What Works? Maine’s Statewide Uniform Assessment and Home Care Planning System Tells All

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Maine’s state-funded home-based care (HBC) program succeeds in aligning resources with the care needs of consumers. Using trained nurse assessors who develop and authorize service plans, the Maine HBC program targets home care services to those most in need. A recent analysis of the program found that authorized service plan costs increased consistently and in a linear relationship with levels of impairment. From a state policy perspective, this finding provides a basis for developing policies that more equitably distribute limited state-funded home- and community-based resources to those most in need of care.

Background

In their meta-analysis of 27 home- and community-based care service studies, Weissert, Cready, and Pavelak (1988) concluded that home- and community-based resources are not adequately targeted to those in greatest need. This failure to align resources with need, combined with the growth in home health expenditures, leaves state policy makers struggling with “how to provide needed services on an equitable basis and do so in such a manner that family caregivers do not try to substitute publicly-funded [sic] care for the care they have been long providing” (Hudson, 1996, p. 456). Although case mix classification systems (Fries & Cooney, 1985) and payment methods have been developed to identify and allocate resources in nursing facilities, methods for aligning home care need with resource requirements remain relatively unknown.

Maine’s Experience

In 1996, Maine instituted a mandatory statewide preadmission screening program using a uniform assessment process for medical eligibility determination (MED). This assessment determines medical eligibility for a range of Medicaid and state-funded services including nursing-facility care, specialized adult family care homes, and Medicaid and state-funded home- and community-care services. A critical component of this process is the development of service plans that provide consumers with estimates of available public support for home care services and estimates of their out-of-pocket costs. For eligible consumers who choose to receive their care at home, this service plan serves as the formal basis (authorization) for payment by Medicaid or the state-funded HBC program. This approach addresses many of the limitations in home care resource allocation that have historically plagued such programs. The use of a standardized assessment instrument with uniform definitions and the use of a single point of entry into Maine’s long-term care system provide a comprehensive system for determining service needs and resource requirements.

The Maine HBC program is designed to provide subsidized home care services to consumers with long-term care needs whose contribution to the cost of care is based on their income and assets. The program permits authorized service plans for eligible consumers for up to 85% of the cost of nursing-facility care. Although the minimum medical need eligibility criteria for the program are relatively low (see Appendix, Note 1), approximately 10% of HBC program consumers meet the medical need definition for Medicaid nursing facility certifiability. Thus, the HBC program provides support to a broad array of long-term care consumers and offers an opportunity to consider how well-trained nurse assessors are able to align resources to consumers’ needs. Prior to the Fall of 2000, service plan authorization guidelines and spending limits other than the maximum amount did not exist.

Analysis

As part of recent state policy deliberations, the Maine Department of Human Services asked the
Muskie School at the University of Southern Maine to conduct an analysis of its program and examine the question: How well do resource allocations reflect the levels of consumers' needs for services? This question was raised in response to occasional instances of consumers with relatively low levels of need for assistance receiving authorized service plans at or near the program cap (i.e., 85% of nursing home care).

The central questions of the analysis were: (a) How should level of need be defined? (b) Who is being served by the HBC program? (c) What is the relationship between service plan costs and level of need? (d) What are the policy implications?

**Definition of Levels**

For purposes of this analysis, consumers with authorized HBC service plans were classified into one of four levels of need for assistance. These levels were defined using a combination of Medicaid program and HBC program eligibility criteria to permit examination of the relationship between Medicaid and HBC client need and payment policies.

Medical eligibility criteria defining Medicaid nursing facility-level care (see Appendix, Note 2) were used to define the highest level of need group, Level Four. The next highest level, Level Three, has no parallel in Medicaid or explicit HBC eligibility policy. Level Three classification criteria were: (a) need for physical assistance with two or more of five higher order activities of daily living (ADLs) and (b) assistance with at least three instrumental ADLs (IADLS) (e.g., meal preparation, routine housework, grocery shopping, or laundry). Level Two classification criteria mirror the minimum need eligibility criteria for services under the Medicaid Private Duty Nursing Program (persons with a nursing need once a month and at least limited assistance on two or more of seven ADLs—bathing, dressing, locomotion, bed mobility, transfer, eating, or toilet use). The minimum eligibility criteria for assistance under the HBC Program (see Appendix, Note 1) were used to define the lowest level of need group, Level One.

**The Consumers**

Table 1 indicates that the distribution among the need level groups was similar in 1999 and 2000 for consumers with authorized HBC service plans. In each year, approximately one half were in the least impaired group, and roughly 10% were in the most impaired group (nursing-facility level).

