibility for self-directed programs is based on cognitive capacity.

Some of Maine’s existing home care programs serve a large number of individuals living alone. See FIGURE 9.

FIGURE 9. Percentage of Maine Community-based LTSS Users Who Lived Alone, by Program, Older Adults and Adults with Disabilities, 2016



SOURCE: Snow *et al.* 2018.

Access to Services

Making sure people have access to the right services at the right time is critical for avoiding unnecessary use of costlier services. For an older person hospitalized to recover from an injury or illness, the “path of least resistance” often leads to a nursing facility or residential care because those are the most commonly known options. Instead, an effective LTSS system makes sure the path of least resistance leads to the right option, whether it be to a nursing or residential care facility, or to home and community-based services. Streamlining access to home and community-based services requires increasing the visibility of information about the service options, how to access them and

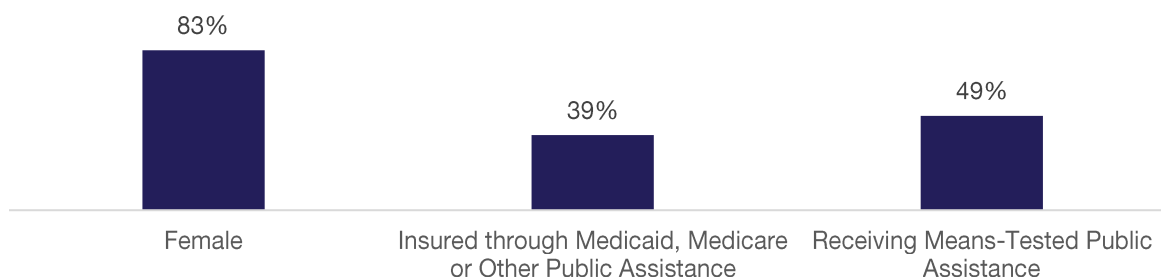
who is eligible; a swift eligibility determination process; and making sure the services are coordinated around the individual, to address needs, preferences and priorities. Maine’s system of access relies on a “no wrong door” approach where information, referral and other enrollment support is provided through a variety of agencies and organizations. See ANALYSIS.

Maine’s publicly funded programs typically require that an individual meet both financial and functional eligibility requirements. Financial eligibility for Medicaid services are determined by the Department’s Office of Family Independence. The organization responsible for determining financial eligibility for state-funded LTSS varies by program. Functional eligibility for most of the publicly-funded LTSS program requires completion of an assessment by a registered nurse. The Department contracts with a single statewide assessing services agency (ASA) to conduct the assessment; for some state-funded LTSS programs, the provider of service also determines functional eligibility. Further context will be provided below as to how Maine’s current delivery system relates to the UHC Program and key elements of enrollment implementation.

The Direct Care Workforce

A “direct care worker” (or a “direct service worker”) is the term used for personal support specialists, home health aides, direct support professionals and other categories of workers who assist people with self-care activities. Maine is currently facing a critical shortage of direct care staff across care settings. Providers have reported as much as 6,000 hours of needed homecare unstaffed each week.²⁰ In a tight labor market, low wages, the lack of benefits and limited opportunities for advancement make direct care work less appealing than other available employment options and impacts retention. In Maine, those who work in home care are primarily female (83 percent); 39 percent are insured through Medicaid, Medicare or another form of public insurance; and 49 percent receive means-tested public assistance. See FIGURE 10.

FIGURE 10. Snapshot of Maine’s Direct Care Workforce



SOURCE: PHI 2017.

NOTE: This analysis uses the 2011-2015 5-Year Public Use Microdata Sample (PUMS) from the American Community Survey (ACS).

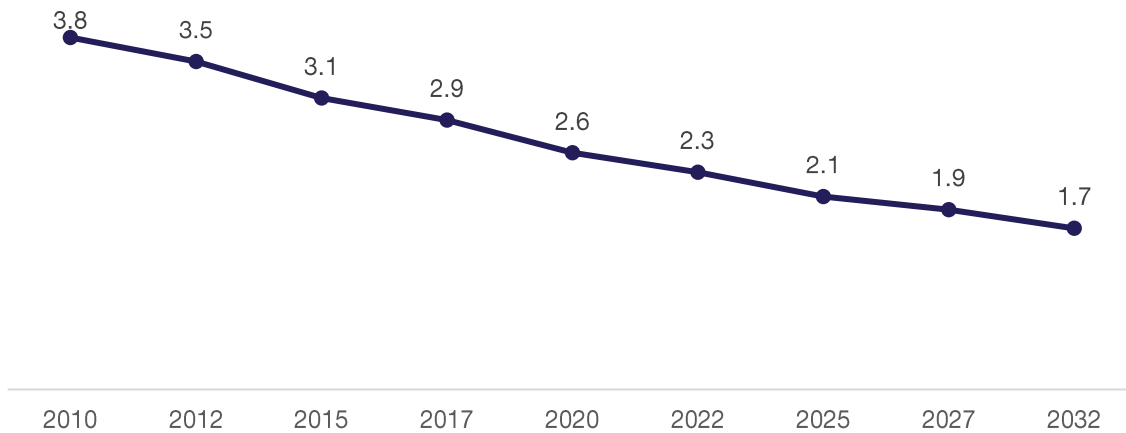
The out-migration of younger adults from many parts of Maine has exacerbated the shortages. Demographic trends suggest this problem will only get worse. As indicated in FIGURE 11, by 2032

²⁰ Maine Council on Aging 2017.

the ratio of working age adults to adults age 65 and up is expected to reach 1.7, less than half of what it was in 2010 (Snow *et al.* 2018).

With or without implementation of the UHC Program, the acute workforce shortage is a growing crisis for Maine. Nationally, states have been engaged in a number of policy reform efforts, including but not limited to direct care workforce initiatives focused on wages and benefits as well as recruitment, training and career advancement.²¹ Maine has recently enacted legislation to establish a Commission to Study Long-term Care Workforce Issues tasked with studying and making policy recommendations for strengthening the direct care workforce.²² As discussed in later sections, it is critical that the UHC Program be implemented in close coordination with the Department, working along with the Legislature and other key stakeholders, to address overall workforce issues and to avoid exacerbating the shortage of workers for those programs serving people with the greatest need.

FIGURE 11. Maine's Historical and Projected Ratio of Working Age Adults (20-64) per Adult Age 65+, 2010 to 2032



SOURCE: Snow *et al.* 2018.

²¹ Cook, A. 2017.

²² LD 1466, voted out as part of LD 925 (An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of Law Necessary to the Proper Operations of State Government, Chapter 460, 128th leg. (2018)).

THE UNIVERSAL HOME CARE PROGRAM

If the legislation is implemented as proposed, the Universal Home Care Program (the “UHC Program”) would provide a range of in-home and community support to eligible individuals and family members. The proposed legislation establishes a Universal Home Care Trust Fund Board to oversee and manage the UHC Fund. Specific UHC Program requirements are to be developed by the Board, which is responsible for adopting rules needed to implement the UHC Program. Key aspects of the proposed legislation are set forth below.

Eligibility and Covered Services

The proposed legislation defines the basic contours of who may access services through the UHC Program, and which services may be offered.

- Eligibility for the UHC Program is defined broadly to include any individual sixty-five years and older, and any individual with a disability,²³ if they live in Maine and need assistance with at least one activity of daily living. The UHC Program relies on a definition of ADLs set forth in the law governing Maine’s Assisted Housing Programs: Activities of daily living mean “tasks routinely performed by a person to maintain bodily functions, including bed mobility, transfers, locomotion, dressing, eating, toileting, bathing and personal hygiene.”²⁴
- Individuals who reside in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, adult family care home or residential care facility,²⁵ are not eligible for the UHC Program.
- Income²⁶ may not be considered when determining eligibility.
- The UHC Program is permitted to offer a range of in-home and community supports, defined as health care and social services and other assistance required to enable adults with long-term care needs to remain in their place of residence. The range of services defined in the legislation²⁷ parallels the services authorized under 22 M.R.S.A. §7302(5), the enabling legislation for the existing publicly funded programs serving adults with LTSS needs.

²³ “Person with a disability” is defined in the proposed legislation as a person with a physical or mental disability as defined in Title 5, Section 4553-A, the Maine Human Rights Act or with a disability as defined in 42 United States Code, Section 12102, the Americans with Disabilities Act (ADA).

²⁴ 22 M.R.S.A. §7852(1).

²⁵ As defined by 22 M.R.S.A. §7852 (14).

²⁶ Typically, program eligibility distinguishes between income and assets. The proposed legislation is silent on the Board’s authority to impose a limit on assets as a condition of eligibility.

²⁷ Section 7281(10) under Section 3 of the proposed legislation defines in-home and community support services as including but not limited to “self-directed care services; medical and diagnostic services; professional nursing; physical, occupational and speech therapy; dietary and nutrition services; home health aide services; personal care assistance services; companion and attendant services; home repair, chore and homemaker services; respite care; hospice care; counseling services; transportation; small rent subsidies; various devices that lessen the effects of disabilities; and other appropriate and necessary social services.”

- Section §7282 under Section 3 of the proposed legislation requires that services be provided at “no cost” to eligible individuals, meaning co-payments or other required contributions are prohibited.
- The UHC Program may not incur expenses in excess of available funds. The proposed legislation contemplates different service levels based on the level of need for assistance with activities of daily living, functional abilities and the need for health and social services of eligible individuals. The Board may create a waiting list if the demand for services exceeds available funds.

Program Administration

The proposed legislation defines the role and responsibilities of the Board and provides some guidance on how the Board may relate to the Department and how the UHC Program might relate to existing LTSS programs.

Board Authority

The proposed legislation grants the Board a set of powers and duties. An abbreviated list of these powers and duties is summarized below:²⁸

*Duties*²⁹

- Design and deliver a home care program.
- Ensure improvements in wages, benefits and working conditions for service providers.
- Create a system for providing stipends to family caregivers.
- Set mandatory standards for quality and safety of in-home and community support services.
- Establish a system for determining eligibility. The Board may not restrict eligibility but may “ramp up” the UHC Program to make services available to the greatest extent possible without curtailing enrollment.
- Manage the UHC Fund to ensure its long-term sustainability.
- Set reimbursement rates for services in a manner that “maximizes access to these services, supports workforce development and ensures service quality.”
- Collect, analyze and disseminate information about the program and the needs of families in Maine, including disparity across race, income, disability and gender.
- Reduce or eliminate disparities in access to services.
- Create a process for assessing an individual’s need for services.
- Conduct outreach to promote public understanding and awareness of the program.
- Report to the Legislature annually.
- Curtail benefits if the UHC Fund is insufficient to cover program costs.
- Take any other action necessary to implement the program, exercise the Board’s powers, and carry out the Board’s duties.

²⁸ See §7284(2) under Section 3 of the proposed legislation for the specific language defining the Board’s powers and duties.

²⁹ Authority is categorized as a “duty” where the legislation uses “shall” to mandate that the Board perform a certain function. Authority is categorized as a “power,” where the legislation uses “may” to permit the Board to perform a certain function.

Powers

- Manage program benefits to ensure the financial health of the UHC Fund.
- Create advisory committees.
- Partner with the Department to provide supplementary funding to existing LTSS programs (including services other than in-home and community supports) to expand eligibility, increase payments to providers, raise quality standards, and maintain a high-quality workforce.³⁰
- Fund initiatives that contribute to the effective use of the UHC Fund, including workforce development, training and quality improvement programs and certifications for direct care workers.

The Board may not expend more than five percent on administrative costs.³¹ The Board is also required to engage in planning with the Department as it develops and oversees the implementation of the UHC Program.³²

Relationship to Department of Health and Human Services

In addition to permitting the Board to partner with the Department to provide supplementary funding, the proposed legislation defines responsibilities for the Department. We focus only on those roles relevant to coordinating the existing LTSS programs with the design and implementation of the UHC Program. These include:

- Creating a simple, unified process for enrollment in coordination with existing programs administered by the Department intended to benefit persons eligible for the UHC Program.
- Submitting a request to the Centers for Medicare and Medicaid Services for any waiver of Medicaid state plan requirements necessary to implement the UHC Program.

In addition, the Commissioner of the Department is a member of the Advisory Committee responsible for reviewing the policies and financial management of the UHC Fund and provides guidance and advice to the Board and its director.

Service Providers

The proposed legislation assumes two models for delivering services:

- *Agency-Based Service Model.* “Direct care service providers” are individuals employed by an agency to provide in-home and community support services.
- *Self-directed Service Model.* “Individual providers” are those providers who work under what is commonly referred to as a self-directed model of care, where the eligible person or the eligible person’s representative is responsible for selecting and directing the worker. Under

³⁰ Using the UHC Fund to supplement Medicaid-funded LTSS provides an opportunity for the Board to increase the purchasing power of the UHC Fund: while a dollar spent on a state-funded (non-Medicaid) program has a dollar’s worth of purchasing power, a state dollar spent on a MaineCare service is the equivalent of about three dollars when combined with the federal contribution.

³¹ See §7284(2)(M) under Section 3 of the proposed legislation. Administrative costs are not defined.

³² See Section 6 of the proposed legislation.

the proposed legislation, individual providers would be considered state employees for the sole purpose of the State Employees Labor Relations Act.³³

The proposed legislation would permit the Board to use the UHC Fund to strengthen the direct care workforce³⁴ through workforce development, training and quality improvement programs.

