

**November 23, 2013 – Questions for HHS Committee Meeting December 10 in
Response to Requests for Questions from DHHS, DOE and DOC**

Riverview Psychiatric Center

1. What progress is DHHS making in the appeal of decertification of RPC?
2. Please provide copies of the appeal document and any other documents filed by DHHS and CMS.
3. What is the timeline for the appeal and a decision by CMS on the appeal?
4. If this appeal is not successful is there another level of appeal?
5. If there is another level of appeal does DHHS intend to appeal?
6. If DHHS files another level of appeal what is the timeline for a decision at that level?
7. What progress is DHHS making in its application for recertification of RPC?
8. Please provide copies of the application and any other documents filed by DHHS.
9. Please provide copies of any correspondence between DHHS and CMS on the application.
10. What is the timeline for a decision by CMS on the application?
11. If the application is not successful is there a right to appeal?
12. If there is a right to appeal or reapply does DHHS intend to appeal?
13. If DHHS files an appeal or reapplication what is the timeline for a decision at that level?
14. How is DHHS paying for the costs of operating RPC at this time?
15. With the loss of federal funding when will DHHS fully spend or encumber its appropriated and allocated funding for RPC?
16. Once DHHS has fully spent or encumbered its appropriated and allocated funding for RPS what is DHHS's plan for operating RPC?
17. Has the loss of federal funding had any impact to date on the operation of RPC?
18. If the loss of federal funding has had an impact please describe that impact in detail.
19. What changes has DHHS made to staffing or training at RPC as a result of enactment of Public Law 2013, chapter 434?
20. What progress is DHHS making in its cooperative work with Department of Corrections on the expanded mental health unit at the Maine State Prison?
21. Has the enactment of Public Law 2013 chapter 434 had any effect on staffing and training, employees, patients, admissions or discharges at RPC? If so please provide details.
22. Have DHHS and DOC made progress on or signed any memoranda of agreement or cooperative agreements regarding the transfer or treatment of patients or persons in the custody of DOC? If so please provide details.

PNMI auditing, Cost of Care auditing

23. Please provide statements from DHHS in response to the audits performed by the State Auditor on any PNMI's and the Cost of Care audit?
24. What action has DHHS taken in response to either audit?
25. Has either audit had an effect on the delivery of services to clients of DHHS?
26. If so please provide information on actions taken by DHHS to protect any clients who might be affected.
27. Please provide detail on the impact of the cost of care overpayments on the 2012-2013 and 2014-15 biennial budgets in the program budgets for each type of facility.

28. Has DHHS incorrectly paid PNMI and nursing facilities because of the improper functioning of the computer systems with regard to cost of care at any time since the initial operation of the MIHMS system?
29. If so please provide information on what time periods, for what categories of facilities, in what amounts DHHS has improperly paid?
30. With regard to the categories of facilities and time periods in answer 29 please provide detail on the amounts that were overpaid and amounts that were recouped from overpaid providers, providing totals of amounts recouped and amounts owed by state fiscal year.
31. With regard the total of amounts owed in answer 30 please provide detail on what actions DHHS intends to take to recoup amounts owed by facilities.
32. With regard to payments to facilities for which cost of care is required to be deducted by DHHS in calculating the proper payment please provide information on what actions DHHS plans to take and when to correct the ongoing overpayment of facilities.
33. If DHHS has had discussions with facilities on cost of care overpayments or errors in payment please provide detail on those discussions.
34. If facilities have approached DHHS in order to repay overpaid amounts or otherwise attempt to return the overpayment please provide information on those communications, what action DHHS has taken in response and the final results of the communications.

