UNIVERSITY OF SOUTHERN MAINE

Charting a Pathway Forward

Redesigning and Realigning Supports and Services for Maine's Older Adults

Prepared by the Muskie School of Public Service for the Maine Health Access Foundation

September 2017

Eileen Griffin & Elizabeth Gattine

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MeHAF
Maine Health Access Foundation

About MeHAF

MeHAF is Maine's largest private nonprofit health foundation dedicated to promoting access to quality healthcare, especially for those who are uninsured and underserved, and improving the health of everyone in Maine. To learn more about MeHAF, please visit www.mehaf.org.

University of Southern Maine
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The Muskie School of Public Service is Maine's distinguished public policy school, combining an extensive applied research and technical assistance portfolio with rigorous undergraduate and graduate degree programs in geography-anthropology; tourism and hospitality; policy, planning, and management; and public health. The school is nationally recognized for applying innovative knowledge to critical issues in the fields of sustainable development and health and human service policy and management, and is home to the Cutler Institute for Health and Social Policy.

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CHARTING A PATHWAY FORWARD

THE CHALLENGE

By 2025, over a quarter of Maine's population is expected to be age 65 and older. As we age, many of us will need help with the basic activities of daily living.

[25%] *The percent of people turning age 65 between 2015 and 2019 projected to need more than one year of paid support over the remainder of their lifetime.*
Assistant Secretary for Planning and Evaluation Services, 2016.

Many of us will not be able to afford that help on our own.

[312%] *In Maine, the median cost of a private room in a nursing facility as a percent of median household income for older adults.*
Reinhard *et al.* 2017.

[102%] *In Maine, the median cost of 30 hours/week of home care for a year as a percent of median household income for older adults.*
Reinhard *et al.* 2017.

SETTING THE COURSE

How can we make sure that public resources are put to their optimal use to make sure that as we age we are able to live healthy, active, secure and engaged lives no matter the type of support we might need?

- What are the most cost-effective strategies for making living at home—the preferred option for most people—a reality whenever possible and preferred?
- When living at home is not an option, what are the best alternatives and how can we make sure we invest in them wisely?

Local Communities and Regional Social Services Providers can provide a critical set of low-cost supports that can help to reduce the need for higher cost services: A local housing authority might marshal volunteers to help with home repairs, forestalling the need to move. A Meals on Wheels home delivery might include a scan to make sure the heat is on, the house is safe and the older adult has what he or she needs.

Long Term Services and Support can coordinate their care and services to improve outcomes and efficiency. Successfully integrated care could help to minimize the unnecessary use of high cost medical services and long term care. Integrating care requires close collaboration among medical providers, social services, long term services and supports providers, communities and families.

State Level Policy Levers can be used to update and reform the types of long term services and supports available to older adults, drive reform of the delivery system and support community-level efforts to help older adults living at home.

THE FIRST LEG OF THE JOURNEY

Support Family Caregivers

Family caregivers are the backbone of support for older adults.

[178,000] *The number of Mainers who served as family caregivers in 2013.*
Reinhard *et al.* 2015.

[$2.2 billion] *The annual value of services Maine family caregivers provide to their parents, spouses and other adults.*
Reinhard *et al.* 2015.

Strengthen the Direct Service Workforce

Maine has a critical shortage of direct service workers, exacerbated by a tight labor market, low pay, a lack of benefits and limited opportunities for advancement.

[6,000] *Hours of homecare need unstaffed each week.*
Maine Council on Aging, 2017.

[53%] *Percent of direct care worker households in Maine relying on means tested public assistance, 2012-2014.*
PHInternational, 2017.

Create New Supports for Those Most at Risk

We need new strategies for helping those at risk of self-neglect and social isolation, particularly those living alone and those with cognitive impairments or behavioral health needs.

Create Affordable Housing Options

Many older adults in Maine need more affordable options.

[21%] *The percent of Maine adults age 55 and older for whom the cost of housing consumed more than 30 percent of their household income in 2012.*

[15,000] *Projected shortfall of affordable housing units for low income older adults in 2022.*
Henry *et al.* 2015.

Address Disparity

We need to ensure that those at greatest risk—particularly the most rural and economically disadvantaged parts of Maine —do not fall through the safety net.

GETTING TO OUR DESTINATION

Redesign the Delivery System

To set strategic priorities for the most cost-effective allocation of public financing, we need to forecast geographic shifts in Maine's population and determine the right level of investment across the continuum of in-home, residential and nursing facility services.

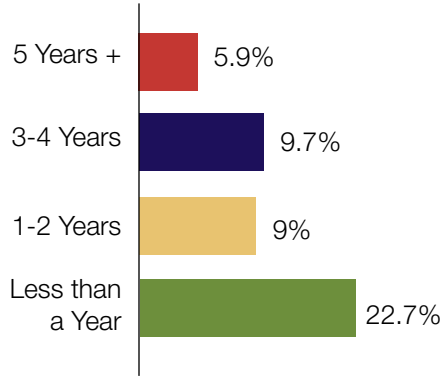
Realign the Payment and Delivery of Services

Integrating the delivery system cannot succeed without fundamentally realigning the incentive system. That means payment reform that rewards providers for successful outcomes rather than the number of services they provide, and outcome measures focused on older adults living healthy, active, secure and engaged lives at home.

Mobilize Communities

Optimizing resource use at the local level means reorienting key stakeholders around a community-level outcome, rather than program or provider level outcomes. Local government and state government can benefit from active community volunteer networks and should find ways to support them.

Projected Use of Paid LTSS for Persons Turning 65 in 2015-2019



Adapted from "Long-Term Services and Supports for Older Americans: Risks and Financing," by Assistant Secretary for Planning and Evaluation Services, 2016.

THE NEED FOR REALIGNMENT

The current growth of the population age 65 and older is one of the most significant demographic trends in the history of this country and is especially significant for Maine, where the number of people age 65 and older is growing even faster than the rest of the nation. By 2025, over a quarter of Maine's population is expected to be age 65 and older (Snow *et al.*, n.d.).

As we age, most of us plan to continue doing the things that we have always enjoyed—being with friends and families, living in our own home or apartment, working or enjoying our hobbies and interests. However, with age the rate of disability increases. At some point the need for assistance is necessary for many: estimates range from 52 to 70 percent of individuals turning age 65 today will eventually need some form of long term assistance with their activities of daily living. (U.S. Department of Health and Humans Services, 2017; Reinhard *et al.,* 2017). For many, family and friends are able to meet those needs. When that is not possible, paid services and supports will be needed, whether at home, in another type of residential setting, or in a nursing facility. Because the cost of long term paid support is out of reach for many Mainers, public financing—particularly Medicaid financing—is an essential tool for addressing the long term support needs of older adults. In Maine, Medicaid spending on long term services and supports for older adults and adults with physical disabilities totaled almost $400 million in 2015 (Eiken *et al.,* 2017). But Medicaid is only one tool, not enough to get the job done. As Maine prepares itself for increasing demand on public resources, it needs to use those resources as cost-effectively as possible by finding new ways to use Medicaid, leveraging and supporting the power of community, and fostering cost-effective innovations to make living at home—the preferred option for most people—a reality whenever possible. This brief provides a snapshot of Maine's older adults, the primary service options in place now, and the key policy levers available for ensuring that public resources are put to their optimal use to make sure that, as we age, we are able to live healthy, active, secure and engaged lives no matter the type of support we might need.

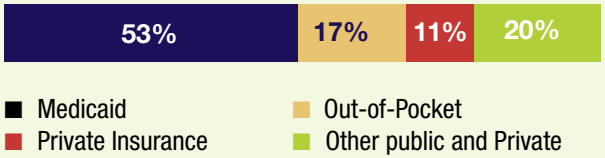
Financing Long Term Services and Supports (LTSS) and the Role of Medicaid

Long-term services and supports (LTSS) provide persons with functional limitations or chronic conditions the assistance they need with the basic activities of daily living (including eating, bathing, and dressing) and living independently (such as preparing meals, managing medication, grocery shopping, and housekeeping). These services can be provided in a private home, another community setting or in a nursing facility. Long term services and supports may also include adult day programs, home health aide and nursing care, residential care and nursing facility services, transportation, respite, home modifications and a range of other types of services and supports.