The proposed legislation also sets a “pass-through” requirement: providers of in-home and community support services participating in the UHC Program must expend a minimum of 77 percent of their reimbursement on direct care costs.

The Number of People Potentially Eligible for the UHC Program

Based on 2016 population estimates, approximately 27,000 people living in the community would be eligible for the UHC Program.³⁵ In 2016, just over 5,600 people were already accessing publicly-funded community-based LTSS. See TABLE 2. We assume those 5,600 people would be counted among the estimated 27,000 eligible individuals and would not be able to access duplicative services through the UHC Program.³⁶

TABLE 2. Number of People in Maine (Age 18 and Older) with Any ADL Need (Estimated) and Already Accessing Community-Based LTSS (Actual) (2016)

AGE GROUP	WITH ANY ADL NEED	ALREADY ACCESSING COMMUNITY-BASED LTSS
18-64	14,000	2642
65+	13,100	2980
TOTAL	27,100	5622

SOURCES: Based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine (See APPENDIX for detail); and Snow *et al.* 2018.

³³ See §7291 under Section 3 of the proposed legislation.

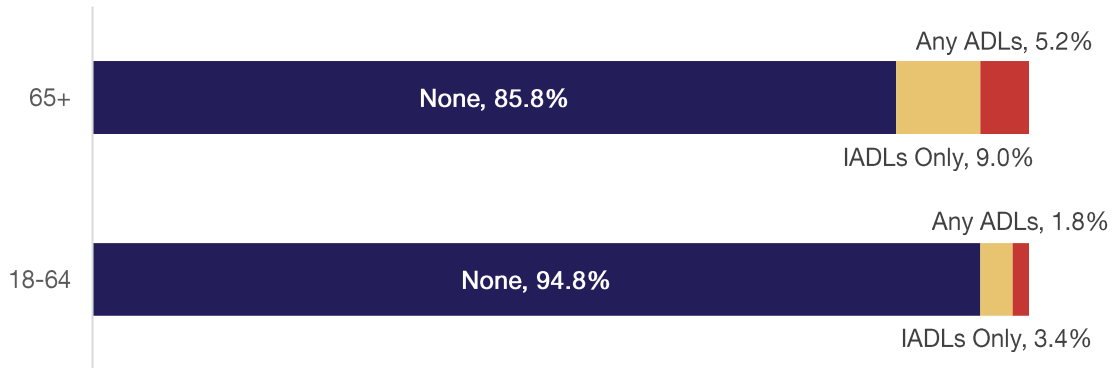
³⁴ The proposed legislation does not specifically define “direct care worker” and could be interpreted to include any type of provider offering some type of in-home or community support. Because “direct care worker” is commonly used to refer to personal support specialists, home health aides, direct support professionals and other categories of workers that provide assistance with ADLs, for this analysis we adopt that definition.

³⁵ It should be noted that these estimates do not exactly replicate the eligibility criteria established under the proposed legislation. In particular, in identifying those potentially eligible we could not replicate the definition of disability identified under the proposed legislation; under the Survey of Income and Program Participation (SIPP), the survey participants self-report on their need for assistance with an ADL, while under Maine’s existing LTSS programs, the need for assistance with an ADL is determined by an independent assessor; the American Community Survey (ACS) does not include people who reside in nursing facilities but our count of those potentially eligible could include people in residential care settings who would not be eligible for the UHC Program.

³⁶ Although, as discussed later, depending on the design of the UHC Program some people enrolled in existing LTSS programs might access nonduplicative services under the UHC Program.

Using Survey of Income and Program Participation (SIPP) data and the 2012-16 ACS 5-year sample in Maine, an estimated 5.2 percent of the population age 65 and up need help with at least one ADL. Less than 2 percent (1.8 percent) of those age 18 to 64 need assistance with at least one ADL. For the full population, approximately 2.6 percent of those age 18 and above need assistance with at least on ADL. See FIGURE 12.

FIGURE 12. Estimated Distribution of the Number of Persons Needing Help with ADLs and IADLs in 2016

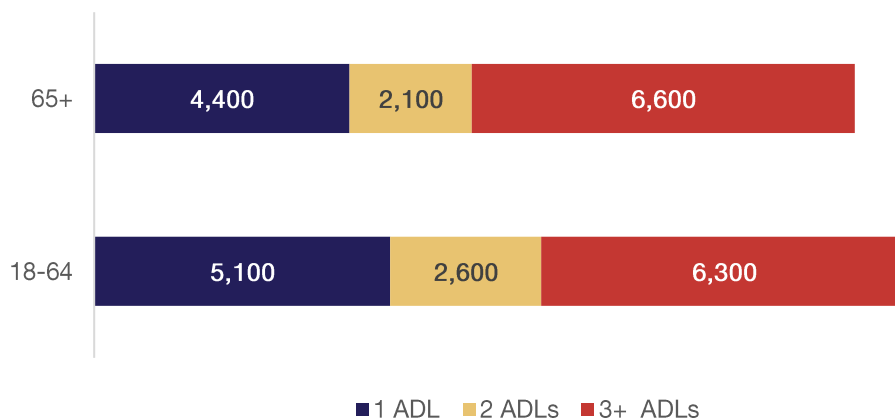


Based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine. See the APPENDIX for detail.

Among those needing assistance with at least one ADL, the level of need varies. As reflected in FIGURE 13, of the estimated 27,100 potentially eligible individuals, an estimated 12,800 (47 percent) need assistance with three or more ADLs, while 9,500 (35 percent) need assistance with only one ADL.

FIGURE 13. Estimated Distribution of the Number of Persons with ADL Needs by the Number of ADL Needs, by Age, 2016

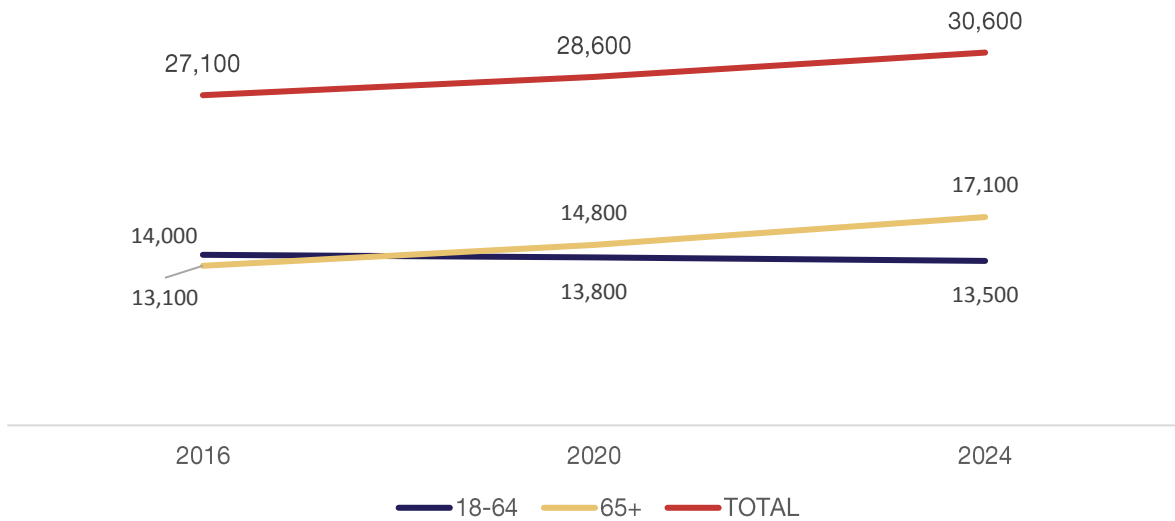
Based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16



ACS 5-year sample in Maine. See the APPENDIX for detail.

The number of people age 18 to 64 needing help with at least one ADL is expected to decline over the next several years, while the number of people at 65 and older with at least one ADL need is expected to grow. By 2020, 28,600 could potentially meet the eligibility criteria for the UHC Program. See FIGURE 14.

FIGURE 14. Estimated Distribution of the Number of Persons Needing Help with One or More ADLs, by Age Group, 2016 – 2024



Based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine, protected forward. See the APPENDIX for detail.

ANALYSIS

This section considers the options the Board would have for implementing the program. For the purposes of this analysis we assume the Board would be governed by the following goals:

- Implementation of the UHC Program will not produce negative unintended consequences for Maine’s existing LTSS programs;
- The use of federal and state dollars, including the UHC Fund, will be optimized; and
- Implementation will advance a “community first” model of care that promotes successfully living at home to help avoid or delay the need for costlier care.

Implementation Strategies

This analysis identifies four broad (but not mutually exclusive) strategies for implementing the UHC Program. Our report will focus on these two primary strategies:

Minimum Coordination Required

We identify the minimum level of coordination required in order to avoid unintended consequences. For example, ensuring parity in worker wages across programs would reduce the likelihood that providers of in-home and community support services would have an incentive to choose one program over another. Coordinating eligibility and enrollment will ensure that people eligible for Medicaid are enrolled in Medicaid and people are receiving the most appropriate service to meet their needs.

Opportunities for Close Coordination

We identify opportunities for optimizing the use of state and federal financing for LTSS in Maine, including the UHC Fund. For example, instead of developing and administering a separate eligibility process, consideration might be given to leveraging those already in place for the existing LTSS programs. The Board could also coordinate with the Department to provide services that “wrap around” Medicaid services. For example, individuals receiving LTSS through Maine’s current Medicaid State Plan services cannot access respite, home modifications, or personal emergency response systems (PERS).³⁷ Program funds could be used to pay for services that are not otherwise available through those programs. The UHC Program could also provide support to individuals on a waitlist for other MaineCare services, providing the individual is eligible for the UHC Program and available services meet their needs. In addition, we identify opportunities where coordination between the Board and the Department could help to promote successfully living at home, when that’s the preferred option.

It would be possible to implement a UHC Program with a mix of both minimally and closely coordinated elements. To the extent possible, our analysis below attempts to capture the range of implementation options along this continuum, and the implications of each.

We do not discuss these two strategies in detail:

³⁷ See *e.g.*, §12 and §96 in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Ch. 101).

A Cash Voucher Program

If the UHC Program were implemented entirely as a Cash Voucher program, rather than a menu of services, all eligible individuals would receive a cash payment to purchase needed supports and services as they saw fit. A cash voucher program might be implemented with few restrictions or it could be implemented to make sure resources are targeted to the people needing them most. The more carefully resources are to be targeted, the more administrative processes are required. For example, the amount of cash might depend on the type or level of assistance needed, meaning applicants would need to have their eligibility assessed and approved. To avoid duplicating coverage under other publicly-funded LTSS, the UHC Program would need to coordinate eligibility with Medicaid and state-funded programs. In addition, to assure that the cash voucher was spent on a particular approved service or support, strong controls and monitoring systems would need to be in place. This option is not fully discussed because certain required elements of the proposed legislation, such as pass-through reimbursement requirements, do not appear consistent with implementation of a Cash Voucher program as the sole means of service delivery.

While we do not analyze the Cash Voucher model on its own, much of the discussion about both a minimally or closely coordinated model could also apply to a Cash Voucher program. Also, a cash voucher for a specific service (*e.g.*, to cover rental subsidies or as a family caregiver stipend) or for individuals with low care needs, could be included as an element of either a minimally or closely coordinated UHC Program, as described below.³⁸

Integration of the UHC Program with MaineCare's LTSS System

If the UHC Program were fully integrated with the existing LTSS system, program monies could be used to supplement the existing Medicaid programs by providing services to a broader pool of those who need them or by enhancing the range of service options available. However, integrating existing LTSS programs with the UHC Program would require some reconciliation between the laws governing each. For example, any level of integration with Medicaid-funded services would need to be consistent with federal regulation governing the State Medicaid Agency's³⁹ permissible delegation of authority and otherwise meet applicable federal requirements.⁴⁰ Federal regulation would restrict the ability of the State Medicaid Agency to delegate certain responsibilities to the Board. In addition, if the UHC Fund were used to support the existing programs, the policies of the existing LTSS programs might need to meet the requirements of the UHC Program (*e.g.*, reimbursement pass-through requirements, and the status of individual providers related to the State Employees Labor Relations Act).

As an example, Maine's §1915(c) waiver for older adults and adults with disabilities (Section 19) provides an array of home and community-based services for individuals who meet Maine's

³⁸ It is also important to consider the impact of cash voucher payments provided to MaineCare members on income definitions for purposes of eligibility.

³⁹ As a condition of participating in Medicaid, each state designates a state Medicaid agency with responsibility for administering the state's Medicaid program. In Maine the State Medicaid Agency is the Maine Department of Health and Human Services.

⁴⁰ See, *e.g.*, 42 CFR 431.10: "The Medicaid agency may not delegate, other than to its own officials the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters."

functional criteria for institutional level of care. This program is capped and can serve up to 1900 individuals. If the number of eligible individuals exceeds this limit, a waitlist is created. Because Maine has set a high eligibility standard for these services, historically there has not been a waitlist. However, should a waitlist occur, a portion of the UHC Fund could potentially be a source of financing for increasing the number of spaces available on the waiver, subject to compliance with all federal requirements. Because federal law restricts the State Medicaid Agency's (*i.e.*, the Department's) ability to delegate certain of its responsibilities, the Department would be responsible for these funds. However, if the UHC Fund contributed to the Medicaid program, it is possible that the Department would have to use those funds consistent with the requirements for the UHC Program.