Recovery audit contractors

35. Please provide information on the activities of any recovery audit contractors who have been working for DHHS during 2013-14.
36. Please provide information on the auditing that is being done this Fall and Winter and the progress of the audits to date.
37. Please provide copies of any auditing contracts with RAC contractors.
38. What authority does DHHS have to provide direction or correction to contractors regarding the performance of the contractors' duties?
39. What MaineCare providers are being audited now and what is the schedule for auditing for the remainder of the biennium?
40. Why were specific categories of providers scheduled for auditing during this biennium?
41. What amounts have the contractors identified to date as overpayments and what amounts have been repaid to DHHS as a result?
42. What amounts have been paid to contractors as a result of repayments to DHHS?
43. What amounts have the contractors identified to date as underpayments and what amounts have been paid to providers as a result?
44. What amounts have been paid to contractors as a result of payment of underpayments to providers?
45. What impact have the audits had on MaineCare providers and members?
46. Has DHHS taken any action as a result of the impact of the audits on MaineCare providers and members?
47. Please provide information in response to questions posed at the October 29th meeting.
 1. *Please provide information on auditing being done by DHHS or a contractor for DHHS of dental clinics. Please provide information on the procedures being used, the agreement with the contractor and the flexibility that DHHS had or still has in designing the auditing procedures.*

MaineCare auditing of school administrative districts

48. Please provide information on MaineCare auditing of school administrative districts during 2012-2013 and 2014-2015.
49. Has the auditing caused DHHS or the Department of Education to take any action to pay underpayments or recoup overpayments?
50. Has the auditing or the results of the auditing had any impact on school administrative districts or their employees or contracted providers of services or children who are MaineCare members?
51. Has the auditing or the results of the auditing had any impact on children who are served through other programs, such as the school districts own programs or Child Development Services?
52. Please provide information on actions taken by DHHS or DOE or any school administrative district as a result of these audits.

MaineCare reimbursement of PNMI's

53. Please provide a detailed update of the progress that DHHS is making with regard to reimbursement of PNMI's.
54. What is the status of any application to federal CMS from DHHS on PNMI reimbursement?
55. What is the timeline for a decision from CMS?
56. What is the status of DHHS-provider discussions for each type of PNMI?
57. What is the impact of the PNMI status quo payment system and any proposed payment systems on the 2014-2015 biennial budget?
58. Do the plans or applications submitted to CMS have an impact on PNMI's or persons living in PNMI's?

DHHS administrative issues

59. Please provide detailed information on each of the following DHHS administrative matters: the SIM grant, MaineCare eligibility system upgrades, and the actuarial study of MaineCare benefits for the purposes of reimbursement level determination under the Affordable Care Act.
60. With regard to the SIM grant please provide information on the initiatives to be studied or implemented and the timeline for accomplishment.
61. With regard to the SIM grant please provide information on how each initiative to be implemented will impact the delivery of services by DHHS, the provision of services by community social service providers and access to services by all Maine residents, by clients of DHHS and by members of MaineCare.

DHHS contract with the Alexander Group

62. Please provide a copy of any contracts with the Alexander Group or Gary Alexander.
63. What services and at what cost and on what schedule for completion has DHHS contracted for with the Alexander Group?
64. What contracting procedures were used in developing and signing the contract with the Alexander Group?
65. With regard to each deliverable under the Alexander Group contracts please provide detailed information on the responsibilities of the contractor and the purpose of the inquiry.

66. With regard to each deliverable under the Alexander Group contracts please provide a schedule and the means for communication with the Legislature and the public when the Alexander Group completes the applicable report.

Children's services

67. Please provide answers to the questions posed after the meeting on the 11th of September.

Children's behavioral health

1. *Please provide a schedule for meetings and progress on the Section 28 rate setting changes.*

Child welfare services foster care

1. *Please provide information on when the white paper vision statement will be released.*

2. *Please provide information on plans for meetings, planning and initiatives after the release of the white paper.*

3. *Please provide information on recruitment of foster families in the last few years. (Sean Scovil, Community Care of Maine)*

68. Please provide answers to questions posed after the meeting on October 29th:

1. *Please provide information on the provision of homeless shelter services to youth statewide, in particular any contraction or closure of services, expansion of services and transfer of service sites by homeless youth.*

Child Development Services

69. Please provide information on changes and improvements in the Child Development System.

70. With regard to changes and improvements in CDS please provide information on the impact of those changes and improvements on children served by CDS, CDS service providers, school administrative units and the MaineCare system.