Among adults over 40, nearly four out of ten erroneously assume that Medicare pays for long term services and supports; only two in ten expect to rely on Medicaid as they age (Benz *et al.*, n.d.). While Medicare pays for limited home health and skilled nursing facility services after a hospital stay, it does not cover those services on a long-term basis. Medicaid—in Maine, known as MaineCare—is the largest payment source for long term services and supports. Medicaid plays an especially critical role in Maine: we rank in the bottom quarter of all states nationally for affordability and access for LTSS (Reinhard *et al.,* 2017).

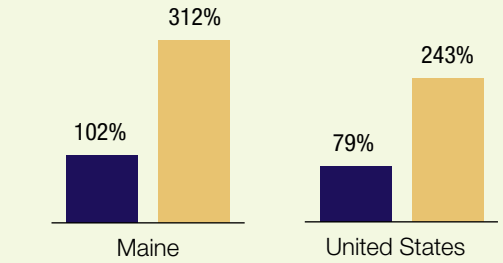
Because Medicaid is the largest source of LTSS financing, its program design and policies have played a major role in shaping the delivery system and the services that are provided. More significantly, Medicaid also has the leverage to drive reform—many states are using their Medicaid programs to realign provider payment and service delivery in order to advance improvements in care and outcomes.

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



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

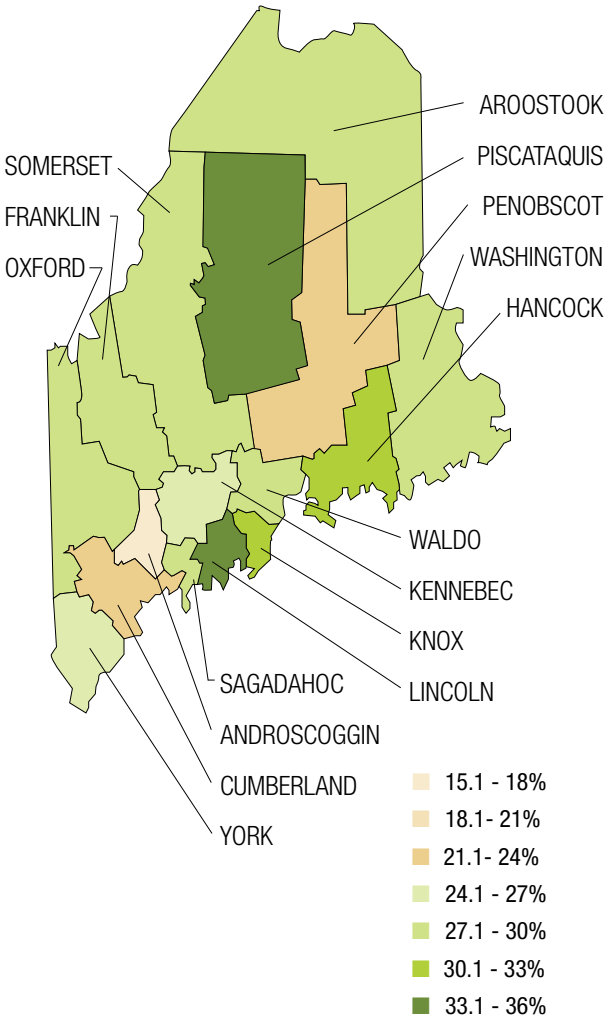
Median Private Pay Cost for LTSS as a Percent of Median Income, Maine and US



- Median Annual Cost of Care for 30 Hours/Week of Home Care, as Percent of Median Household Income Age 65+
- Median Annual Cost of Care in Nursing Home Private Room, as Percent of Median Household Income Age 65+

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 S.C. Reinhard *et al.,* 2017.

Projected Percent of Maine's Population 65+, 2025



Adapted from "Adults Using Long Term Services and Supports: Population and Service Use Trends in Maine, State Fiscal Year 2014" by K.I. Snow *et al.,* n.d.

PROFILE OF MAINE'S OLDER ADULTS

Aging does not necessarily lead to disability. However, many of us may develop one or more chronic health conditions or functional impairments as we age and those that do may eventually need help performing some of the basic activities of daily living. Others of us have a disability before reaching an older age, either because we were born with one or acquired it as a result of an injury or health condition. This section provides a snapshot of some of the factors that influence the need for long term services and supports and profiles Maine's older adult population based on those characteristics that are associated with the need for those services.

Maine's Aging Demographics

By 2025, 26 percent of Maine's population is projected to be age 65 and older. In Lincoln and Piscataquis counties older adults will account for 35 percent of the population (Snow *et al.,* n.d.). Maine's median age is the oldest in the country (44.6 years in 2015) and is projected to increase, with the projected population loss for other age groups, especially working age adults between ages 18 and 54, contributing to Maine's disproportionate share of older adults.

The Social Determinants of Health

Poor health can precipitate the onset of disability, increasing the need for long term services and supports. While the causes of poor health are varied, increasingly the link between health and certain social, economic and environmental factors, termed the "social determinants of health," is recognized. For example, people with low income and low educational levels tend to experience poorer health than those at higher levels. Social isolation is associated with increased rates of falls, coronary heart disease, stroke, suicide and depression (Ciolfi & Jimenez, 2017). The social determinants of health are also associated with whether or not an individual with needs for long term services and supports will have those needs met (Allen *et al.,* 2014).

The social determinants include:

- Income
- Employment status
- Housing
- Education
- Food insecurity
- Social inclusion

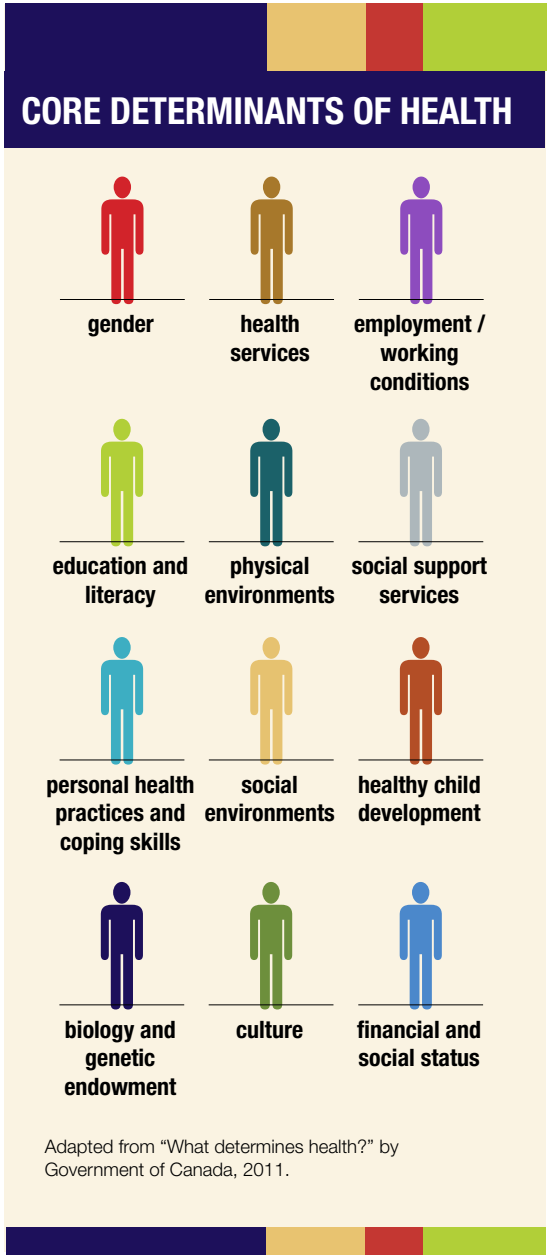
A high level snapshot of Maine counties indicates that some face more challenges than others when it comes to measures of health and social status, with Aroostook, Piscataquis, Somerset and Washington counties falling into the lowest ranking for several measures. See table on page 10.

Factors Associated with Long Term Service Support Use

Projecting the use of public and private expenditures for long term services and supports depends on many factors, including individual characteristics, health and disability status, personal resources, proximity to amenities, availability of community-level services and supports, and access to information and needed health services and providers. Among individual characteristics and circumstances, research has identified a number of factors associated with a higher likelihood of nursing facility admission. A recent study in Maine identified age as the primary predictor of nursing facility admissions, with individuals age 65 and older representing 90 percent of all MaineCare admissions to nursing facilities for long-term stays. That study also indicated that a majority of nursing facility admissions were precipitated by a hospitalization frequently due to a chronic condition, falls or fractures, or dementia (Smith *et al.,* 2017). This study, and other research, have identified the following factors associated with nursing facility admission:

- Age
- Certain chronic conditions (including diabetes, high blood pressure, cancer, and stroke)
- The need for assistance with three or more activities of daily living (ADLs)
- Cognitive function
- Living alone
- Homeownership

Gaugler *et al.,* 2007; Miller & Weissert, 2011; Kinosian *et al.* 2000.