Integration with Broader Medicaid LTSS Reforms. Over 20 years have passed since the last comprehensive reform of the existing funding structure for Maine's LTSS system. In that time, the federal government has developed new Medicaid policy options aimed at promoting home and community-based services and avoiding the unnecessary use of more expensive service options. To ensure that resources are used effectively, Maine may choose to reevaluate the current structure of its Medicaid LTSS program to improve efficiency and outcomes through service delivery and payment reform. Should the new administration choose to pursue some of these reform opportunities, UHC Funds could potentially support reform efforts.⁴¹ We did not evaluate this strategy because it is not clear what, if any, reform strategies would be considered by the next administration.

Analysis of Implementation Options

The remainder of the ANALYSIS section reviews options for implementing key elements of the UHC program, within the context of Maine's existing LTSS programs, including eligibility and covered services, eligibility determination and enrollment, person-centered planning and care coordination, the agency-based service model, the independent provider service model and quality management. We review some of choices the UHC Board will have in designing the UHC Program and we identify where coordination with the Department is required in order to avoid having a negative impact on existing LTSS programs, as well as opportunities for optimizing program implementation through close coordination with the Department.

⁴¹ See, *e.g.*, §7284(2)(L) under Section 2 of the proposed legislation.

Program Eligibility and Covered Services

Program eligibility standards are tools for making sure that public resources are targeted to those who need them most. For publicly-funded LTSS, a combination of functional, medical and financial criteria are often used for determining eligibility and the scope of benefits or services that can be accessed. Ideally, the combination of eligibility criteria and covered services ensure that the right services are available to the right person at the right time, to help people avoid higher cost nursing or residential care facility services when they are not necessary. Eligibility criteria is also used as a basis for establishing the scope and amount of covered benefits. This section reviews program eligibility and covered services for Maine's existing LTSS programs and outlines factors to be taken into account when implementing the UHC Program in the context of these programs.

Program Eligibility and Covered Services for Maine's Existing LTSS Programs

Program eligibility and covered services for the three LTSS program groups were designed together with the goal of providing access to LTSS to those most in need:

The §1915(c) HCBS Waiver

As required by federal law, eligibility for the §1915(c) waiver is comparable to that required for individuals receiving care in a nursing facility (or intermediate care facility for individuals with intellectual disabilities): among other federal requirements, only individuals who meet institutional level of care may be served under a §1915(c) waiver. Financial eligibility is determined based on income up to 300 percent of the current Supplemental Security Income benefit (\$2,022/month). The §1915(c) waiver for older adults and adults with disabilities⁴² covers care coordination, assistive technology, attendant services, home delivered meals, home health services, living well for better health, matter of balance, personal care services, personal emergency response systems, respite services, transportation services, environmental modifications, and the use of a financial management service (FMS) and skills training for the self-directed option.

Medicaid State Plan

Because Maine has stringent medical and functional criteria for nursing facility services,⁴³ and eligibility for a §1915(c) waiver is tied to those criteria, only a limited portion of those in need of LTSS may access §1915(c) HCBS waiver services. To provide for those with a lower level of functional need, Maine leverages service options under the Medicaid state plan. LTSS services funded under the Medicaid state plan have different thresholds for functional and medical eligibility and vary in scope. While functional eligibility for Medicaid state plan services is more flexible than the waiver, financial eligibility is stricter: only individuals with income up to 100 percent of the federal poverty limit are eligible for Medicaid state plan services. Additionally, Maine's Medicaid state plan provides a more limited menu of LTSS services than the §1915(c) waiver.

⁴² §19 in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Ch.101).

⁴³ Reinhard *et al.* 2017, indicating that nationally, Maine has the lowest percent of residents in nursing facilities with low care needs.

State-Funded Home Based Care Program

Individuals who are not eligible to receive MaineCare LTSS services but who have limited assets may be eligible to receive LTSS services through one of Maine's state-funded (non-Medicaid) programs, subject to available funding. The three largest of these programs in terms of expenditures and individuals served are:

- *Section 63, In-home and Community Support Services for the Elderly and Other Adults (referred to as "Home Based Care")*⁴⁴ provides a range of covered services including but not limited to personal care, nursing, adult day, and home modifications. This program has assets limits, cost of care requirements based on income and serves individuals with a range of ADL needs.
- *Chapter 11, Consumer Directed Personal Assistance Services (CDPAS)*⁴⁵ provides attendant services (personal care), supports brokerage (care coordination), skills training and financial management services. It has cost of care requirements based on income but no asset limit for eligibility and serves individuals with a range of ADL needs.
- *Section 69, Independent Support Services (Homemaker)*⁴⁶ provides assistance with IADLs and incidental personal care up to 8 hours per month. The program has an asset limit and cost of care requirements.

Taken together, these three state-funded programs served approximately 3,800 individuals in 2016.⁴⁷ They provide a continuum of care ranging from homemaker services alone to a more intensive complement of services for individuals needing institutional (nursing facility) level of care. The administering agencies for these programs are procured through a competitive bid process; each agency operates under a contract with the Department.⁴⁸ Because funding is limited by the amount of funding appropriated by the Legislature, waitlists for services can occur for these programs.

Medical and Functional Eligibility. Medical and functional eligibility is determined based on an assessment completed by a nurse. Using a standardized assessment tool, the nurse assesses whether an individual needs nursing services and how frequently, whether an individual needs help with ADLs, which type and how many, and whether an individual needs assistance with instrumental activities of daily living and how many. That information is used to determine whether an individual would be eligible for nursing facility level of care or not, and how many hours of personal assistance or care the individual needs each week. For example, a person with a daily nursing need will meet

⁴⁴ §63 of OADS Policy Manual (found in 10-149 CMR Ch.5).

⁴⁵ Ch. 11 of the OADS Policy Manual (found in 14-197 CMR Ch.11).

⁴⁶ §69 of the OADS Policy Manual (found in 10-149 CMR Ch. 5).

⁴⁷ Wolcott, *An Introduction to the Office and Aging and Disability Services*, Prepared for the 128th Legislative Session, 2017.

⁴⁸ The current administering agencies are EIM, a division of SeniorsPlus (for *Home Based Care*, §63 of OADS Policy Manual (found in 10-149 CMR Ch.5)); Alpha One (for *Consumer Directed Home Based Care*, Ch. 11 of the OADS Policy Manual (found in 14-197 CMR Chapter 11)); and Catholic Charities of Maine (*Homemaker*, §69 of the OADS Policy Manual (found in 10-149 CMR Ch. 5)).

the standard for nursing facility level of care. A person who needs nursing services but less frequently, may qualify for LTSS under the Medicaid state plan or the state-funded *Home Based Care* program, depending on the individual’s financial circumstances. If a person does not need daily nursing services but does need extensive assistance with three of five specific ADLs, the individual requires a nursing facility level of care. Again, a person who needs less extensive assistance with ADLs may be found eligible for LTSS under the Medicaid state plan or the state-funded *Home Based Care* program. The need for assistance with instrumental activities of daily living (IADLs)⁴⁹ may also be taken into account for determining eligibility for a lower level of care.⁵⁰

TABLE 3 provides a snapshot of program eligibility under the existing LTSS programs in comparison to the UHC Program.

TABLE 3. Eligibility and Access by Program

	MEDICAID WAIVER	MEDICAID STATE PLAN	STATE-FUNDED HBC	UHC PROGRAM
Age	18 and up	18 and up	18 and up	65 and up Under 65 with a disability
ADL Need	Minimum of 2	Minimum of 2	Minimum of 1 plus a combination of additional nursing and IADL needs	Minimum of 1
Nursing Need	Always required	Depends on benefit level & number of ADL or IADL needs	Depends on benefit level & number of ADL or IADL needs	Permitted if Board decides to offer nursing services
Income Limit	222% federal poverty level ⁵¹	100% federal poverty level	None	Prohibited
Asset Limit	\$8000/\$12,000	\$8000/\$12,000	\$50,000/\$75,000	Silent
Cost-sharing	Permitted	Copay (services not contingent on copay)	Permitted	Prohibited

⁴⁹ IADLs include meal preparation; routine housework; grocery shopping; laundry and other activities related to living independently.

⁵⁰ An individual who only needs help with IADLs will not qualify for personal care or support services but may qualify for homemaker services, a state-funded program that will help an individual with grocery shopping, preparing meals, household chores and similar activities. *Homemaker* services are considered an important service for helping to delay or avoid the need for more expensive services.

⁵¹ Calculated based on 300 percent of Supplemental Security Income (3 x \$750/month is \$2,250) and the current federal poverty limit for an individual (\$1,012/month): $\$2,250/\$1012 = 222$ percent of the federal poverty level.

Waitlist for Services	Permitted	Not Permitted	Permitted	Permitted
Participation in Other Programs?	Limited to services not covered under waiver (e.g., adult day services)	Limited to services not covered under MaineCare (e.g., emergency response)	Must access MaineCare when MaineCare eligible	May supplement but not supplant other services

As indicated in TABLE 3, an individual must also meet financial eligibility criteria for publicly-funded LTSS and may also be subject to cost-sharing or co-payment requirements depending on the funding source. Though these terms are not always used consistently, they generally require an individual to pay an amount, usually monthly, towards their total cost of services or pay an amount towards a specific service upon receipt of that service. Depending on the particular program and circumstances, these costs can sometimes be waived.

Covered Services. Services available to some or all of those eligible for Maine’s existing LTSS programs include personal care services,⁵² in-home nursing services, physical, occupational or speech therapy, respite, non-emergency medical transportation, assistive devices, home modifications and others. See TABLE 5 for more on covered services.

Personal care is a key service. It involves assisting an individual with activities of daily living, such as getting dressed, bathing, eating, and using the toilet. Depending on an individual’s needs, the type of support might involve physical assistance, monitoring to make sure these activities are completed safely, or reminding an individual to complete an activity. Under Maine’s LTSS programs, personal care or assistance services also include helping with instrumental activities of daily living, such as grocery shopping, household chores, meal preparation, or laundry. Many of Maine’s programs with self-direction allow for assistance with health maintenance activities which can include catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.⁵³

None of the existing LTSS programs designed for older adults and adults with physical disabilities cover protective supervision as a stand-alone service. Protective supervision involves monitoring or observing an individual with a cognitive impairment to protect against injury or other harms.

MaineCare and state-funded LTSS programs are also subject to various program and service limits, some of which are prescribed by federal law⁵⁴ and others are at the discretion of the State, based on

⁵² “Personal care services” is the term typically used in LTSS programs in Maine. Other terms used include “personal assistance services,” “personal attendant services” and “personal support services.”

⁵³ See, e.g. §§ 12 and 19 in Chapter II of the MaineCare Benefits Manual (found in 10-144 CMR Chapter 101); Chapter 11 (found in 14-197 CMR Chapter 11); §63 (found in 10-149 CMR Chapter 5).

⁵⁴ For example, the state must ensure that §1915(c) waiver program costs do not exceed the cost of institutional programs for the same population enrolled in the waiver.

available funding and other considerations. Typically, Maine’s LTSS programs include one or more of the following:

- *Program Caps:* Some programs limit the authorized plan of care to a total monthly dollar amount. Other programs, particularly those providing a limited number of services, set program limits based on a number of total authorized hours. In some cases, the regulations may exclude a particular cost from the program cap.
- *Service Limits:* In addition to program caps, some services may be subject to other limits. For example, under the state-funded *Home Based Care* program, home modifications (e.g., ramps and bathroom modifications) are subject to a \$3,000 lifetime cap, while home modifications under Maine’s §1915 (c) waiver are subject to a \$3,000 annual service limit.

Several of the programs limit the number of hours that can be authorized for assistance with IADLS as part of delivering personal care. See TABLE 4 for more about program and service limits.

TABLE 4. Program and Service Limits

ELIGIBILITY LEVELS	CAP ON EXPENDITURES (PER MONTH)			CAP ON HOURS		
	MEDICAID WAIVER ⁵⁵	MEDICAID STATE PLAN ⁵⁶	HBC ⁵⁷	CD PAS ⁵⁸	CD HBC ⁵⁹	HOMEMAKER ⁶⁰
I	-	\$925	\$1,077	12/week	-	8/month
II	-	\$1,165	\$1,317	18/week	-	-
III	-	\$1,904	\$2,056	28/week	-	-
IV	-	-	\$4,170	-	-	-
Only one level	\$5,000	-	-	-	40/week	-

Note: The Medicaid state plan §96 and the state-funded HBC both have the same service cap, except that the fee paid for care coordination is counted toward the program cap for the HBC program; the Medicaid state plan does not have a similar fee.

⁵⁵ *Home and Community Benefits for the Elderly and Adults with Disabilities*, §19, in Chapter II of the MaineCare Benefits Manual (found under 10-144 CMR Ch.101).

⁵⁶ *Private Duty Nursing and Personal Care Services*, §96, in Chapter II of the MaineCare Benefits Manual (found under 10-144 CMR Ch.101).

⁵⁷ State-funded *Home Based Care*, §63, under the OADS Program Manual (found under 10-149 CMR Ch. 5).

⁵⁸ *Consumer Directed Attendant Services*, §12, in Chapter II of the MaineCare Benefits Manual, 10-144 CMR Ch.101.

⁵⁹ State-funded *Consumer Directed Home Based Care* of the OADS Policy Manual (found under 14-197 CMR Ch.11).

⁶⁰ State-funded *Homemaker*, §69 of the OADS Policy Manual (found under 10-149 CMR Ch.5).