Table 1 also presents the average authorized service plan costs for each of the four levels. These costs include all authorized covered services, and may include homemaker, personal care attendant, certified nursing assistant, home health aide, nursing fees, and monthly emergency response service fees. At the highest level of need, Level Four, the average authorized service plan cost was $1,279. In contrast, consumers with authorized service plans who are at the lowest need level (Level One), had average costs of $500, less than half the average authorized cost for those with nursing facility-level (Level Four) needs. For persons in the Level Two group, where some nursing need is required in addition to ADL and IADL assistance, average service plan costs were $619; this was due, at least in part, to the introduction of monthly nursing visit costs. For consumers in the Level Three group, who have need for assistance with higher order ADLs but not necessarily nursing services, average authorized service plan costs ($830 per month) were higher than for Levels One and Two. The standard deviations for average authorized service plan costs are consistently smaller than the mean or median, although not surprisingly; as the group sizes diminish at levels of greater need, the standard deviations become larger.

Figure 1 shows that the pattern of relative linearity between need and authorized expenditures persists over time. Furthermore, during SFY 2000 HBC consumer’s average authorized service plan costs were very similar across the four levels of need when compared with data on average authorized service plan costs in 1999.

**Policy Implications**

This analysis has a number of important policy implications. First, the current system for assessing the need for services using trained nurse assessors, a uniform assessment instrument, and authorized service plans has resulted in an alignment of resources with care needs. Second, this analysis suggests that state program data can be used for the analysis of care needs and spending patterns. Third, the data from this analysis can be used for developing payment guidelines and policies that will support the equitable allocation of resources to people with different care needs.

**Unanswered Questions**

In light of the challenges faced by state policy makers to meet growing demand for in-home services with
limited resources, research is needed to find acceptable and meaningful measures of need for home-care services. Such research must control for the quality of home-care services offered and the adequacy of such services to meet consumers’ needs. As the cost and demand for home care continues to rise, it is becoming increasingly critical for policy makers to obtain assistance in finding optimal consumer need classification options and resource allocation metrics. This is complicated by the varying home-care policies and available funding in each state. Further research needs to provide options that can be effectively tailored to the specific policies and systems in each state. Research is also needed to explain the potential pitfalls of various need-based home care resource allocation options.

Conclusions

As data on long-term care consumers, the services they use, and the costs of such services become increasingly available, analyses to consider the rationality of policies will become increasingly possible. This mini-analysis suggests the need for further collaboration between state long-term care policy makers, policy analysts, and university-based researchers in the alignment of policy questions with available data for addressing long-term care policies. Further, by moving beyond simple descriptive analyses, collaborating states and state–university partnerships can offer new insights through interstate comparative analyses and a broader understanding of the dynamic of long-term care service utilization and potential improvements in the allocation of public resources.

References


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Appendix

Notes

1. Home-based care eligibility: (a) consumer requires cueing support daily for dressing, eating, toilet use or bathing, or (b) consumer requires assistance with one ADL and assistance with two or more IADLs—meal preparation, routine housework, grocery shopping or laundry, or has a combination of nursing need ADL and IADL needs.

2. Nursing facility-level of need in Maine is defined by need for: (a) skilled nursing services 7 days per week; (b) therapies 5 or more days per week; (c) extensive assistance required in three or more higher order ADLs such as locomotion, bed mobility, transfer, eating or toilet use; or (d) a combination of ADL of cognitive impairment, behavioral problems, or skilled service need.

Table 2. Functional Limitation of Home-Based Care Program Clients By Level of Need Group, State Fiscal Year 2000 (N = 2,620)

<table>
<thead>
<tr>
<th>Level of Need Group (n = consumers served)</th>
<th>Average ADL Count (out of 7 ADLs)</th>
<th>CPS ≥ 3 (moderate impairment, %)</th>
<th>Average Authorized Service Plan Cost M (Median/SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One (n = 1,376)</td>
<td>1.5</td>
<td>14</td>
<td>$500 ($426/$301)</td>
</tr>
<tr>
<td>Level Two (n = 591)</td>
<td>2.3</td>
<td>17</td>
<td>$619 ($522/$344)</td>
</tr>
<tr>
<td>Level Three (n = 368)</td>
<td>4.5</td>
<td>27</td>
<td>$830 ($654/$518)</td>
</tr>
<tr>
<td>Level Four (n = 285)</td>
<td>5.6</td>
<td>46</td>
<td>$1,279 ($1,035/$854)</td>
</tr>
</tbody>
</table>

Notes: Data exclude those receiving adult day services. ADL = activity of daily living; CPS = Cognitive Performance Scale.

Figure 1. Average Authorized Service Plan Cost for State Fiscal Year 1999 and 2000.