Adapted from "What determines health?" by Government of Canada, 2011.

A Snapshot of Health and Social Status by County

COUNTY	Total Population	Percent Rural	Percent Reporting Fair or Poor Health	Percent Below Poverty	Percent with Less Than Bachelor's Degree	Percent Unemployed	Percent Food Insecure	Percent Living in Stressed Housing	Percent Reporting Inadequate Social Supports
ANDROSCOGGIN	107,393	43	14	11	86	5	16	35	18
AROOSTOOK	70,005	80	17	13	88	4	17	27	18
CUMBERLAND	286,119	36	10	8	73	4	14	37	14
FRANKLIN	30,402	83	13	9	84	5	14	29	17
HANCOCK	54,658	90	11	10	80	5	15	32	16
KENNEBEC	121,112	63	13	9	85	5	14	30	15
KNOX	39,723	68	11	8	79	4	13	37	18
LINCOLN	34,156	100	11	8	81	3	13	33	17
OXFORD	57,421	83	15	11	88	5	15	33	20
PENOBSCOT	153,437	58	14	11	84	5	16	33	16
PISCATAQUIS	17,156	100	15	13	88	5	17	30	19
SAGADAHOC	35,092	62	12	9	79	4	13	32	14
SOMERSET	51,577	80	16	13	89	6	16	33	21
WALDO	38,976	91	13	11	81	5	15	35	16
WASHINGTON	32,191	92	16	13	86	5	17	30	21
YORK	199,682	57	12	6	80	4	13	37	16

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NOTES: "Housing Stress" is defined as the percent of houses with one or more housing conditions: 1) housing unit lacked complete plumbing; 2) housing unit lacked complete kitchens; 3) household is overcrowded; and 4) household is cost burdened (Community Health Statistic Indicators, 2015).

SOURCES: For Total Population, Below Poverty, Less Than Bachelor's Degree, and Unemployed, 2011-2015 American Community Survey 5-Year Estimates; For Rural and Poor or Fair Health. 2017 County Health Rankings; for Food Insecure, Map the Meal Gap 2017; for Stressed Housing, and Inadequate Social Supports, Community Health Statistics Indicators, 2015.

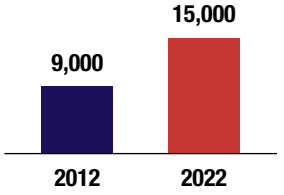
National studies also suggest that older adults living in rural areas may be at greater risk of admission to a nursing facility than their urban counter parts (Coburn *et al.,* 2016). Maine ranks sixth in the country for the highest incidence of cancer (U.S. Cancer Statistics Work Group, 2017). An estimated 64 percent of older adults in Maine have two or more chronic conditions (CMS.gov, 2017b). County level data provide a high level snapshot of other factors related to nursing facility admission. These data indicate that some counties face more challenges than others, with several counties falling into the lowest rankings for multiple measures. See table on page 12.

Living at Home

Health and functional status are only some of the factors that play a role in making it possible for a person to remain in his or her own home and community. Even with paid, in-home services and supports, successfully living in a private home may depend on where one lives, with whom, and on the personal and community resources available.

The Characteristics of "Home." A "home" might be a privately owned or rented house or apartment, or another private living arrangement. Some housing options are specifically designed to serve older adults, and including senior housing or larger retirement communities. No matter the type, affordability and accessibility are factors in determining the viability of living in one's own home. For 21 percent of Maine adults age 55 and older, the cost of housing consumed more than 30 percent of their household income in 2012; 52 percent of renters fall into this category (Henry *et al.,* 2015). Some people will want to sell their homes and move to a more accessible home, or closer to a town or a city, where there might be public transportation. However, the option to do that is not available if the value of their home, the primary asset for most Maine residents, is not enough to purchase a more conveniently located or accessible home: in 2016, the median sold value of a home in Aroostook County was $82,500 (Maine Association of Realtors, 2017). In Piscataquis County, the median sold price for a single family home fell 27 percent between 2007 and 2016; Washington County saw a 14 percent drop.[1] Affordable housing options are very limited.

Projected Shortfall of Affordable Housing Rental Units for Low income Older Adults in Maine, 2012-2022



Adapted from "A Profile of Maine's Older Population and Housing Stock," by M. Henry *et al.,* 2015.

When Driving Is Not an Option

Older adults who no longer drive make . . .

- 15 percent fewer trips to the doctor
- 59 percent fewer trips to shop or eat out
- 65 percent fewer trips to visit friends and family and religious activities

compared to drivers of the same age.

(Bailey, 2004)

A Snapshot of Factors Related to LTSS Use by County, Adults Age 65 and Up

COUNTY	Population Age 65 and Up	Percent Below Poverty	Percent Living With a Disability	Percent With Six or More Chronic Conditions	Percent Living with Chronic Obstructive Pulmonary Disease	Percent Living with Diabetes	Percent Living with Depression	Percent Living with Alzheimer's or Dementia	Percent Living Alone
ANDROSCOGGIN	16,813	10	37	15	14	25	19	13	11
AROOSTOOK	14,748	14	43	20	17	30	19	11	15
CUMBERLAND	45,866	8	31	13	10	21	18	12	12
FRANKLIN	5,968	7	34	11	12	23	15	8	11
HANCOCK	11,427	9	34	13	11	20	17	10	14
KENNEBEC	20,923	9	35	14	12	23	17	12	12
KNOX	8,736	8	32	13	10	20	17	11	15
LINCOLN	8,462	7	30	11	10	19	15	*	14
OXFORD	10,920	9	39	12	14	23	17	9	12
PENOBSCOT	24,868	9	38	16	14	26	18	11	11
PISCATAQUIS	4,046	11	42	13	14	25	14	*	15
SAGADAHOC	6,676	5	32	11	9	19	16	9	11
SOMERSET	9,618	10	40	14	17	26	16	9	12
WALDO	7,425	9	35	10	10	22	13	8	12
WASHINGTON	6,984	12	39	15	15	25	15	9	15
YORK	34,920	7	34	15	12	24	17	11	12

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NOTE: An "*" indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.

SOURCES: For Population Age 65 and Up. Percent Below Poverty, Percent Living with a Disability, Percent Living Alone, 2011-2015 American Community Survey 5-Year Estimates; all others, CMS.gov, 2017a.

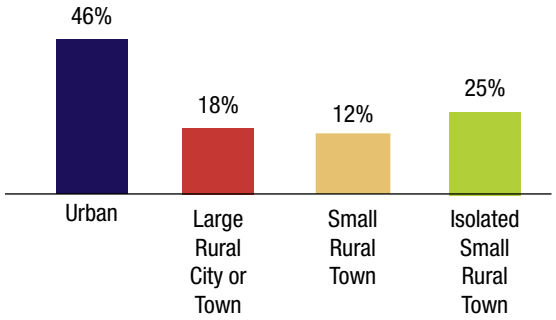
Maine's housing stock is the eighth oldest in the country—31 percent of homes were built before 1950 (Henry *et al.,* 2015)—making the costs of maintaining a private home expensive. Structural modifications are often required to make a home accessible and safe for persons with mobility impairments. The types of chores associated with keeping up a home, such as stacking wood for the woodstove or shoveling out after a snowstorm, also impact how long an older adult can remain in his or her home without help. In Franklin County, for example, 29 percent of occupied homes rely on wood for heat (2011-2015 ACS 5-Year Estimates).

Living Arrangements and the Proximity of Family. Living with someone or having family nearby can be critical for making living in one's own home possible. In Maine, 10 percent of adults age 65 and older live alone; in some rural counties (*e.g.,* Aroostook, Washington and Piscataquis), that number is closer to 15 percent (2011-2015 ACS 5-Year Estimates). Patterns of out-migration likely have reduced the number of family members in close proximity.

Personal Resources. Living in a private home requires resources—to maintain the home, pay for heat and utilities, transportation, and living expenses. The cost of living for a single older adult living in Maine and owning a home without a mortgage is 9th highest in the country, based on 2011 estimates (Mutchler *et al.,* 2016). The average social security benefit in Maine covers only 57 percent of the cost of living for single older adults who rent (Mutchler *et al.,* 2016). In Maine, 38 percent of those over age 75 are below 200 percent of the Federal Poverty Level; for those between age 65 and 74, 26 percent are below that mark (2011-2015 ACS 5-Year Estimates).