Considerations for Implementing the Universal Home Care Program

When it comes to eligibility for the UHC Program, the Board has very limited authority. It cannot limit eligibility using income criteria, nor require that individuals or families contribute towards the cost of services. Functional and medical eligibility is satisfied by the need for assistance with only one ADL, and the UHC Program considers a relatively broad set of qualifying ADLs to meet that standard.⁶¹

When it comes to eligibility for a particular service, the Board has more discretion. For example, the proposed legislation makes clear that the UHC Program is not required to cover all possible services for all eligible persons. In fact, the Board is prohibited from providing services in excess of available funds. Instead, the Board is authorized to allocate funding or service levels, based on the assessed level of need.⁶² The Board has authority to “curtail benefits as necessary while maintaining eligibility standards.”⁶³ The Board may also create wait lists.⁶⁴ Setting caps and limits on covered services are the primary tools available to the Board to support the appropriate allocation of resources across all eligible individuals in the UHC Program.

The proposed legislation requires that the UHC Program be designed to meet unmet need, supplementing but not supplanting existing programs.⁶⁵ Accordingly, this analysis assumes that individuals who meet the financial and functional requirements for MaineCare services will continue to be served primarily through MaineCare LTSS programs. At the same time, the Board is permitted to partner with the Department to provide supplementary funding to existing state programs. The UHC Program could be designed to provide “wraparound services” for MaineCare beneficiaries to cover services for individuals who need additional services not covered under MaineCare. Alternatively, as discussed in more detail below, UHC funding could be blended into the state-funded HBC program to expand the eligibility and scope of covered services under that program.

Implementation Requirements and Options

While the proposed legislation sets forth broad parameters for eligibility, the Board will need to develop specific criteria for service eligibility as well as the scope and limits of covered services. For example, some of the considerations that relate to eligibility include:

- Defining the ADLs used for service eligibility and establishing the level of assistance required for those ADLs (*e.g.* limited assist or extensive assist).
- Defining specific residency requirements consistent with the requirement that eligible individuals live in Maine.

⁶¹ Personal hygiene, included in the proposed legislation, is typically not an ADL considered for eligibility purposes.

⁶² See §7284(1), in Section 3 of the proposed legislation.

⁶³ See §7284(2)(Q), in Section 3 of the proposed legislation.

⁶⁴ See §7286, in Section 3 of the proposed legislation.

⁶⁵ See §7284(1), in Section 3 of the proposed legislation.

- Specifying whether and to what extent individuals eligible for the UHC Program may be eligible for or participate in other LTSS programs consistent with the language that the UHC Program is “to supplement and not supplant existing programs.”
- Creating eligibility for family caregiver stipends required by the proposed legislation.
- Establishing different levels of eligibility based on “the extent of interference with activities of daily living, functional abilities and the need for health and social services.”
- Establishing criteria for prioritizing service delivery for individuals subject to a UHC Program waitlist (*e.g.*, first come/first served or by level of need).

The Board will also need to determine the specific types of services to be covered by the UHC Program, define those services and develop any needed service or program limits. The Board may choose to define caps on the total service package, place limits on particular services, or use a combination of both.

The Board may want to consider the eligibility and benefit levels associated with the state-funded LTSS programs described above, as a starting point for defining eligibility and covered services under the UHC Program. While key differences exist, these programs serve individuals who are primarily not eligible for Medicaid. Eligibility and covered services under *Section 63 Home Based Care* program were developed within the context of the Medicaid state plan and §1915(c) waiver programs and covered services are very similar to those that can be offered under the UHC Program. (See TABLE 5 for a side-by-side comparison of the scope of services that are and could be covered under Maine’s existing LTSS programs, and the services that could be covered under the UHC Program.)

We do not suggest that the eligibility levels and covered services offered by the state-funded programs be adopted by the UHC Program⁶⁶ but rather that full analysis of those programs, including but not limited to costs of services authorized and actual amount spent, be evaluated as a basis for comparison to the UHC Program, which would have a significantly larger eligible population and funding allocation. This analysis would require access to program information that is currently not publicly available.

For example, based on the projected number of eligible individuals and funding, the Board may want to consider eligibility that falls between the state-funded *Homemaker* services and Level I for the state-funded *Home Based Care* program or offer a limited set of more easily accessible benefits (*e.g.*, a caregiver stipend or limited cash voucher) for those meeting the lowest level of program eligibility.

The Board will also need to consider the extent to which it wishes to provide additional benefits to individuals receiving MaineCare LTSS services, either to provide benefits not otherwise

⁶⁶ Threshold eligibility for the state-funded *Home Based Care* program requires a combination of nursing or IADL needs in addition to assistance with at least one ADL.

available (e.g. family caregiver stipend) or to supplement existing services (e.g. providing respite services).

Thorough attention and analysis will need to be paid to developing strategies for initial implementation of the program to ensure an orderly phase-in of eligibility and service delivery to eligible individuals. Implementation strategies will need to be based on administrative readiness and system and provider capacity.

TABLE 5. Services that May be Accessed through Existing Community-Based LTSS Programs Compared to the UHC Program’s Statutory Authority

Type of Service	MEDICAID WAIVER	MEDICAID STATE PLAN	STATE-FUNDED	UHC PROGRAM Statutory Authority to Cover
	Covered Under Existing Programs			
Assistance with IADLs	Yes	Yes	Yes	Permitted
Assistance with ADLs	Yes	Yes	Yes	Permitted
Nursing Services	Yes	Yes	Yes	Permitted
Nursing Facility Level of Care	Yes	No	Yes	Permitted
PT, OT & Speech	Yes	Yes	Yes	Permitted
Respite	Yes	No	Yes	Permitted
Transportation	Yes	Yes	Yes	Permitted, not specified
Devices	Personal Emergency Response Assistive technology	Durable medical equipment	Personal Emergency Response	Permitted, not specified
Other Covered Services	Adult day Home modifications Medical & diagnostic services under MaineCare Matter of Balance and Chronic	Adult day Medical & diagnostic services under MaineCare	Adult day Home modifications Diagnostic services Handyman/chores Mental health	<i>Permitted:</i> Medical & diagnostic services Handyman/chores Counseling

	Disease Management education programs			
	Meals on Wheels			
Family Caregiver	No	No	Family Caregiver Program for Alzheimer's (OADS)	<i>Required:</i> Stipend
Other Services Permitted But Not Currently Offered⁶⁷				Statutory Authority to Cover
Other Services	<i>Permitted:</i> Caregiver training & education Social supports (e.g., companion services) Other services permitted by statute or approved by CMS		<i>Permitted:</i> Dietary & nutrition Home repair Hospice Rent subsidies Other social services	<i>Permitted:</i> Dietary & nutrition Home repair Hospice Rent subsidies Other social services

A Minimal Level of Coordination with Existing LTSS Programs

Eligibility for the UHC Program should be conditioned on an individual's ineligibility for MaineCare services if comparable services are available and able to be accessed. In this way, Maine can maximize the contribution of federal dollars.⁶⁸

The Board and the Department will also need to coordinate eligibility criteria for state-funded and UHC Programs to avoid potential inequities and other inconsistencies. As an example, the state-funded *Home Based Care* program (Section 63) currently has an asset limit for eligibility (\$50,000 or \$75,000 liquid assets per individual or couple, respectively) and requires cost-sharing based on income. If the UHC Program provides comparable benefits but without a cost-sharing requirement (prohibited under the proposed legislation) potential inequities arise, especially if the *Home Based Care* program is serving individuals with fewer resources than those served under the UHC Program.

⁶⁷ Maine has elected to cover a subset of services that it could offer under its MaineCare and state-funded programs; *i.e.*, Maine has the option of broadening the scope of covered services with funding and, in the case of MaineCare services, approval from the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the Medicaid program.

⁶⁸ The federal government matches every state dollar with approximately two federal dollars, effectively turning each dollar contributed by the State into three dollars of purchasing power within the LTSS system.

To avoid confusion, the Department and Board will also need to determine which state-funded (non-Medicaid) program is the program “of last resort,” *i.e.*, which program must an individual access before the other. The proposed legislation for the UHC Program and the rules for the state-funded programs are both intended to “supplement but not supplant” existing programs.⁶⁹

Opportunities for Close Coordination with Existing LTSS Programs

Design options for closer coordination with existing LTSS programs could include offering services that “wrap around” Medicaid. Under the Medicaid state plan, the primary LTSS offered are personal care (agency and self-directed), private duty nursing and care coordination for those services. Under Maine’s current structure, some important LTSS services are not allowable under the Medicaid state plan (*e.g.*, home modification, respite, personal emergency response system, etc.). The UHC Fund could finance those additional needed “wraparound” services for individuals served on the Medicaid state plan to address the unmet needs of those MaineCare beneficiaries.

Close collaboration might also allow a comprehensive approach in the re-design of the state-funded LTSS programs that has been under consideration for several years.⁷⁰

⁶⁹ See, *e.g.*, Section 63 of the OADS Policy Manual (found under 10-149 CMR Ch. 5): “State funds furnished through 22 MRSA §§ 7301-7306 and §§ 7321-7323 may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section.”

⁷⁰ See *Resolve 2011, Chapter 71 (LD 1461)* which identified specific action items for streamlining Maine’s existing LTSS system to meet all long term care needs within existing resources. One action item included consolidating Maine’s state-funded in-home care and community support services programs.

Eligibility Determination and Enrollment

Navigating the system of long term services and supports can be confusing and even overwhelming for individuals and their families. Individuals may not know the options available to them or even where to start the process of getting information. Because funding for services comes from multiple sources, with different rules and access points, the system tends towards fragmentation, especially for individuals who have multiple support needs (for example, an individual with behavioral health and LTSS needs). Limited information about care choices can lead to limited access and a greater likelihood of suboptimal outcomes for that individual. For example, if a person with an immediate need for services (*e.g.*, someone being discharged from a hospital after a stroke) is not aware of home and community-based service options, that person may think a residential care or nursing facility is their only choice.

To make sure “the right people have the right services at the right time,” the LTSS system needs to have a clear, streamlined process that helps people understand their options and assists with timely access to services.

Eligibility Determination and Enrollment for Maine’s Existing LTSS Programs

Financial eligibility for Medicaid state plan services and the §1915(c) HCBS waiver is determined by the Department’s Office of Family Independence. Financial eligibility for state-funded LTSS is determined by whichever agency has a contract with the Department to administer that program or service.

Medical and functional eligibility for most – but not all – of the publicly-funded LTSS programs requires completion of an assessment by a registered nurse. The Department contracts with a single statewide assessing services agency (ASA) to conduct the assessment; the ASA may not also be a provider of the services the eligible individual would receive.⁷¹ For some state-funded LTSS programs, the provider of service also determines functional eligibility (*e.g.*, Section 69 *Homemaker* program; Section 61 *Adult Day Services* program).

For eligibility determined by the statewide ASA, the assessment is captured in an electronic assessment system. If the individual is eligible and chooses to receive in-home services, a referral is generated to one of the two state-wide service coordination agencies.⁷² Those agencies provide assistance with implementing either agency-based or consumer-directed care as chosen by the individual, facilitate service authorizations to the providers of in-home and community supports, and provide on-going care coordination and monitoring.

Over the past decade, the federal government has focused on “no wrong door” systems that support streamlined access to LTSS options.⁷³ Though Maine has taken advantage of some of these federal

⁷¹ *I.e.*, the ASA must be “conflict free;” it may not be someone with an incentive to score an individual’s assessment in a certain way to influence the amount of services it would be providing to that individual.

⁷² EIM, a division of Seniors Plus or Alpha One.

⁷³ *E.g.*, federal funding to develop Aging and Disability Resource Centers (ADRCs) and federal funding through the Balancing Incentive Payment program.

opportunities, it has not yet achieved a robust and coordinated “no wrong door” approach, in part due to lack of sustainable funding.⁷⁴

Considerations for Implementing the Universal Home Care Program

The Board has a duty to “conduct outreach activities to ensure public understanding of the program and promote awareness of application procedures.” The proposed legislation also requires coordination between the UHC Program and the Department to create “a simple, unified process for enrollment in coordination with the other services provided by the department intended to benefit an eligible person.” As discussed below, the degree of coordination will depend on the choices the Board makes relative to how it designs application procedures and benefits and the degree to which the Board and Department invest in coordination and collaborate with other community-based partners providing information and referral services.

Implementation Requirements and Options

As a new program, the UHC Program will need to invest in significant public outreach and have a clear path for program entry and application. Rather than creating entirely new processes that could further fragment an already complex system, the Board should consider leveraging and investing in access points that already exist and could be strengthened. For example, in addition to coordinating with the Department, the Board may also choose to partner with community organizations that currently provide options counseling and related information and referral services.

While the UHC Program does not set financial criteria for eligibility, there still needs to be a process for determining service eligibility based on the need for assistance with ADLs and other criteria. In designing the assessment instrument and process, the board has a range of significant considerations, including:

- Using a standardized assessment tool that applies consistent and objective standards for determining an individual’s needs;
- How and what information will be captured and system requirements for storage and exchange of information (*i.e.*, use of an electronic system);
- The professional qualifications and training required for individuals to complete assessments;
- Whether the assessment should be completed by someone who is not also a provider of the services the eligible individual would receive;⁷⁵
- The frequency of the assessment and the process for updating the assessment for a change in service need; and

⁷⁴ Maine is ranked 33rd in the nation for how well it coordinates and streamlines access to services, the accessibility of information about services, and how person-centered the process is. See measure of ADRC/No Wrong Door Functions in the AARP’s *Long Term Services & Supports State Scorecard* (Reinhold *et al.* 2017).