The Local Community. Not all Maine residents have easy access to grocery stores, services and health care. Access to affordable transportation is the linchpin for meeting many other needs. In Maine, 72 percent of adults age 65 and older live in communities without access to fixed or flexible transit routes (Millar *et al.,* 2015). Some communities support volunteer networks to help fill in these gaps. A quarter of Maine's older adults (age 60 and older) live in an isolated small rural town (2011-2015 ACS 5-Year Estimates).

Percent of Maine's Age 60 and Older Population by Rural-Urban Commuting Area (RUCA) Categories



NOTE: Applies The Univ. of Washington's Rural-Urban Commuting Area (RUCA) codes by Zip Code, grouped by RUCA Categorization A.

SOURCE: 2011-2015 ACS 5-Year Estimates.

THE ROLE OF FAMILY CAREGIVERS

Family caregivers serve as the backbone of the LTSS system.

Nationally:

- About 44 million Americans provide 37 billion hours of unpaid, "informal" care each year.
- Family caregivers provide over 75 percent of caregiving support (Family Caregiver Alliance).

In Maine:

- 41 percent of survey respondents who were receiving publicly-funded LTSS indicated that a family member (paid or unpaid) helps them the most (NASUAD *et al.,* n.d.).
- 178,000 Mainers were serving as family caregivers in 2013 and provided services worth $2.2 billion (Reinhard *et al.,* 2015).

Impact of family caregiving:

- Family caregivers can experience a negative impact on their own physical and emotional health; financial security, social networks and employment (Reinhard *et al.* 2015).

THE LTSS DELIVERY SYSTEM

Older adults who need long term services and supports are likely to live in one of three types of settings: a private home or apartment, congregate or shared living environment with an integrated service component, such as a residential care or assisted living facility, or a nursing facility. Within each of these three categories there is wide variation in the characteristics of the setting, the community around it, and the types of supports that may be needed and can be provided in that setting. As the number of individuals needing long term services and supports increases, policymakers must decide where and how to allocate resources among these three general settings.

Social Services and Community Resources

There are a range of social services that can play a role in helping an individual living at home. Services including home-delivered and congregate meals, caregiver support, transportation, health promotion activities, and benefits counseling are coordinated through Maine's five area agencies on aging. Maine also has an independent living center that provides technical assistance on how to make homes accessible, and other services. Maine's ten community action programs provide help with heating costs, home weatherization and repair and other services that help people remain safely in their homes. Other supports include the Supplemental Nutrition Assistance Program, rental assistance or a subsidized apartment in a senior housing project. Local governments, individual community members and networks of volunteers also take an active role in helping older adults age in their homes and communities, when help is needed. Together these social services and community-level resources provide a critical set of low-cost interventions that can help to reduce the need for higher cost services. For example:

- A local housing authority might marshal volunteers to help with home repairs, forestalling the need to move.
- A community volunteer might provide a respite visit while a family caregiver goes to the grocery store and has some time away from the house.
- A Meals on Wheels home delivery might include a scan to make sure the heat is on, the house is safe and the older adult has what he or she needs.

In the absence of these and other supports, the risk of social isolation increases, with a corresponding increase in the risk of negative health outcomes and higher rates of potentially avoidable service use (Ciolfi & Jimenez, 2017).

In-Home Services

Many people who need long term services and supports can be served successfully in the community, even people with extensive needs who otherwise would reside in a nursing facility. Because a single, unforeseen event, such as the death of a spouse or a fall, can quickly precipitate the need for a higher level of care, making sure that people receive the "right service at the right time" is critical. If an individual's needs cannot be adequately met at home in a timely manner, a move to a nursing facility becomes more likely.

For many people, their need for help may be met by family members, social services or by community resources. For others paid supports are needed to help with household tasks or hands-on assistance such as bathing, dressing and transfer. For those who cannot pay privately for these services, Maine provides assistance through its publicly-funded long term services and supports programs administered through Maine's Department of Health and Human Services. Depending on what is needed, these publicly-financed programs provide a range of in-home benefits to those that are eligible. These services can include personal care, nursing and therapy services, home modifications, respite for caregivers, assistive technology and homemaker services.

The type, frequency and duration of services needed also influences whether living at home is a viable option. Generally, long term services and support programs do not provide supervision as a covered in-home service, even for individuals with Alzheimer's disease or other dementia. Even for those eligible to receive the maximum service plan, around-the-clock in-home services are not typically available. For individuals who are at risk when they are on their own—perhaps because they need help managing medications or making sure the stove is turned off—the availability of family or other informal caregivers becomes critical. Adult day services, another type of community support, can provide necessary supervision and services in a safe setting outside of the home for part of the day. In addition to benefitting the older adult, these services allow family members the ability to work and provide respite from caregiving responsibilities.

Examples of Publicly-Financed In-Home and Community-Based LTSS

- Homemaker services (assistance with, *e.g.,* laundry, meal preparation, shopping, chores)
- Personal care or assistance (assistance with, *e.g.,* bathing, dressing, toileting, mobility and eating)
- Nursing services
- Therapies (including physical, occupational and speech)
- Chronic disease self-management and fall prevention programs
- Personal emergency response services
- Transportation necessary to access covered services
- Respite care
- Home modifications such as a ramps or widening of doorways
- Adult day services
- Assistive technology
- Care coordination

The LTSS Workforce

While some older adults have the help of family members or friends for all their personal care needs, many are dependent on the direct care workforce to meet these needs. A "direct service worker" is a generic name for many different kinds of workers who provide personal care and other services.

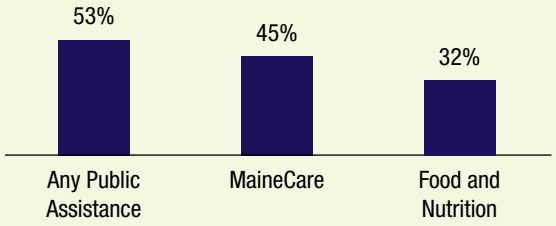
Nationally and in Maine, there is a critical shortage of direct service staff across the entire care continuum. In a tight labor market, low wages, the lack of benefits and limited opportunities for advancement make direct service work less appealing than other available employment options and impacts retention. For many direct service workers, low pay is supplemented with public assistance. The out-migration of younger adults from many parts of Maine has exacerbated the shortages.

For in-home services, many factors impact available staffing, including the region of the state, the number of hours needed, and the complexity of the care needs. For example, it can be challenging to find staff to cover split shifts (when a person needs assistance in the morning and then again in the evening), weekends or evenings, to serve people with very complex needs, or people who live in remote areas with long drive times. Because many agencies are not able to guarantee staffing in a home setting, individuals relying on in-home services must also have contingency plans in place in the event of worker absence.

Maine providers have reported as much as 6,000 hours of needed homecare unstaffed each week. Maine's nursing facilities report 600 unfilled certified nursing assistant positions and assisted living providers have a 10 percent vacancy rate in personal support specialist positions (Maine Council on Aging, 2017). These shortages affect the entire system of caregiving and have a larger impact on the economy: family members may need to quit or reduce job hours to provide needed care. Importantly, some of Maine's LTSS programs provide an option for older adults (or their surrogates) to use Medicaid or state funding to hire, train, manage, and supervise their own worker directly. Although the rules vary by type of program, family members can also be paid to provide care under these "self-directed" options.

Technological solutions, such as home monitoring services, offer promising strategies for mitigating the impact of workforce shortages. However, they are not a substitute for hands on care.

Direct Care Worker Households Relying on Means-Tested Public Assistance, 2013-2016



Adapted from "Direct Care Worker Households Relying on Means-Tested Public Assistance, 2012-2014," PHInternational, 2017.

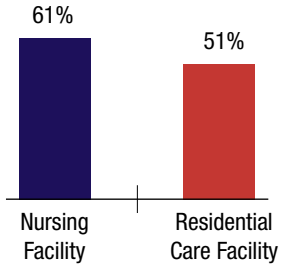
When Living At Home is Not an Option

When living at home is not an option, an older adult may need to reside in a provider-owned or controlled congregate residential setting. The most restrictive setting, for those at the highest level of need, is a nursing facility. For those who do not need nursing facility level of care but still have care needs that require around-the-clock supportive living, Maine has a range of residential care services that can be paid for privately or reimbursed through Medicaid. For older adults, MaineCare-funded residential care is typically provided through adult family care homes or other, typically larger, residential care facilities.[2]

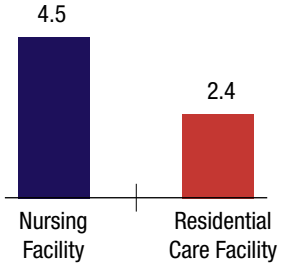
Maine currently has 6834 licensed nursing facility beds across 101 facilities. In 2016 64 percent of nursing facility occupancy can be attributed to MaineCare beneficiaries (MaineCare Data Management Occupancy Reports, January-December 2016). In addition, Maine has 44 adult family care homes, which have eight or fewer beds, and 132 Medicaid-financed residential care facilities for older adults, which can range greatly in size but average just over 30 beds. Some residential care settings are freestanding and others are part of or attached to a nursing facility. A number of facilities specialize in caring for individuals with dementia. In addition to the level of service provided, there is a key difference in the way nursing facility and residential care services are financed: because nursing facility services are considered "institutional services" under federal law, the cost of room and board is an allowable expense under Medicaid. The same does not apply to residential services, and room and board costs must be covered by the individual receiving services or through the use of state funds.

As Maine moves forward, it will need to be strategic about fostering desired models of nursing facility and residential care and determining where these services should be located. The supply of nursing facility and residential care beds varies considerably across Maine and may not match the demand for services, as demographics change. Maine will also want to consider the characteristics of these settings. Where a setting is located, the number of people residing in it, its design, and the level of privacy and individual autonomy offered all play a role in making a residential setting feel more like a home or more like an institution to its residents. These factors may also have implications for how Maine chooses to finance these services.[3]

Percentage of Maine LTSS Users Who Have Dementia in Nursing Facility and Residential Care Settings (All Payers), 2014

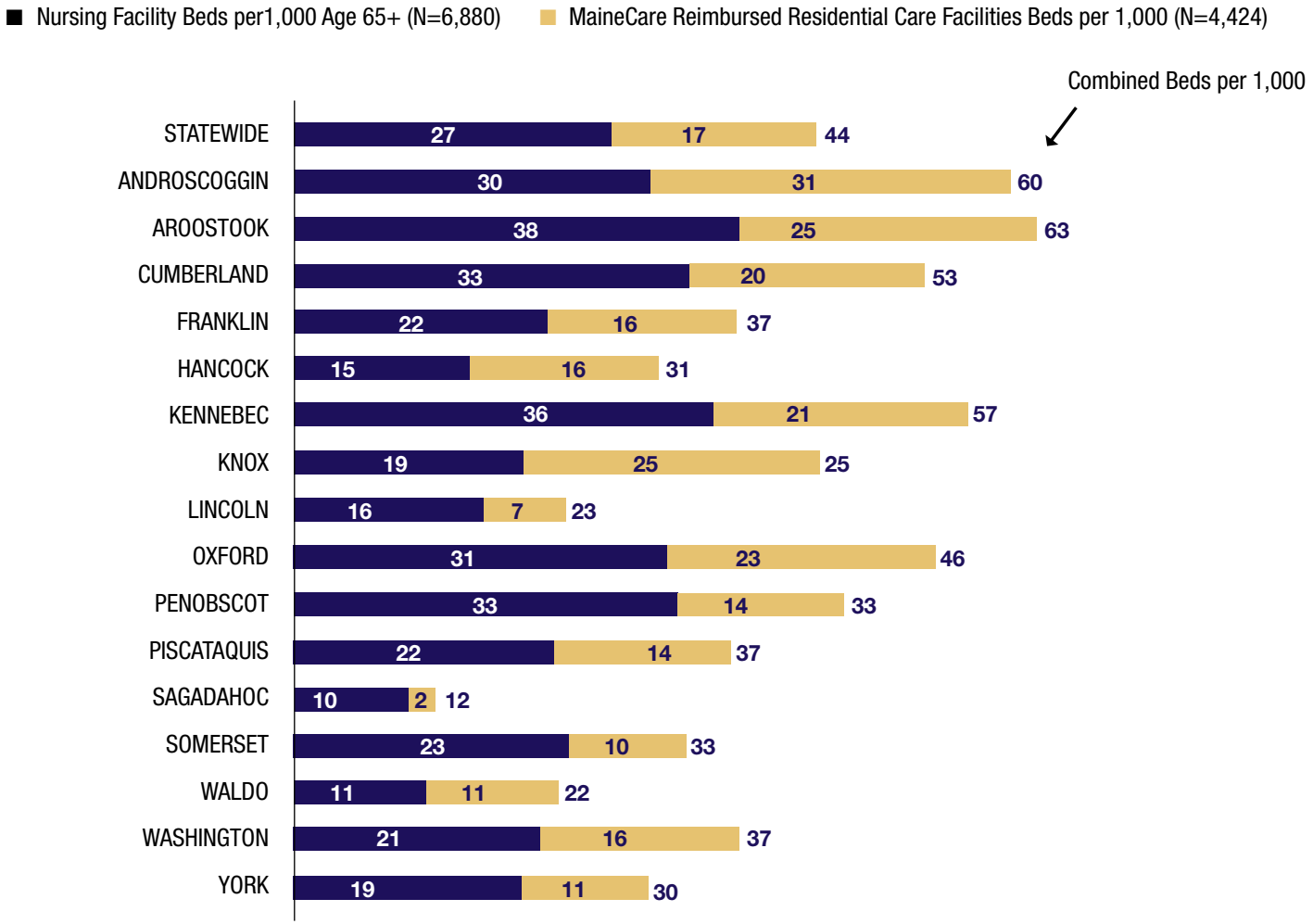


Average Number Out of Five Activities of Daily Living (ADLs) Requiring Supervision or Greater Levels of Assistance, Among Adults in Nursing Facility



Both charts adapted from "Adults Using Long Term Services and Supports: Population and Service Use Trends in Maine, State Fiscal Year 2014," by K.I. Snow *et al.,* n.d.

Nursing Facility and Residential Care Beds per 1,000 Persons Age 65+, 2016

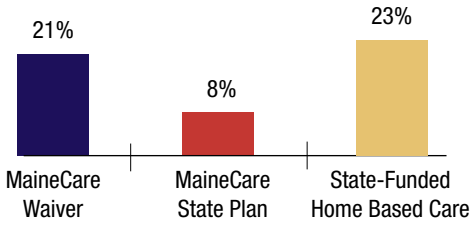


Sources: MaineCare Data Management Occupancy Reports, Roster Date 12/15/2016. Division of Licensing and Regulatory Services. U.S. Census Bureau population estimate as of July 1, 2016, age 65 years and over.

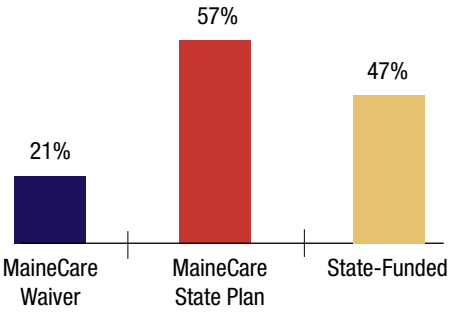
Accessing LTSS

Providing a clear, streamlined pathway to services is critical to making sure people have the "right services at the right time," so that an avoidable admission to a nursing facility is, in fact, avoided. Unfortunately, many of us do not consider the types of home and community-based services available and how to access them until a time of crisis when services are needed quickly. Without advance planning, the older adult or family member has little time to explore the full range of options before putting a plan in place. The process of determining financial and medical eligibility must be coordinated in order to make sure the individual is timely matched to the right program. Finally, help putting a service plan together that supports an individual's goals, and helping that person find needed services and providers is critical. In Maine, publicly financed service coordination services are not typically available to older adults who are not accessing Medicaid or state-funded long term services and supports. Nor are these services adequate for everyone—preliminary results from Southern Maine's Alzheimer's Disease Initiative study suggest that the system is not designed for persons with dementia who are living alone in the community, particularly those who do not have identified caregivers. Intensive case management is required for this population and there is limited public funding for this service (Samia, 2017).

Percentage of Maine LTSS Users Who Have Dementia Receiving In-Home Care, 2014



Percentage of Maine Community-Based LTSS Users Who Lived Alone Receiving In-Home Care, 2014



Both charts adapted from "Adults Using Long Term Services and Supports: Population and Service Use Trends in Maine, State Fiscal Year 2014," by K.I. Snow *et al.,* n.d.