⁷⁵ Maine typically requires an independent assessment process. Exceptions include but are not limited to the state-funded *Homemaker* and *Adult Day Services* programs.

- Whether the assessment process will both determine eligibility and authorize a service plan.

A Minimal Level of Coordination with Existing LTSS Programs

A minimal level of coordination with the Department is essential. First, because the proposed legislation requires that the UHC Program “supplement and not supplant existing programs,” coordination across programs is needed to ensure that individuals eligible for Medicaid are enrolled in Medicaid. The Board and the Department will need to coordinate how the UHC Program will identify and refer applicants who are potentially eligible for Medicaid, and whether applications for services will be coordinated through one entry point, with the Department referring applicants who are ineligible for Medicaid to the UHC Program.

In either case, the UHC Program will need to have an ongoing basis for ensuring that, as circumstances change, an individual potentially eligible for Medicaid is referred for a determination of Medicaid eligibility. Because the UHC Program may have more flexibility in program design compared to Medicaid, some UHC Program enrollees may prefer UHC Program services to those available through Medicaid (*e.g.*, the ability to hire a spouse as the self-directed personal services provider might be an option under the UHC Program but is not allowed under Medicaid).

Coordination across enrollment systems is also needed to ensure program integrity: no one should be receiving duplicative services in violation of program rules.⁷⁶ The UHC Program and the Department will have to agree on how they can manage enrollment across programs.

If only minimal coordination is considered, then the Board will need to develop an assessment tool, consider qualifications for vendor organization(s) to perform functional eligibility determinations, and determine the extent to which the assessment process will be separate, or part of, determining the level of services and providing other coordination functions.

Opportunities for Close Coordination with Existing LTSS Programs

Partnerships by and among the UHC Program, the Department and community organizations, such as Maine’s Aging and Disability Resource Centers (ADRCs), and other information and referral systems would allow for the development of a more robust and streamlined system to assist individuals in navigating the LTSS system and understanding service delivery options.

Close coordination with the Department would allow the UHC Program to potentially leverage existing assessment processes and avoid conducting multiple assessments. While considerations would include capacity and added costs for conducting additional assessments, advantages include a streamlined process for individuals, leveraging existing systems and expertise, and facilitating appropriate exchange of information across programs.

⁷⁶ Because the Program may be designed to offer supplemental services to persons enrolled in one of the existing LTSS programs, duplicative enrollment may be possible without duplicating the services provided.

Person-Centered Planning & Care Coordination

Unless the UHC Program is implemented entirely as a Cash Voucher program, individuals will need some level of care coordination to assist with service access and implementation. As states have reformed their delivery and payment systems, increasing focus has been placed on care coordination, especially in the delivery of home and community-based LTSS, to improve beneficiary experience, provide expanded access to necessary LTSS and community supports, and better integrate LTSS with the larger health care system.

Person-Centered Planning and Care Coordination for Maine’s Existing LTSS Programs

In 2014, the Centers for Medicaid and Medicare Services (CMS) promulgated rules defining the requirements for person-centered planning for Medicaid-financed home and community-based services.⁷⁷ The person-centered planning process must consider health and LTSS needs, in a manner that reflects the participant’s preferences and goals. The rule defines requirements relating to the planning process, who participates, and the required elements of a person-centered plan, all with the goal of helping the individual to achieve personally defined outcomes in the most integrated community setting; ensuring the delivery of services in a manner that reflects personal preferences and choices; and contributing to the assurance of the individual’s health and welfare.

Maine’s publicly-funded in-home LTSS provide varying degrees of person-centered planning and care coordination, primarily limited to assisting with implementation of LTSS, monitoring on-going LTSS needs, and providing information and referral on additional resources needed.⁷⁸ Once an eligible individual has been assessed and provided a plan of care, that individual works with a service coordination agency to implement the plan of care. The service coordination agency, through a care coordinator, is responsible, among other things, for monitoring overall health status and following up with identified needs, as well as advocating on behalf of the member for appropriate community resources and services by providing information, making referrals and facilitating access to these supports.

For Medicaid and state-funded LTSS, care coordination is currently provided by two different agencies, both working with agency and self-directed models of care.

	MEDICAID WAIVER	MEDICAID STATE PLAN	STATE-FUNDED	UNIVERSAL PROGRAM
Care Coordination	24 hours per year	18 hours per year	Per Member Per Month (PMPM) fee	Not specified

⁷⁷ *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers.* 79 Fed. Register 2947.

⁷⁸ Some individuals may be eligible for more targeted case management services in addition to LTSS care coordination.

Considerations for Implementing the Universal Home Care Program

Implementation Requirements and Options

The UHC Program does not explicitly require care coordination. However, the Board may consider it important to provide different levels of care coordination, tailored to the needs of those participating in the program. For example, a minimal level of care coordination is needed to help eligible individuals develop and implement a service plan, which might involve educating the individual about available agencies or explaining self-directed care. This minimal level of service – more navigator than care coordinator – may be sufficient for some but others may need a significantly higher level of support to remain in their homes and communities, particularly for those individuals with complex needs. There may be opportunities to provide care coordination in the form of transition assistance to individuals as they move across settings (*e.g.*, from hospital to home). The design of service coordination, including defining the roles and responsibilities of the care coordination agency, will be shaped by participant needs and how closely the UHC Program is coordinated with other programs and delivery systems, including behavioral health services and other community supports. As with many aspects of the UHC Program, developing additional capacity in the existing system for delivery of care coordination services needs to be carefully considered and developed with input from stakeholders and providers.

A Minimal Level of Coordination with Existing LTSS Programs

As some individuals may transition between or among programs, a minimal level of coordination would allow for appropriate exchange of information to mitigate service disruption for individuals, their families and providers.

Opportunities for Close Coordination with Existing LTSS Programs

The more integrated the programs, the greater the opportunities exist for more meaningful care coordination that integrates the full spectrum of a person's needs, although the potential for duplication in care coordination services also exists and would need to be addressed. Opportunities might exist for integration of the UHC program with other LTSS care management systems. Developing additional capacity in the existing system needs to be carefully considered. For example, considering the type of electronic care management system that would be required and whether information on participants might be centralized, for continuity of care as the participant moves from agency to agency or to a different program.

The Agency-Based Service Model

Under the UHC Program, in-home personal care could be delivered through two service models: the traditional agency-based model or through a self-directed model. In an agency-based model, home care agencies employ nurses, social workers and aides to provide in-home care. The home care agency is the employer responsible for hiring, training, supervising and paying workers.

The Agency-Based Service Model in Existing LTSS Programs

Under Maine's existing LTSS programs, individuals may choose to receive LTSS through the traditional agency-based model. Qualifications for Medicaid providers are set by federal law and the state Medicaid agency, including any requirement relating to licenses, certifications and training. For example, agencies providing personal care services must register with Maine's Division of Licensing and Certification pursuant to 22 M.R.S.A. §1717. Specific training and other qualifications for different categories of workers are set within individual program regulation.

For Maine's Medicaid LTSS programs, any qualified and willing provider may enroll with the Medicaid agency.⁷⁹ A care coordination agency enrolled with Medicaid assists the member in choosing a direct care provider and is responsible for submitting service authorizations for provider reimbursement. Provider agencies then submit claims directly to the Medicaid agency through its claims management system and are reimbursed consistent with the service authorizations.

For the state-funded (non-Medicaid) LTSS programs,⁸⁰ the Department contracts with a vendor organization, referred to as the Home Care Coordination Agency (HCCA), through a competitive bid process. The HCCA is responsible for administering the program, including responsibility for managing a statewide network of provider agencies.⁸¹ This means that providers contract directly with the HCCA and all payment and reimbursement to the agencies is managed through the HCCA. The provider network is similar, but not always identical, to the number of providers enrolled as Medicaid providers.⁸² Provider qualifications are set by state regulation and tend to be similar to qualifications required by the Medicaid programs.⁸³

Maine delivers LTSS through a fee-for-service system. The hourly reimbursement rate to the agency provider comprises the worker wages, fringe benefits, and other employee related administrative costs. In Maine, the provider agency receiving payment for services sets the wages for the staff providing services. The reimbursement rates identified in TABLE 6 do not reflect the worker's actual wages.

⁷⁹ The Department contracts with an external vendor to manage provider enrollments.

⁸⁰ §63 of the OADS Policy Manual (found in 10-149 CMR Ch. 5).

⁸¹ The current contract for HCCA services is held by EIM, a division of SeniorsPlus.

⁸² As discussed more fully later, there is no significant difference in reimbursement rates for personal care services between the Medicaid and state-funded programs.

⁸³ For example, both MaineCare and state-funded LTSS programs require services delivered through an agency be provided by an individuals trained as a Personal Support Specialist (PSS) but the timeframe for completing PSS training differs between funding sources (6 months after hire for the State-funded program; 9 months after hire for MaineCare reimbursed programs).

TABLE 6. State Reimbursement to Agency-Based Providers for Personal Support (e.g., Personal Care) Services

PROGRAM	SERVICE	HOURLY RATE
Medicaid State Plan (Sec. 96)	Personal Support Specialist (Agency)	\$18.48
Medicaid §1915 (c) Waiver (Sec. 19)	Personal Support Specialist (Agency)	\$18.48
State-Funded Home Based Care (Sec. 63)	Personal Support Specialist (Agency)	\$18.48
State-Funded Home Based Care (Sec. 63)	Certified Nursing Assistant/Home Health Aide	\$19.60
Medicaid State Plan (Sec. 96)	Certified Nursing Assistant/Home Health Aide	\$19.60

Considerations for Implementing the Universal Home Care Program

Implementation Requirements and Options

The Board has a number of significant responsibilities relating to the workforce providing in-home and community support services. It is responsible for improving wages, benefits and working conditions and setting reimbursement rates to maximize access to services. It is responsible for setting mandatory standards for quality and safety and may fund workforce development, training and quality improvement programs, certifications for direct care workers and partner with the Department on other efforts to maintain a stable, high quality workforce.

The UHC Program also includes a requirement that providers of in-home and community support services shall expend a minimum of 77 percent of the funding received from the UHC Program on direct worker costs, with the remainder of the funds available to be spent on administrative or program support costs.⁸⁴ The Board can look to how other states have implemented wage pass-through requirements, taking into account some of the lessons learned.⁸⁵

In addition, the Board will have a number of practical decisions to make. What standards will it set for provider participation in the UHC Program and what process will it use for confirming provider qualifications? Will it use an “any willing provider” model similar to that used for the Medicaid program and who will be responsible for developing and holding the provider network? Will it delegate to a single coordinating agency or develop multiple administering agencies? The Board will have to consider the costs and needed infrastructure associated with these choices. As discussed below, it could also work with the Department to leverage existing infrastructure and systems to minimize duplication while addressing issues that arise due to the need for increased capacity.

⁸⁴ The proposed legislation does not define “direct care worker costs.” Labor costs are commonly defined as including wages, benefits and payroll tax. Whether “direct care worker costs” are to be defined using this common definition is unclear.

⁸⁵ See, e.g., ASPE 2002; PHI 2003.

A Minimal Level of Coordination with Existing LTSS Programs

Qualified Providers. At a minimum, the Board must consider the standards that currently exist for provider types and qualifications for publicly-funded LTSS. Working to minimize inconsistencies in this area is important for ensuring that personal care agencies and their staff, as well as individual providers, have the ability to easily transition across programs. Differences in training requirements, certifications, and other criteria can create barriers for workers changing jobs and agencies deploying their workers across programs. Program participants are potentially subject to an unnecessary disruption, if a trusted worker can no longer provide services because the participant's circumstances and program have changed.

Provider Reimbursement. It is vital that the Board be highly sensitive to the comparability of service reimbursement affecting worker wages across the UHC Program and the existing LTSS programs, both for in-home and facility-based services as well as programs providing LTSS to other populations (*e.g.*, individuals with intellectual disabilities). Because of critical shortages in the direct care workforce across settings, a lack of parity in rates could create unintended access issues across programs and exacerbate the critical workforce shortage now facing the existing LTSS programs, programs which serve those with the greatest needs. It is essential that the Board, Department and Legislature understand the interrelationships and interdependency of these programs in setting reimbursement rates. Similarly, the Board, Department and Legislature will also need to pay attention to the impact of the pass-through requirements on providers and worker wages to ensure that the effect of these requirements does not create disparities across funding sources that limit access to LTSS.

Opportunities for Close Coordination with Existing LTSS Programs

Whether or not the proposed legislation is approved, Maine already faces a critical workforce shortage that requires a comprehensive and multifaceted approach involving multiple stakeholders. Among other reforms, states have been increasingly focused on strategies that address training and career opportunities as well as wages and benefits. The proposed legislation authorizes the Board to partner with the Department to strengthen and stabilize the direct care workforce. Collaboration could lead to opportunities to effect the broader reforms that are needed to increase stability in the direct care workforce.