The Olmstead Imperative

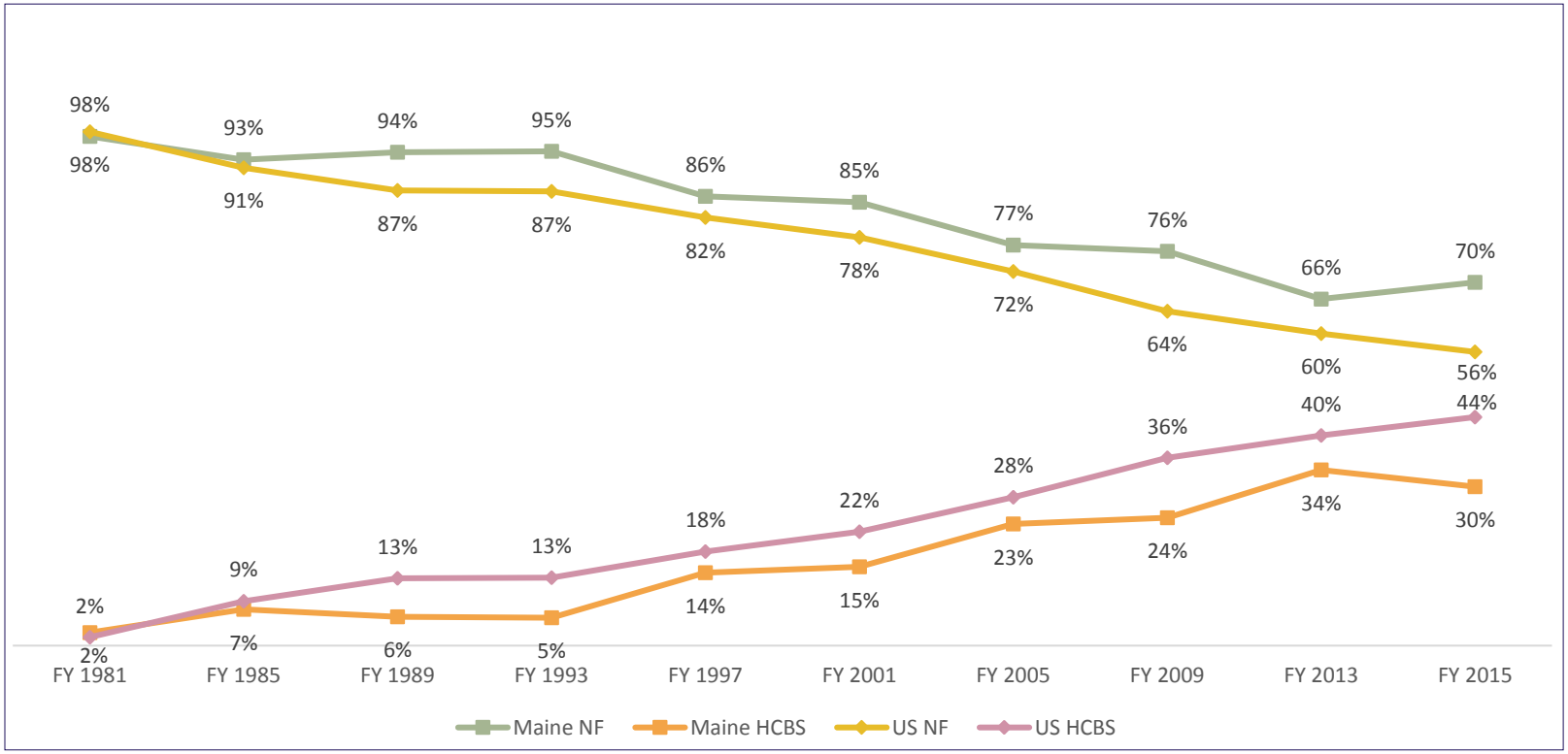
When an older adult needs help with the activities of daily living, most people do not think of that person as "disabled." However, the civil rights accorded under the Americans with Disabilities Act (ADA) apply across age groups: any person who has a physical or mental impairment that substantially limits one or more major life activities is protected under the ADA.

The ADA requires states to provide public services in the "most integrated setting" appropriate to the needs of the individual. The most integrated setting is one that "enables individuals to interact with non-disabled persons to the fullest extent possible" (Americans With Disabilities Act of 1990, 1990).The ADA has helped to precipitate a major transformation of Medicaid-funded LTSS programs. Under its 1999 *Olmstead* decision, the Supreme Court held that states are required to provide community-based services to persons with disabilities when the services are appropriate and preferred, and can be reasonably accommodated, taking into account the resources available to the state and the needs of others receiving disability services (Olmstead v. L.C., 1999). In response to that decision, the federal government sponsored a range of reform initiatives, encouraging states to bring their Medicaid programs into compliance with the *Olmstead* decision. In 2010, under the Affordable Care Act, Congress granted states greater flexibility for designing their LTSS programs. By using Medicaid to support community living for individuals with disabilities, state Medicaid programs have been transitioning to a more social model of care that supports a comprehensive range of services that help people to live as independently as possible.

These reforms continued and accelerated a trend that began in 1981. Medicaid coverage for nursing facility services is mandatory, but states historically had few options for using Medicaid to fund home and community-based alternatives. In 1981, Congress granted the Centers for Medicare & Medicaid Services (CMS) waiver authority to allow states to offer a comprehensive set of home and community-based services (HCBS) through Medicaid, as an alternative to nursing facility services. In the 1990s, before the *Olmstead* decision, Maine had already initiated a comprehensive set of reforms to divert older adults from the unnecessary use of nursing facility services.

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, 1981-2015



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. In recent years, expenditures on facility services have increased relative to home and community-based LTSS, possibly reflecting an increase in nursing facility payment, 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.

Sources: Authors' analysis of historic LTSS expenditure data retrieved from Medicaid.gov, 2017; Adapted from "Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2015," by S. Eiken *et al.,* 2017 and "Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 percent of LTSS Spending," by S. Eiken *et al.,* 2016.

Eligibility Criteria as Policy Levers

Policymakers use both clinical and financial criteria to target services to those who need them most.

Functional and Medical Eligibility Criteria

There are three basic types of functional and medical needs that are used, alone or in combination, to determine eligibility for different types and levels of services.

Instrumental Activities of Day Living (IADLs). IADLs are activities associated with the ability to live independently and can include meal preparation, housework, grocery shopping, and other supports.

Activities of Daily Living (ADLs). ADLs are the basic activities associated with the ability to take care of oneself and include eating, mobility, toileting, bathing, and dressing.

Nursing Services. Nursing service include the regular, ongoing need for injections, treatments, procedures, observation, and other types of care that must be provided by a nurse.

PUBLICLY-FINANCED POLICY AND PROGRAMS

The last comprehensive reform of Maine's system of long term services and supports occurred over twenty years ago. At that time, Maine's system of programs and services was designed to conform to existing Medicaid rules, which are less flexible than those in place today. Newer options allow states more opportunities to target populations, and to expand eligibility and the types of covered services. When originally designed, Maine built its programs around three primary funding streams, Medicaid State Plan, Medicaid waiver, and state dollars. Alone or in combination these three funding streams finance over a dozen long term services and supports programs for older adults. This section reviews the services and programs offered through each funding stream, how they relate to each other and how funding for long term services and supports relates to that for physical and behavioral health services, and social services.

Medicaid State Plan Services

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan has to comply with federal rules governing who must be covered under Medicaid and provides states the choice to expand eligibility to other groups. Federal law also requires certain services to be covered (*e.g.,* nursing facility, home health and non-emergency medical transportation services). Other services may be offered at the state's option (*e.g.,* personal care and private duty nursing). The federal government contributes toward Medicaid services at a rate calculated based on per capita income for that state. Maine receives one of the higher rates of federal matching funds (64 percent), higher than any other New England state (Federal Financial Participation in State Assistance Expenditures, 2015). Maine offers several types of long term services and supports under its Medicaid state plan including in-home personal care or personal assistance services and private duty nursing services, adult day services, residential care services, and nursing facility services. Medicaid state plan services must be provided to anyone who meets the eligibility criteria for the program; the state may not cap the number of eligible people who can be served under the Medicaid state plan.

Medicaid Waiver Services

Congress created the §1915(c) home and community-based waiver authority to allow CMS to "waive" or set aside certain Medicaid state plan requirements so that states could offer an expanded array of home and community-based services that could not otherwise be covered by Medicaid. To be eligible for §1915(c) covered services a person must require the level of care provided in a nursing facility and, but for the §1915(c) services, would be admitted to a nursing facility services. Federal law allows states to apply the more favorable financial eligibility rules associated with nursing facility eligibility, to expand access under a §1915(c) waiver to those who need a nursing facility level of care but are not otherwise financially eligible for Medicaid state plan services.