The Individual Provider Service Model

In a self-directed model,⁸⁶ the individual being served selects and manages the worker. Depending on the individual, a self-directed model might be preferred because the individual has more flexibility in selecting and training the person that provides their care; others might prefer having an agency be responsible for that. The individual worker is known as an “individual provider.” Nationally, the use of self-directed program enrollment is on the rise.⁸⁷ Key variations in self-directed models include:

- *Employer authority:* Under employer authority, individuals have decision-making authority to recruit, hire, train and supervise the individual providing services.
- *Budget authority:* Under budget authority, individuals (or their representatives) also have decision-making authority to manage expenditures within the limits of an individually specified budget allocation. This may include authority to negotiate hourly wage rates within applicable federal and state requirements.⁸⁸

The Individual Provider Service Model in Existing LTSS Programs

Maine currently has several similar, but distinct, models of self-direction for personal care services, all with varied requirements about the ability to have a representative or surrogate act on the participant’s behalf,⁸⁹ the minimum age of the worker, criminal background requirements, and other program elements. With limited exceptions, program participants may hire family members and friends. While state-funded LTSS programs allow spouses to be paid to provide personal care, MaineCare programs do not.⁹⁰ Individual workers are exempt from training requirements that otherwise apply to agency staff. See TABLE 7.

Typically and in Maine, financial management services (FMS) are provided to individuals who choose to self-direct. The FMS entity pays workers, withholds any federal, state and local taxes and other payments; tracks and monitors self-directed budget expenditures; and assures adherence to federal and state laws and regulations and program requirements. The FMS agency is reimbursed by the State for the care hours delivered and paid to the individual providers and for the administrative services they provide. Other supportive services provided to individuals who self-direct include skills training and care coordination (also called “supports brokerage”) for those who self-direct.

For the most part, individuals in Maine’s self-directed programs set the worker wage within certain limits. Participants in Maine’s §1915(c) HCBS waiver have budget authority and are the employer.

⁸⁶ “Consumer-directed” is also referred to as “self-directed” or “participant-directed.”

⁸⁷ Edwards-Orr & Ujvari 2018.

⁸⁸ National Council on Disability 2013.

⁸⁹ Allowing a representative or surrogate to act on behalf of the participant ensures that individuals with cognitive impairment may also benefit from this type of service delivery. This is currently allowed in several of Maine’s existing LTSS programs including its §1915(c) waiver for elders and adults with physical disabilities.

⁹⁰ In part, this is due to differing federal and state law requirements. See, *e.g.*, 22 MRSA §7307, requiring the Department to allow for payment to relatives unless prohibited by federal law or regulation.

TABLE 7. Comparison of Maine's Self-Directed Programs

TYPE OF SERVICE	MEDICAID WAIVER §19	MEDICAID STATE PLAN §96	STATE FUNDED HBC § 63	MEDICAID STATE PLAN §12	STATE FUNDED CD-PAS CH. 11
Name of Program Option	Participant-Directed Option	Family Provider Services Option	Family Provider Services Option	Consumer Directed Attendant Services	Consumer Directed Personal Assistance Services
Allows use of representative to act on behalf of participant	Yes	Yes, if family member or significant other	Yes, if family member or significant other	No	No
Allows for relatives as paid caregivers	Yes, except for spouses and legal guardians	Yes, except for spouses and legal guardians	Yes, except for legal guardians.	Yes, except for spouses and legal guardians	Yes
Requires participant or surrogate to register as an agency	No	Yes	Yes	No	No
Services included in self-direction option	Personal care and respite	Personal care	Personal care and respite	Personal care	Personal care

The hourly reimbursement rate to the FMS provider comprises worker wages, worker's compensation and other employee related costs. The reimbursement rates identified in TABLE 8 do not reflect the worker's actual wages.

TABLE 8. State Reimbursement Rate to Financial Management Services (FMS) Agency for Self-Directed Personal Attendant Services

PROGRAM	SERVICE	HOURLY RATE
State-Funded Home Based Care FPSO	Personal Care Attendant (FPSO)	\$14.88
MaineCare PDN FPSO	Personal Care Attendant (FPSO)	\$14.88
MaineCare Elder & Adults Waiver PDO	Personal Care Attendant (PDO)	\$13.88
State Plan Consumer-Directed Attendant Services	Personal Care Attendant (self-directed)	\$13.32
State-Funded Consumer Directed Home Based Care	Personal Care Attendant (self-directed)	\$14.04

Considerations for Implementing the Universal Home Care Program

Under the proposed legislation, an "individual provider" is an individual providing in-home and community support services⁹¹ who has been selected by and is working under the direction of a program participant or the participant's representative. An "individual provider" does not include a person providing care as an employee or independent contractor for a provider agency. The Board is responsible for setting reimbursement rates for individual providers, as it is for agency-based providers. The proposed legislation also identifies the individual provider as a state employee for the sole purpose of the State Employees Labor Relations Act.⁹² The State Employees Labor Relations Act governs the right of state employees to be represented by a labor union.

Implementation Requirements and Options

The Participant's Representative. Some, but not all, of Maine's models of consumer direction allow an individual to have a representative manage an individual provider on their behalf. Allowing a representative (or "surrogate") act on the individual's behalf expands access to this type of service delivery for individuals with dementia who otherwise would not meet the capacity (or competency) requirements to self-direct. The Board would need to consider the qualifications required for individuals acting as representatives.

Qualifications for the Individual Provider. The Board is required to set mandatory standards for quality and safety for in-home and community support services, but the proposed legislation does not set limits on who may serve as an individual provider. These requirements would need to be developed. For example, whether spouses would be allowed to provide care, requirements around the need for criminal background checks and any disqualifications; whether any training requirements will be required, etc.

Collective Bargaining. Several states have given individual providers who are paid for providing care under publicly-funded programs the right to collectively bargain with the state. While program participants would have the ability to hire, fire and manage their worker, the reimbursement rate under the proposed legislation would be determined through a collective bargaining process.

A Minimal Level of Coordination with Existing LTSS Programs

As currently constructed, Maine's system for offering self-direction varies and is not consistent across programs and funding sources. Coordination between the Board and the Department would still be required around reimbursement rates and policies to avoid inequities across programs, though individual providers caring for family members may not be as influenced by wage differentials across programs to the extent other workers might be.

⁹¹ "In-home and community support services," as defined under the proposed legislation (§7281(9), under Section 3 of the proposed legislation) is defined broadly to include the full complement of services that could be covered under the UHC Program. For the purposes of this analysis, we assume that the individual provider provides only self-directed personal care or personal assistance services.

⁹² See §7291 under Section 3 of the proposed legislation.

Opportunities for Close Coordination with Existing LTSS Programs

Promoting Increased Use of the Individual Provider Model. The Board and the Department could also work together to support the increased use of self-directed services; for example, some states have developed a statewide registry that allows for the matching of individual providers with individuals needing services. Working in collaboration with the Department would be particularly beneficial for individuals choosing to self-direct their own services, especially to maximize consistency across requirements. For example, options might include:

- Setting consistent qualifications and training requirements for individual providers.
- Permitting the use of a representative who could direct services on behalf of an individual with a cognitive impairment.
- Developing a single skills training curriculum for people participating in self-direction.

Adopting a comprehensive approach for consolidating the existing self-directed service models into a single uniform self-directed model has been a long-standing initiative for Maine's LTSS programs.⁹³

⁹³ See *Resolve 2011, Chapter 71 (LD 1461)* which identified specific action items for streamlining Maine's existing LTSS system to meet all long term care needs within existing resources. One action item included consolidating Maine's self-directed service models.

Quality Management

A quality management system is essential for effective stewardship of public dollars. Quality management is necessary to make sure participants have the best possible outcomes; problems at the individual and systems level are detected and resolved in a timely and effective manner; state and federal requirements are met; efforts are targeted and coordinated with other quality management functions to avoid duplication; and information on performance and quality improvement initiatives is shared with participants, providers, legislators and other stakeholders to inform decision-making. Ensuring beneficiary protections is also a critical component of a strong quality management system.

Quality Monitoring in Existing LTSS Programs

Quality management involves at a minimum:

- Assuring compliance with state and federal requirements. Common compliance efforts focus on assuring that providers are qualified to provide the services (*i.e.*, meet minimum standards for education, licensing or certification, age, etc.) and public resources are used for their intended purpose (as defined under regulation and contract).
- Monitoring and measuring quality to assure that the services paid for with public money meet a minimum standard of quality.
- Establishing a critical incident management system for reporting, tracking and trending of critical incidents, abuse and neglect to assure health and welfare.
- Continuously improving quality to make sure public resources are put to their optimal use.
- Developing processes for receiving and resolving grievances and complaints.
- Integrating robust stakeholder involvement and engagement during design, implementation and as part of on-going operations.

For Medicaid-funded LTSS, the federal government establishes both specific and general requirements for quality. For the §1915(c) waiver, the federal government has established a comprehensive list of quality assurances, a minimum set of standards that states must monitor, measure and report on. Maine has delineated program integrity standards under the MaineCare Benefits Manual, the state regulations governing Maine's Medicaid program. Assuring program integrity involves activities such as provider audits and reviews to ensure compliance with program requirements, including recoupment activities when necessary.

Maine has both internal and external methods for assuring quality. Externally, providers are subject to mandatory reporting for significant events, including but not limited to reports of suspected abuse, neglect, and exploitation. Maine statute also established a Quality Assurance Review Committee (QARC) that includes internal and external stakeholders, including program participants, with an annual reporting to the Legislature.⁹⁴ Maine's Long Term Care Ombudsman has authority

⁹⁴ See 22 M.R.S.A. §5107-I.

to investigate complaints in nursing and residential care facilities as well as from individuals receiving a range of in-home and community LTSS.⁹⁵ Program participants also provide a quality check. The process for receiving and resolving complaints differs across the existing publicly-funded programs, but all appeals of adverse actions are conducted by the Office of Administrative Hearings at the Department.⁹⁶

Considerations for Implementing the Universal Home Care Program

Although the proposed legislation requires some elements of a quality management system, it does not define a comprehensive strategy for quality assurance and quality improvement. This will be another key area for stakeholder involvement, particularly to ensure adequate beneficiary protections.

Implementation Requirements and Options

Under the proposed legislation, the Board is required to:

- Set mandatory standards for quality and safety for in-home and community support services delivered with funding from the UHC Fund, without adversely affecting communities of color or low-wage earners;
- Collect, analyze and disseminate information related to the program and the broader needs of families in the State, as applicable, including measuring and studying disparities in access to relevant services by race, income, disability and gender; and
- In the event the board identifies disparities in access to relevant services by race, income or gender, manage the program so that those disparities are reduced or eliminated.

In addition to meeting these requirements, a comprehensive quality monitoring system would, at a minimum, ensure compliance with UHC Program rules. Other examples of quality monitoring and oversight include:

- Developing a quality management plan that includes defined roles and responsibilities; quality measurement using data to inform program performance and system improvement; and surveys or other forms of input directly from program participants.
- Providing a mechanism for making quality information and metrics easily available to the public consistent with the Board's responsibility to collect, analyze and disseminate information related to the program and broader needs of families in the State.⁹⁷
- Maintaining a system for reporting significant events, including but not limited to reports of suspected abuse, neglect, and exploitation.

⁹⁵ 22 M.R.S.A. §5107-A. The extent to which program services fall under the current statutory authority may depend in part on the structure of the Program as implemented.

⁹⁶ See Administrative Hearing Regulations, 10 144, Chapter 1.

⁹⁷ See §7284(2)(I) in Section 3 of the proposed legislation.

- Developing a system for receiving and resolving grievances (complaints) and a process for appeals.
- Designating an Ombudsman to provide an independent voice for communication and complaint resolution, as well as advocacy at the individual and system level.

A Minimal Level of Coordination with Existing LTSS Programs

At a minimum, for those providers that participate in both the UHC Program and other LTSS programs, the Board and the Department should consider developing protocols for exchanging information about significant issues of non-compliance and in particular, findings that could impact the health and welfare of program recipients.

Opportunities for Close Coordination with Existing LTSS Programs

Close coordination would allow for the development of uniform quality measures and leverage other administrative oversight activities and structures. For example, the UHC Program could leverage the structure of the QARC to include the UHC Program or include UHC Program participants in quality evaluation activities for existing LTSS programs (*e.g.*, the National Core Indicators-Aging and Disabilities (NCI-AD) survey, which assesses the outcomes of LTSS for those served).⁹⁸

⁹⁸ The NCI-AD survey measures a state's performance on a set of core indicators, including service planning, rights, community inclusion, choice, health and care coordination, safety and relationships. It is a useful tool for states to identify opportunities for improvement as well as compare its performance with other states. See <https://nci-ad.org/>.

CONCLUSION

Many would agree that there are opportunities for improving Maine’s capacity for serving older adults and persons with disabilities. In November, Maine voters will have the opportunity to decide whether the UHC Program proposed under Question 1 is the right strategy for investing in Maine’s LTSS capacity.

The UHC Board and Implementation of the UHC Program

If Question 1 is approved, the UHC Program will be the first of its kind in the country. There are no clear guidelines or models or “lessons learned” that can help the Board navigate this new territory. The Board will need to exercise diligence to keep its administrative costs within the five percent limit defined under the proposed legislation. At the same time, the Board will have to allow for start-up costs associated with designing and implementing the UHC Program.

Significant responsibilities have been placed on the Board, and regardless of whether activities are integrated with the Department, or key aspects of the program are contracted out to vendor agencies for management and administration, the Board must be able to account for the efficient and effective use of public resources, compliance with statutory requirements and the quality of services delivered. The UHC Board will need adequate oversight capability and meaningful measures of quality outcomes.