Maine currently has five active §1915(c) waivers, one of which is designed for older adults and adults with disabilities. Unlike the Medicaid state plan services, access to waiver services are capped and the cost of waiver services cannot exceed the cost of care in a nursing facility.

State-Funded LTSS Programs

Resources for state-funded programs are appropriated by Maine's legislature. These programs provide a broad range of community long term services and supports and services are primarily targeted to those who need services but do not qualify for Medicaid-funded care. For example, they may not need the level of care provided in a nursing facility or the waiver program and may not meet the more stringent financial criteria required for MaineCare state plan services. State funds are also used to provide services that are not otherwise available under MaineCare. The homemaker program, for example, helps people maintain their independence and avoid or postpone the need for a higher, more expensive level of service. While state-funded programs have more flexibility than MaineCare, they do not draw down a matching federal contribution—a state dollar spent on a state-funded program has a dollar's worth of purchasing power while a state dollar spent on a MaineCare service is the equivalent of about $3, when combined with the federal contribution. State-funded programs are also limited by the amount the Legislature appropriates; waitlists for services can and often do occur for many of state-funded programs.

Financial Eligibility

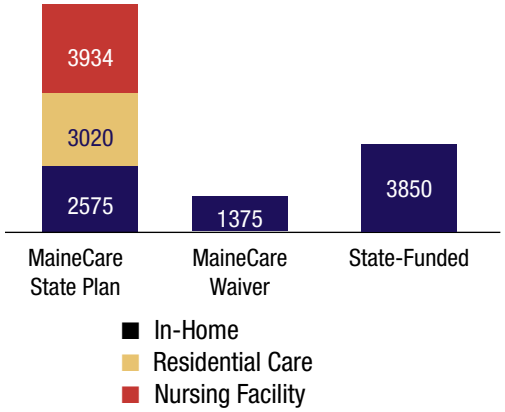
Tools used for targeting services based on ability to pay include:

Income and Asset Limits. Eligibility thresholds vary by program, as do the rules for how income and assets are counted. Some individuals who deplete their financial resources to pay for their services, can effectively "spend down" to meet financial eligibility criteria.

Cost of Care Payments. Depending on a person's income, some programs require that individuals contribute a portion of their income towards the cost of their care.

Co-Payments. Some services require a co-payment, which is triggered by receipt of a service. The payment amount is determined based on the service, not the person's income or assets.

Number of Older Adults and Adults With Physical Disabilities Receiving LTSS by Funding Source, November 2016



Adapted from "An Introduction to the Office of Aging and Disability Services: Prepared for the 128th Legislative session," by G. Wolcott, 2017.

Average Annual Per Person Total MaineCare Costs, SFY 2014

Nursing Facility Services	$53,648
Medicaid Waiver Services	$38,635
Residential Care Services	$30,571
Adult Family Care Home	$26,662

NOTE: Includes LTSS and non-LTSS MaineCare costs and total federal and state expenditures.

Adapted from "Adults Using Long Term Services and Supports: Population and Service Use Trends in Maine, State Fiscal Year 2014," by K.I. Snow *et al.,* n.d.

The Relationship Among LTSS Programs

The different funding authorities each have limitations and flexibilities, creating both opportunities and challenges for designing a comprehensive delivery system. While the programs were designed to serve individuals across the continuum of care, differences in eligibility, benefits and provider requirements can affect individuals moving across differently funded programs when their needs or financial circumstances change. For example, state-funded program allow spouses to be paid for providing care but MaineCare does not; home modifications are available under the waiver program but not under the Medicaid state plan.

The interrelationship across the three funding streams also means that a policy change in one program could have implications for others. For example, if Maine wanted to change the eligibility criteria for accessing nursing facility services, it must consider the impact that change will have throughout the system: changing the bar for nursing facility admission also means changing the bar for waiver services, and is likely, in turn, to impact the use of residential care options and other types of services in less predictable ways. This interdependency across programs makes reforming them complex and challenging, potentially leading to unintended consequences. Over time, some targeted reforms have been implemented in Maine but the underlying foundation has remained essentially unchanged.

The Relationship to Medicare

Individuals who receive services from both the Medicare and Medicaid programs are often referred to as "dually-eligible beneficiaries" and are among the most disadvantaged older adults (Allen *et al.,* 2014). Federal and state policymakers have been increasingly focused on this population, especially the ways in which the program designs and separate structures of Medicare and Medicaid affect care costs and quality.

Medicare generally pays for acute care (hospitalization and other short-term care) and post-acute care (short-term services provided in skilled nursing facilities or elsewhere to help people recover from an acute illness or surgery). For persons dually eligible for both Medicare and Medicaid services, Medicaid pays for long-term services and supports and other benefits not covered by Medicare.

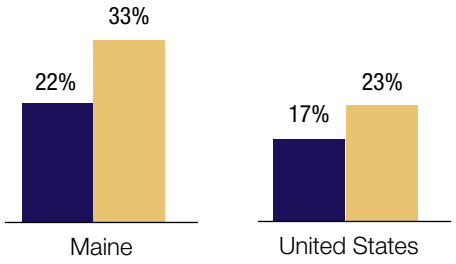
Medicare, a federal program administered through the Center for Medicare and Medicaid (CMS), has an incentive to manage Medicare costs rather than the overall cost of providing services to a given individual. Similarly, a state administering a state Medicaid program has an incentive to focus on managing only Medicaid expenditures, without reference to how its choices impact Medicare expenditures. As a result, while a larger state investment in a Medicaid service might reduce hospital admissions or emergency room use, a state has little incentive to make that investment when the financial benefit accrues to Medicare, which pays for hospital services for dually-eligible beneficiaries. In addition to higher costs, the lack of coordination across these programs can also result in fragmented care for those covered by both, potentially leading to worse outcomes.

In 2010, the federal government established the Medicare-Medicaid Coordination Office to focus on the needs of dually-eligible beneficiaries. In partnership with CMS, a number of states are developing and testing new models

The Relationship of LTSS to Other Delivery Systems

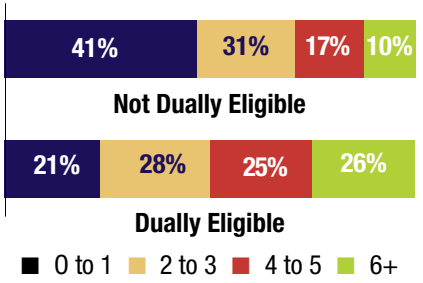
Particularly for those most at risk – those with the most complex needs or the fewest resources—the relationship among the long term services and supports, medical and social service delivery systems plays an important role. Coordination across these systems can help to compensate for the lack of social supports and streamline the efficient use of resources. For example, a nurse making a home visit following a person's discharge from a hospital can also deliver meals, scan for other concerns and identify any additional services that might be needed to keep the person healthy and safe in their home and community for as long as possible. When one system fails, there can be negative consequences for the others as well as for the individual and his or her family. Uncoordinated discharge planning might leave an in-home provider unprepared for the types of services that are needed. An unmet homecare need or poor quality in-home care may result in an avoidable hospitalization or emergency department use.

Medicare and Medicaid Beneficiaries as Percent of Total Population US and Maine, 2012



Adapted from "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," by Medicare Payment Advisory Commission & Medicaid and CHIP Payment and Access Commission, 2017.

Number of Chronic Conditions by Medicare-Medicaid Dual-Eligibility Status, Age 65+, Maine 2015



SOURCE: CMS.gov. (2017b).

Community Initiatives

Nearly 100 communities across northern New England are developing initiatives to become more "age friendly" and support active aging—optimizing opportunities for health, participation and security—that benefit community members of all ages (Tri-State Learning Collaborative on Aging, 2016). These initiatives tend to be grassroots, self-governing and self-supporting, mobilizing the skills and contributions of older adults as part of a broader coalition with their cities and towns, organizations and businesses. They vary in design, governance, and scope, but typically focus on one or more of the following areas:

- Transportation
- Housing
- Outdoor spaces and buildings
- Social participation
- Respect and social inclusion
- Civic participation and employment
- Communication and information
- Community supports and health services

(World Health Organization, 2007).

OPPORTUNITIES AHEAD

Investing too little in a relatively low cost intervention administered in one silo can have a big impact on how much money is spent in another silo and on outcomes for the people served. There are many good reasons why policies, programs and services operate side-by-side rather than as an integrated whole. Very often programs are held accountable for managing their budget and providing a service rather than the outcomes they produce. Service providers are held accountable for providing specific services and often do not have the capacity, the incentive or the authority to address a broader set of needs. Restrictions on how public dollars are spent, and regulations that set standards for health and safety and protecting individual rights are important, but they can also make it harder for policies, programs and service providers to work together.

While these challenges are significant, there are also promising new models and tools that offer opportunities for realigning and redesigning Maine's long term service and supports delivery system. This section reviews some of the opportunities for optimizing the use of private, community and state-level resources to better address the needs of Maine's older adults.

Successful Aging at Home as a Community-Level Outcome

The ability to successfully age at home depends on layers of individual and community-level strengths and resources, as well as publicly financed social services, health care and long term services and supports. Optimizing the use of all of these resources means making sure they are coordinated and aligned around a shared goal. Communities play a critical role in fostering the health and well-being of their residents and anticipating and addressing the needs of older adults. By making sure new development and community planning promotes easy access to services and amenities, zoning and housing codes promote affordable and accessible housing options, and finding ways to promote social connectedness, local government can lay the foundation for age-friendly communities initiatives. By mobilizing local volunteers and other community resources, communities can also help to fill in some of the gaps when an older adult's needs cannot be met with their own resources.

Social service programs offer an added layer of support that can help address nutritional and other needs. The outermost layers—the health care and long term services and supports delivery systems—provide a range of needed services, including some higher cost options that can and should be avoided when they are not needed. As the primary payers for these higher cost services, the Medicaid and Medicare programs have an interest in helping to make sure personal and community-level resources and social services are as effective as they can be at helping an older adult to live at home as successfully as possible, when that is the best and preferred option. To do that, the system needs to ensure the right services and supports are available when and where they are needed. That involves advance planning at the individual level, surveillance at the community level, and navigational services to make sure the most cost-effective interventions are implemented when they are needed, whether it is a ride to a doctor's appointment, home repair, accessing Medicaid services, or making the transition to a residential setting or nursing facility.

Optimizing resource use at the local level means reorienting key stakeholders around a community-level outcome, rather than program or provider level outcomes. For example, a community might take on the goal of making sure that all older adult living in that community have what they need to live healthy, active, secure and engaged lives. With that as the goal, and with defined measures of success in place, stakeholders have a different perspective on how they fit into the larger system and how they can more effectively help to marshal their resources side-by-side with others.

Integrating the delivery system cannot succeed without fundamentally realigning the incentive system. That means payment reform that rewards providers for their patients' outcomes rather than the number of services they provide. For example, in a traditional fee-for-service payment system, hospitals are paid for each emergency department use or hospitalization, whether or not it could have been avoided. The federal government is currently testing new Medicare payment models that allow hospitals to share in the savings they produce for the program when they reduce the use of emergency departments or the number of hospital readmissions. In many cases, achieving these outcomes requires close collaboration among medical providers, social services, long

Payment Models

There are several types of Medicaid payment models that states typically use alone or in combination.

Fee for Service. A payment for providing a service, based on an established rate. This payment model rewards the quantity of service, regardless of the outcome.

Capitation. A per person payment for providing a complement of services (*e.g.,* a managed care model). This payment model rewards efficient management of care, and typically includes quality metrics to assure quality.

Value Based Payments. A variety of payment models that are designed to reward outcomes. Value-based payment models can be variants of or separate parts of fee-for-service and capitated models (*e.g.,* an accountabale care organization shares in savings produced from better, more effective care).

Medicaid Policy Levers

The Medicaid program has a big role to play in influencing the success of aging at home and much to gain from it. Policymakers can drive change using a number of different levers, including:

- Functional & medical eligibility criteria
- Financial eligibility criteria
- Provider qualifications and standards
- Provider payment
- Benefit design
- Delivery system design
- Payment system design

Other State Policy Levers

The State has many other tools in the toolbox that it can use to both strengthen communities and support successful aging at the community level, including:

- Social services policy
- Public health
- Regulatory policy
- Labor & education
- Community planning
- Economic development
- Transportation policy
- Housing policy
- Public safety and protective services

term service and supports providers, communities and families. These new models are promising and over time should be expanded to more systematically integrate desired health and long term service and supports outcomes and savings, and to leverage and support the low cost intervention strategies that are essential components of a community-based system.

State-Level Policy Reform

The State has many levers it can use to support successful aging at home and a continuum of care. Below are some opportunities for state level reform.

Medicaid Reform. To make sure resources are used effectively, Maine has an opportunity to reevaluate the structure of its long term services and supports programs to optimize flexibility, ensure that the benefit design, the delivery system and eligibility criteria target resources to where they are most needed and will be most cost-effective.

The Continuum of Care. Not everyone will be able to successfully live at home—residential and nursing facility options are needed components of a continuum of care. As the primary source of payment for residential and nursing facility services, the Medicaid program can influence the development of more person-centered models by setting standards for the types of settings it wants to finance, and promote the development of residential options where they are needed most.

Payment and Delivery System Reform. The Medicaid program also can play an important role in driving integrated care. The models for integrating care that have been implemented in Maine can be expanded to more systematically integrate desired health and long term service and supports to produce better outcomes and savings, and to leverage and support the low cost interventions offered through social services and local community resources. For older adults these kinds of reforms are difficult without a partnership with the Medicare program and the federal government.

Other State Level Policy Levers. The state has many other policy levers it can use to support successful aging at home. For example, the state can reward communities for developing age-friendly housing and public transportation options. While the focus here is on meeting the needs of older adults, all Mainers benefit from strong communities that can respond to the needs of all their residents.

LOOKING FORWARD

The pathway forward requires leadership at all levels, a commitment of resources, a comprehensive long term vision and a systematic, incremental strategy for addressing the most urgent needs while still working toward the long term goal of realignment.

Key elements of a long term vision include:

- Forecasting the most cost-effective allocation of public financing across the continuum of home, residential and nursing facility settings, and redesigning MaineCare and state-funded programs to support that allocation.
- Forecasting population trends to determine where affordable housing, residential care options and nursing facility services will be needed most and making strategic investments to develop those resources.
- Realigning payment and delivery systems to integrate care and support the social and community services that contribute to improved outcomes and avoided costs.
- Promoting community-level efforts focused on aligning local resources to make sure that all older adults living in that community have what they need to live healthy, active, secure and engaged lives.

Short term needs must also be addressed, including:

- Developing strategies to address the disparity in circumstances and capacity across the state, to ensure that those at risk in those parts of the state most at risk do not fall through the safety net.

- Improving the well-being of the direct service workforce. Compensation, benefits and the organizational supports provided by an employer, as well as opportunities for training and professional advancement are all important elements of reform and are critical to recruiting and retaining a quality workforce adequate to serve current and future needs.

- Supporting family caregivers, particularly in the face of direct services worker shortages. Supports and services that provide respite, help with managing a family member's benefits and care, and policies that support the financial stability of caregivers are some of the steps that can be taken.

- Designing and testing new strategies for identifying and serving people at risk of self-neglect and social isolation, focusing particularly on those living alone and those with cognitive impairments or behavioral health needs. Reforming the current array of service options to target a higher level of support to those at greatest risk.

- Exploring options to increase the flexibility of Medicaid-funded services to address the social determinants of health and that ensure state dollars are leveraged to their maximum potential.

- Developing affordable housing options that can be coordinated with long term services and supports.

- Making sure that all Maine residents are aware of the services and supports available, the need to plan for themselves or a family member, and have a trusted source for information and guidance, equipped with concrete and simple tools to assist them.

Systems change is not easy in the best of circumstances. For the resource-poor system of long term services and supports, systems change is daunting. Fortunately, Maine has a history of being resourceful, working together, and forging a path forward for others to follow.

ENDNOTES

1. Based on authors' analysis of Maine Association of Realtors' statistics on median sold price for family homes in Maine. The Maine Association of Realtors compiles statistics on homes sold through Maine's Multiple Listing Service (MLS), which does not include all homes sold in Maine.

2. These facilities are a type of "Private Non-Medical Institution" (PNMI), a term used in Maine to indicate that certain of the services to residents are reimbursed by MaineCare.

3. Rules promulgated by the federal government in 2014 clarified how a home and community-based setting eligible to receive Medicaid payment is defined. For example, these rules set standards for resident privacy and control over their personal space. These standards may have implications for how Maine structures and funds services provided in non-nursing facility residential settings.

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