As the Board moves forward with implementation, establishing a robust infrastructure to solicit stakeholder feedback is critical to the UHC Program’s viability and success. The proposed legislation establishes both mandated responsibilities and discretionary powers for the UHC Board. However, even when a responsibility is mandated, in many instances the UHC Board will have discretion on how to fulfill its responsibilities. To develop a thoughtful program design that both leverages the opportunities and accounts for the challenges of implementing the UHC Program, it will need the ongoing input of Department representatives; eligible individuals and family members, providers, advocates, community organizations and others. While our analysis describes how the UHC program might be implemented in the context of Maine’s existing LTSS programs, input from key stakeholders could provide more detail and identify both more issues and opportunities.

Coordination and Collaboration

As we have discussed in the ANALYSIS section, to avoid unintended, negative consequences, implementation of the UHC program would require, at a minimum, a certain level of coordination with existing LTSS programs. For example, the UHC program would need to be designed to avoid inconsistency in eligibility policy and provider qualification and reimbursement that could create unfair differences in access to services or exacerbate workforce shortages for the programs serving those with the greatest need. Processes would need to be coordinated to avoid duplication and confusion for those being served.

We also described a number of opportunities for close collaboration with the existing LTSS programs. For example, in partnership with the Maine Department of Health and Human Services, the UHC Program could join forces to strengthen and stabilize the direct care workforce; provide wraparound LTSS services not allowed under MaineCare to meet the unmet needs of those served

under the Medicaid state plan; develop a more robust and streamlined system to help people access services; and leverage existing infrastructure and systems to avoid building duplicative capacity.

The more the Board coordinates and integrates with the existing LTSS programs, the more questions will arise about how to reconcile the Board's and the Department's roles and responsibilities, and how the programs can come into greater alignment and still comply with their governing authorities. While the Board would need to comply with the proposed legislation, the Department would have to ensure Medicaid-funded programs were consistent with federal regulations governing the delegation of authority by the State Medicaid Agency and other applicable federal requirements.

A collaborative relationship between the Board and the Department could go beyond the goals of efficient use of resources and consistency across programs. Over 20 years have passed since the last comprehensive reform of the existing funding structure for Maine's LTSS system. In that time, the federal government has developed new Medicaid policy options aimed at promoting home and community-based services and avoiding the unnecessary use of more expensive service options. Should the new administration choose to pursue some of these reform opportunities, its chances of success would be strengthened by a partnership between the Board and the Department around the shared goal of improving outcomes for Maine's older adults and adults with disabilities, through improvements to home and community-based services, strengthening and stabilizing the direct care workforce, and better integration with medical, behavioral health and social service delivery systems.

REFERENCES

Alzheimer's Association. (2018). *Alzheimer's disease facts and figures*. Chicago IL: Alzheimer's Association. Retrieved from <https://www.alz.org/media/Documents/facts-and-figures-2018-r.pdf>

Assistant Secretary for Planning and Evaluation Services (ASPE). (2016, February). *Long-term services and supports for older Americans: risks and financing*. Washington, DC: United States Department of Health and Human Services. Retrieved from <https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf>

Assistant Secretary for Planning and Evaluation Services (ASPE). (2002, December). *State wage pass-through legislation: An analysis*. Washington, DC: United States Department of Health and Human Services. Retrieved from <https://aspe.hhs.gov/system/files/pdf/73246/wagepass.pdf>

Centers for Medicare & Medicaid Services (CMS). Medicaid LTSS expenditures, fiscal year (FY) 1981-2014. [Data file]. Retrieved from: <https://www.medicaid.gov/medicaid/ltss/reports-and-evaluations/index.html>

Benz, J., Titus, J., Malato, D., Cancino, A., Tompson, T., Reimer, B., Alvarez, E., Sterrett, D., Kirchhoff, B., Zeng, W., Rajan, J., & Swanson, E. (n.d.) *Long-term care in America: Expectations and preferences for care and caregiving*. Chicago, IL: The Associated Press-NORC Center for Public Affairs Research. Retrieved from <http://www.longtermcarepoll.org/pages/polls/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving-research-highlights.aspx>

Commission on Long-Term Care. (2013). *Report to Congress*. Washington DC: United States Senate. Retrieved from <http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf>

Cook, A. (2017). *Improving job quality for the direct care workforce: A review of state policy strategies*. [Policy brief] The Working Poor Families Project. Retrieved from <http://www.workingpoorfamilies.org/wp-content/uploads/2017/12/Winter-2017-WPFP-Policy-Brief.pdf>

Edwards-Orr, M. & Ujvari, K. (2018). *Taking it to the next level: Using innovative strategies to expand options for self-direction*. Washington, D.C.: AARP Public Policy Institute. Retrieved from <https://www.aarp.org/ppi/info-2018/taking-it-to-the-next-level-using-innovative-strategies-to-expand-options-for-self-direction.html>

Eiken, S., Sredl, K., Burwell, B., & Saucier, P. (2016). *Medicaid expenditures for long term services and supports (LTSS) in FY 2014: managed LTSS reached 15 percent of LTSS spending*. Cambridge, MA: Truven Health Analytics. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>

Eiken, S., Sredl, K., Burwell, B., & Woodward, R. (2017). *Medicaid expenditures for long term services and supports (LTSS) in FY 2015*. Cambridge, MA: Truven Health Analytics. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-expenditures-ffy2015-final.pdf>

- Eiken, S., Sredl, K., Burwell, B., & Amos, A. (2018). *Medicaid expenditures for long term services and supports (LTSS) in FY 2016*. Cambridge, MA: IBM Watson Health. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf>
- Houser, A., Fox-Grage, W., & Ujvari K. (2018). *Across the states: Profiles of long-term services and supports*. Washington, D.C.: AARP Public Policy Institute. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf>
- Johnson, Richard A. (2016). *Who is covered by private long-term care insurance?* Washington, D.C.: Urban Institute.
- Maine Council on Aging. (2017). *Invest in me, invest in care: Valuing Maine's long term care workforce*.
- National Council on Disability (2013). *The case for Medicaid self-direction: A white paper on research, practice and policy opportunities*. Washington DC: National Council on Disability. Retrieved from https://www.ncd.gov/rawmedia_repository/23720a02_e755_42f4_b366_dff166ba0c96.pdf
- Paradise, J. (2017). *10 things to know about Medicaid: Setting the facts straight*. Washington, D.C.: The Kaiser Family Foundation.
- PHI. (2003, April). *State wage-pass through legislation: An analysis*. Workforce Strategies No. 1. Bronx, NY: PHI. Retrieved from <https://phinational.org/wp-content/uploads/legacy/clearinghouse/WorkforceStrategies1.pdf>
- PHI. *Workforce Data Center*. (Website) Last modified November 10, 2017. <https://phinational.org/policy-research/workforce-data-center/>.
- Reinhard, S.C., Accius, J., Houser, A., Ujvari, K., Alexis, J., & Fox-Grage, W. (2017). *Picking up the pace of change: A state scorecard on long-term services and supports for older adults, people with physical disabilities, and family caregivers*. Washington, D.C.: AARP Public Policy Institute. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf
- Reinhard, S.C., Feinberg, L.F., Choula, R., & Houser, A. (2015). *Valuing the invaluable: 2015 update*. Washington, D.C.: AARP Public Policy Institute. Retrieved from <http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf>
- Snow, K., Jimenez F., Gressani, T. and Olsen L. (2018.) *Adults using long term services and supports: Population and service use trends in Maine, state fiscal year 2016*. (Chartbook). Portland, ME: University of Southern Maine, Muskie School of Public Service. Retrieved from <https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1110&context=aging>
- Ujvari, Kathleen. (2018). *Disrupting the marketplace: The state of private long-term care insurance, 2018 update*. Washington, D.C.: AARP Public Policy Institute. Retrieved from <https://www.aarp.org/ppi/info-2018/disrupting-the-marketplace-the-state-of-private-long-term-care.html>

University of Washington's Rural Health Research Center. (2013). 2010 Rural-urban commuting area codes. [Data file]. Retrieved from <https://www.ers.usda.gov/data-products/rural-urban-commuting-areacodes.aspx#.U9lO7GPDWHo>

Wolcott, G. (2017). *An introduction to the Office of Aging and Disability Services: prepared for the 128th legislative session*. Augusta, ME: Maine Department of Health and Human Services.

APPENDIX

Population Estimates - Methodology

The initial 2014 estimates of the number of Maine adults requiring another person's help with one or more Activities of Daily Living (ADLs) are based on data from two U.S. Census Bureau surveys: one, a nationwide survey with detailed questions on a variety of disability measures; and the other, the Maine-specific portion of a survey on broader characteristics.⁹⁹

During the summer of 2010, the Census Bureau's nationwide Survey of Income and Program Participation (SIPP) asked each of 66,410 adults if he or she had difficulty, or needed another person's help with a variety of individual Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) among other disability measures.¹⁰⁰ The Bureau's continuous, on-going American Community Survey (ACS) covers a much broader variety of issues and participant characteristic, including a small number of broad questions on disabilities. However, the much larger size of the ACS survey sample is big enough to provide a useful subset for each State. The Maine subset of the 5-year, 2012-2016 sample includes responses from 52,278 adults living in non-institutional settings.

The Bureau provides de-identified, person-level Public-Use Microdata Samples (PUMS) for each survey. The microdata samples allow the user to view each survey respondent's full set of answers to every question (excluding questions like town or date of birth that might help identify a given participant).

Both surveys include data on age, family income relative to the Federal Poverty Level (FPL), and the SIPP also includes an identical set of the same broad disability questions appearing in the ACS. This allowed us to merge the detailed disability data in the SIPP with the Maine-specific data in the ACS by:

1. Dividing each survey's sample into matching sets of 120 population cells defined by age group, income category relative to the FPL, and the pattern of answers to three of the broad disability questions common to both surveys. See TABLE 9.
2. For each population cell in the SIPP survey, calculate the percentage of survey respondents needing another person's help with: 1 ADL, 2 ADLs, 3 to 6 ADLs, IADLs only, or no ADLs or IADLs.
3. We assume that adults sharing similar characteristics in both surveys will share similar probabilities of having different levels ADL or IADL need. For example, if 20% of low-income persons in the SIPP survey, who were age 65-to-74 and gave a yes answer to all three of the shared disability questions said they needed another person's help with one ADL, then we assume about 20% of the Maine adults who gave the same answers in the ACS will

⁹⁹ U.S. Census Bureau, 2012-2016 American Community Survey (ACS) 5-Year Public Use Microdata Sample (PUMS).

¹⁰⁰ U.S. Census Bureau, Survey of Income and Program Participation (SIPP) 2008 Panel Wave 6 Topical Module Microdata File (conducted between May 2010 and August 2010).

also require assistance with one ADL. Using that assumption, we apply the percentages calculated for a given population cell in in step 2 to the Census Bureau’s ACS-based estimate of the number of Mainers sharing the same characteristics and repeat the process across all 120 population cells.

- Our 2014 results table divides the adult Maine population into three income categories and two age groups (age 18 to 64 and age 65 and above).¹⁰¹ So, for the first line in the table, we take all the population cells with ages between 18 and 64 and with incomes below the FPL and add up the total number of persons at each disability level.

TABLE 9. Defining characteristics for population cells in both surveys

AGE GROUPS	INCOME ¹⁰²	SELF-CARE DIFFICULTY	AMBULATOR Y DIFFICULTY	INDEPENDENT LIVING DIFFICULTY
18 to 34	Less than FPL	Does [X] have difficulty with dressing or bathing? (Yes/No)	Does [X] have serious difficulty walking or climbing stairs? (Yes/No)	Because of a physical, mental, or emotional problem, does [X] have difficulty doing errands alone such as visiting a doctor’s office or shopping? (Yes/No)
35 to 54	100% to 221% of the FPL			
55 to 64	222% or more of the FPL			
65 to 74				
75 and above				

To produce disability prevalence tables 2016, 2020 and 2024 we applied age-specific population growth rates derived from Maine population estimates and forecasts provided by Woods and Poole Economics, Inc.¹⁰³ The forecast for Maine’s population growth varies tremendously by age. It predicts that between 2014 and 2024 Maine’s 65-to-74 and age 75-and-above age groups will have both increased by more than 40% while the 55-to-64 group remains unchanged and the number of younger adults goes into decline.

The reader should keep in mind that numbers presented in the tables are estimates. The limitations of the available data dictate a variety of assumptions. Our estimates assume that:

- Maine’s age and income-adjusted disability rates are the same as the national age and income-adjusted disability rates estimated by the SIPP survey;
- Age and income-adjusted disability rates will remain steady over time and we make no allowance for medical discoveries or new assistive devices that could decrease rates, or

¹⁰¹ We chose 2014, because it represents the mid-point of the 2012 - 2016 ACS survey.

¹⁰² We defined the income categories to match the income criteria for general MaineCare eligibility (income less than the FPL), and the MaineCare eligibility limit for nursing home or long-term services and supports (up to 221% of the FPL).

¹⁰³ Population growth rates are based on the 2017 New England edition of population forecasts published by Woods & Poole Economics, Inc. Washington, D.C. Copyright 2018. Woods & Poole does not guarantee the accuracy of this data. The use of this data and the conclusion drawn from it are solely the responsibility of the Muskie School of Public Service at USM.

changes in lifestyle, disease prevalence and environmental factors that could affect rates either way;

- Maine will see no increase or decrease in the distribution of incomes relative to the Federal Poverty Level; and
- We will see no changes in government policy or economic conditions affecting the number of persons moving into or out of the state.

Population Estimates - Detail

2014

Estimated distribution of the *number* of persons needing help with ADLs and IADLs in 2014 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	95,500	9,200	5,300	1,900	1,200	2,200	110,000
65+	15,700	2,900	1,800	800	300	800	20,500
Subtotal	111,200	12,100	7,200	2,700	1,500	3,000	130,500
Persons with family incomes between 100% and 221% of the FPL							
18-64	157,500	9,300	4,700	1,600	800	2,300	171,500
65+	52,500	8,000	4,300	1,500	900	1,900	64,900
Subtotal	210,000	17,300	9,100	3,100	1,700	4,300	236,300
Persons with family incomes at-or-above 222% of the FPL							
18-64	511,300	9,200	4,100	1,600	700	1,800	524,500
65+	132,900	10,700	6,300	1,800	900	3,600	149,900
Subtotal	644,200	19,900	10,400	3,400	1,600	5,400	674,400
Persons with family incomes > 100% FPL							
18-64	668,700	18,500	8,800	3,200	1,500	4,100	696,000
65+	185,500	18,700	10,600	3,300	1,800	5,500	214,800
Subtotal	854,200	37,200	19,400	6,600	3,200	9,600	910,800
All Incomes							
18-64	764,200	27,700	14,100	5,100	2,700	6,300	806,100
65+	201,200	21,600	12,500	4,200	2,000	6,300	235,200
TOTAL	965,400	49,300	26,600	9,300	4,700	12,600	1,041,300

NOTE: Any differences between the Subtotal and the sum of the two age groups are due to rounding.

2014

Estimated distribution of the *percentage* of persons needing help with ADLs and IADLs in 2014 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	86.8%	8.4%	4.8%	1.8%	1.1%	2.0%	100.0%
65+	77.0%	14.1%	9.0%	3.9%	1.2%	3.9%	100.0%
Subtotal	85.2%	9.3%	5.5%	2.1%	1.1%	2.3%	100.0%
Persons with family incomes between 100% and 221% of the FPL							
18-64	91.8%	5.4%	2.7%	0.9%	0.5%	1.4%	100.0%
65+	81.0%	12.3%	6.7%	2.4%	1.3%	3.0%	100.0%
Subtotal	88.9%	7.3%	3.8%	1.3%	0.7%	1.8%	100.0%
Persons with family incomes at-or-above 221% of the FPL							
18-64	97.5%	1.7%	0.8%	0.3%	0.1%	0.3%	100.0%
65+	88.7%	7.2%	4.2%	1.2%	0.6%	2.4%	100.0%
Subtotal	95.5%	2.9%	1.5%	0.5%	0.2%	0.8%	100.0%
Persons with family incomes > 100% FPL							
18-64	96.1%	2.7%	1.3%	0.5%	0.2%	0.6%	100.0%
65+	86.4%	8.7%	4.9%	1.6%	0.8%	2.6%	100.0%
Subtotal	93.8%	4.1%	2.1%	0.7%	0.4%	1.1%	100.0%
All Incomes							
18-64	94.8%	3.4%	1.8%	0.6%	0.3%	0.8%	100.0%
65+	85.5%	9.2%	5.3%	1.8%	0.9%	2.7%	100.0%
TOTAL	92.7%	4.7%	2.6%	0.9%	0.4%	1.2%	100.0%

2016

Estimated distribution of the *number* of persons needing help with ADLs and IADLs in 2016 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	94,700	9,200	5,300	1,900	1,200	2,200	109,100
65+	16,900	3,000	1,900	900	300	800	21,800
Subtotal	111,500	12,200	7,200	2,800	1,500	3,000	130,900
Persons with family incomes between 100% and 221% of the FPL							
18-64	155,900	9,300	4,700	1,600	800	2,300	169,800
65+	56,000	8,300	4,600	1,600	900	2,000	68,900
Subtotal	211,900	17,600	9,200	3,200	1,700	4,300	238,700
Persons with family incomes at-or-above 222% of the FPL							
18-64	506,600	9,100	4,100	1,600	700	1,800	519,800
65+	142,900	11,200	6,600	1,900	1,000	3,700	160,700
Subtotal	649,500	20,400	10,600	3,500	1,600	5,500	680,500
Persons with family incomes > 100% FPL							
18-64	662,400	18,400	8,800	3,200	1,400	4,100	689,600
65+	198,900	19,600	11,100	3,500	1,900	5,700	229,600
Subtotal	861,300	38,000	19,900	6,700	3,300	9,900	919,100
All Incomes							
18-64	757,100	27,500	14,000	5,100	2,600	6,300	798,700
65+	215,800	22,600	13,100	4,400	2,100	6,600	251,400
TOTAL	972,900	50,100	27,100	9,500	4,800	12,800	1,050,100

NOTE: Any differences between the Subtotal and the sum of the two age groups are due to rounding.

2016

Estimated distribution of the *percentage* of persons needing help with ADLs and IADLs in 2016 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	86.8%	8.4%	4.8%	1.8%	1.1%	2.0%	100.0%
65+	77.3%	13.8%	8.9%	3.9%	1.2%	3.8%	100.0%
Subtotal	85.2%	9.3%	5.5%	2.1%	1.1%	2.3%	100.0%
Persons with family incomes between 100% and 221% of the FPL							
18-64	91.8%	5.5%	2.7%	0.9%	0.5%	1.4%	100.0%
65+	81.3%	12.1%	6.6%	2.3%	1.3%	3.0%	100.0%
Subtotal	88.8%	7.4%	3.9%	1.3%	0.7%	1.8%	100.0%
Persons with family incomes at-or-above 221% of the FPL							
18-64	97.5%	1.8%	0.8%	0.3%	0.1%	0.3%	100.0%
65+	88.9%	7.0%	4.1%	1.2%	0.6%	2.3%	100.0%
Subtotal	95.4%	3.0%	1.6%	0.5%	0.2%	0.8%	100.0%
Persons with family incomes > 100% FPL							
18-64	96.1%	2.7%	1.3%	0.5%	0.2%	0.6%	100.0%
65+	86.6%	8.5%	4.8%	1.5%	0.8%	2.5%	100.0%
Subtotal	93.7%	4.1%	2.2%	0.7%	0.4%	1.1%	100.0%
All Incomes							
18-64	94.8%	3.4%	1.8%	0.6%	0.3%	0.8%	100.0%
65+	85.8%	9.0%	5.2%	1.7%	0.8%	2.6%	100.0%
TOTAL	92.6%	4.8%	2.6%	0.9%	0.5%	1.2%	100.0%

2020

Estimated distribution of the *number* of persons needing help with ADLs and IADLs in 2020 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	92,800	9,000	5,200	1,900	1,200	2,100	107,000
65+	19,700	3,400	2,200	1,000	300	900	25,400
Subtotal	112,500	12,400	7,400	2,900	1,500	3,100	132,400
Persons with family incomes between 100% and 221% of the FPL							
18-64	152,700	9,100	4,600	1,500	800	2,300	166,400
65+	65,600	9,400	5,200	1,800	1,000	2,300	80,100
Subtotal	218,200	18,500	9,700	3,400	1,800	4,600	246,500
Persons with family incomes at-or-above 222% of the FPL							
18-64	497,200	9,000	4,000	1,600	600	1,800	510,200
65+	167,900	12,700	7,400	2,200	1,100	4,100	188,000
Sub-Total	665,000	21,700	11,400	3,800	1,700	5,900	698,200
Persons with family incomes > 100% FPL							
18-64	649,800	18,100	8,600	3,200	1,400	4,000	676,600
65+	233,400	22,100	12,600	4,000	2,100	6,500	268,100
Subtotal	883,200	40,200	21,200	7,100	3,500	10,500	944,700
All Incomes							
18-64	742,600	27,100	13,800	5,000	2,600	6,200	783,500
65+	253,200	25,600	14,800	5,000	2,400	7,400	293,500
TOTAL	995,800	52,700	28,600	10,000	5,000	13,600	1,077,100

NOTE: Any differences between the Subtotal and the sum of the two age groups are due to rounding.

2020

Estimated distribution of the *percentage* of persons needing help with ADLs and IADLs in 2020 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	86.8%	8.4%	4.8%	1.8%	1.1%	2.0%	100.0%
65+	77.6%	13.6%	8.8%	3.9%	1.2%	3.7%	100.0%
Subtotal	85.0%	9.4%	5.6%	2.2%	1.1%	2.3%	100.0%
Persons with family incomes between 100% and 221% of the FPL							
18-64	91.8%	5.5%	2.8%	0.9%	0.5%	1.4%	100.0%
65+	81.8%	11.8%	6.4%	2.3%	1.3%	2.9%	100.0%
Subtotal	88.5%	7.5%	4.0%	1.4%	0.7%	1.9%	100.0%
Persons with family incomes at-or-above 221% of the FPL							
18-64	97.4%	1.8%	0.8%	0.3%	0.1%	0.4%	100.0%
65+	89.3%	6.8%	3.9%	1.2%	0.6%	2.2%	100.0%
Subtotal	95.3%	3.1%	1.6%	0.5%	0.2%	0.8%	100.0%
Persons with family incomes > 100% FPL							
18-64	96.0%	2.7%	1.3%	0.5%	0.2%	0.6%	100.0%
65+	87.1%	8.3%	4.7%	1.5%	0.8%	2.4%	100.0%
Subtotal	93.5%	4.3%	2.2%	0.8%	0.4%	1.1%	100.0%
All Incomes							
18-64	94.8%	3.5%	1.8%	0.6%	0.3%	0.8%	100.0%
65+	86.2%	8.7%	5.0%	1.7%	0.8%	2.5%	100.0%
TOTAL	92.5%	4.9%	2.7%	0.9%	0.5%	1.3%	100.0%

2024

Estimated distribution of the *number* of persons needing help with ADLs and IADLs in 2024 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	90,400	8,800	5,100	1,800	1,100	2,100	104,300
65+	22,700	4,000	2,600	1,200	300	1,100	29,300
Subtotal	113,200	12,800	7,700	3,000	1,500	3,200	133,600
Persons with family incomes between 100% and 221% of the FPL							
18-64	149,100	8,900	4,500	1,500	800	2,200	162,500
65+	76,300	11,000	6,000	2,100	1,200	2,700	93,300
Subtotal	225,400	19,800	10,500	3,600	1,900	4,900	255,700
Persons with family incomes at-or-above 222% of the FPL							
18-64	485,500	8,700	3,900	1,600	600	1,700	498,100
65+	192,300	14,700	8,500	2,500	1,300	4,700	215,500
Subtotal	677,700	23,400	12,500	4,100	1,900	6,500	713,600
Persons with family incomes > 100% FPL							
18-64	634,600	17,600	8,400	3,100	1,400	3,900	660,600
65+	268,600	25,600	14,500	4,600	2,400	7,500	308,700
Subtotal	903,200	43,300	22,900	7,700	3,800	11,400	969,300
All Incomes							
18-64	725,000	26,400	13,500	4,900	2,500	6,000	764,900
65+	291,300	29,600	17,100	5,800	2,800	8,600	338,100
TOTAL	1,016,300	56,000	30,600	10,700	5,300	14,600	1,103,000

NOTE: Any differences between the Subtotal and the sum of the two age groups are due to rounding.

2024

Estimated distribution of the *percentage* of persons needing help with ADLs and IADLs in 2024 based on 2010 data from the Survey of Income and Program Participation (SIPP) and the 2012-16 ACS 5-year sample in Maine

AGE GROUP	NONE	IADLS ONLY	ANY ADLS	1 ADL	2 ADLS	3+ ADLS	TOTAL POP.
Persons with family incomes below the FPL							
18-64	86.7%	8.4%	4.8%	1.8%	1.1%	2.0%	100.0%
65+	77.5%	13.6%	8.9%	3.9%	1.2%	3.8%	100.0%
Subtotal	84.7%	9.6%	5.7%	2.2%	1.1%	2.4%	100.0%
Persons with family incomes between 100% and 221% of the FPL							
18-64	91.8%	5.5%	2.8%	0.9%	0.5%	1.4%	100.0%
65+	81.8%	11.7%	6.4%	2.2%	1.3%	2.9%	100.0%
Subtotal	88.2%	7.8%	4.1%	1.4%	0.8%	1.9%	100.0%
Persons with family incomes at-or-above 221% of the FPL							
18-64	97.5%	1.8%	0.8%	0.3%	0.1%	0.3%	100.0%
65+	89.2%	6.8%	4.0%	1.2%	0.6%	2.2%	100.0%
Subtotal	95.0%	3.3%	1.7%	0.6%	0.3%	0.9%	100.0%
Persons with family incomes > 100% FPL							
18-64	96.1%	2.7%	1.3%	0.5%	0.2%	0.6%	100.0%
65+	87.0%	8.3%	4.7%	1.5%	0.8%	2.4%	100.0%
Subtotal	93.2%	4.5%	2.4%	0.8%	0.4%	1.2%	100.0%
All Incomes							
18-64	94.8%	3.5%	1.8%	0.6%	0.3%	0.8%	100.0%
65+	86.2%	8.8%	5.1%	1.7%	0.8%	2.5%	100.0%
TOTAL	92.1%	5.1%	2.8%	1.0%	0.5%	1.3%	100.0%

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