MaineCare non-emergency transportation

71. Please provide monthly data through the end of November on rides requested, rides scheduled, rides given, rides not provided, rides for which the member did not show up, and complete data on telephone inquiries and complaints, complaint line waiting time, service time, hangups, reimbursement to all 3 brokerage contractors.

72. Please provide a copy of the plan or correction filed by CTS and any response from DHHS.

73. Please provide information on any contractual requirement for a performance bond, information on which contractors provided performance bonds and information on what DHHS would use a performance bond for.

74. What amounts were paid to contractors providing MaineCare non-emergency transportation services in State FY2011-12 and 2012-13 and how many rides were provided by each contractor during those fiscal years?

75. Please provide information posed after the meetings on the 11th of September and on October 29th.

From 11th of September

2. *Please provide data by October 1st on challenges and problems in the system. Please provide this data on a monthly basis thereafter.*

3. *Please provide information on what is being done to make things right for consumers and their families who have not been served properly by the new system and the providers that have lost clients.*
4. *Please provide information on the other parts of the transportation system that have been separated from the MaineCare nonemergency transportation system and the effect of the brokerage system on persons needing rides for other purposes. (See question 1 below from October 29 meeting.)*
5. *Is there work going on, particularly in rural areas, that would allow sharing riders in a vehicle for (1) a MaineCare member needing a ride to a medical appointment, (2) an elderly person needing a ride to the supermarket, and (3) a child needing a ride for educational or health care purposes?*

From October 29

1. *Please provide information about the relationships of the regional transportation systems to the MaineCare program and the new MaineCare non-emergency transportation system. Please provide information on other DHHS programs that use the regional transportation system. Please provide information on any recent changes in or challenges in DHHS programs that use the regional transportation systems.*

Orbeton, Jane

From: Adolphsen, Nick <Nick.Adolphsen@maine.gov>
Sent: Thursday, November 21, 2013 2:15 PM
To: Orbeton, Jane
Cc: Lusk, Holly E; Margaret Craven (mmcraven@roadrunner.com); Richard Farnsworth (omc@maine.rr.com); Mullen, Micki
Subject: RE: HHS Committee meeting December 10

Hi Jane,

DHHS will not be in attendance at the December 10th meeting of the Health and Human Services Committee. Please submit any specific questions related to the discussion topics to me in writing, and I will ensure answers are provided to the Committee for the meeting on the 10th.

Thanks,
Nick

From: Orbeton, Jane [<mailto:Jane.Orbeton@legislature.maine.gov>]
Sent: Monday, November 18, 2013 11:28 AM
To: Adolphsen, Nick; Mcewen, Marylouise; Breton, Jody L.; Buckley, Pola; Downs, Herb F.; Sucy, Alison P; Nadeau, Stefanie; Cahill-Low, Therese; Ashcroft, Beth; Holmes, Jaci; Albert, Kenneth; Sullivan, Brian
Cc: Craven, Margaret M. (mmcraven@roadrunner.com); Farnsworth, RepRichard; Nolan, Christopher; Avore, Alexandra
Subject: HHS Committee meeting December 10

Hello,

Please forgive the group email but I think you will find it convenient.

I am attaching the agenda for the HHS Committee meeting on December 10. I am sending you this email as you have an item on the agenda and the chairs anticipate offering you an opportunity to speak and the committee may have questions for you. So here we go:

Nick, Mary Louise and Jody, the 9am item is an update on Riverview and also a progress report on work with DOC on the expanded mental health unit at the Maine State Prison.

Pola and Nick and Stefanie and Herb, the 10am item is an update on the RAFTS audit and the Cost of Care issue.

Herb and Nick and Stefanie, the 10:20 item is a briefing on RACA contracting.

Herb and Nick and Alison, the 10:40 item is a briefing on MaineCare auditing of school administrative units. This may be special schools such as Spurwink, I'm not in the discussion on this.

Ken and Nick, the 11am item is an update on the adult day program, nonmedical model.

Stefanie and Nick, the 11:30 item is MaineCare reimbursement of PNMIs, a briefing on progress.

Stefanie and Nick, the 1pm item is all MaineCare and SIM grant.

Nick, the 1:30 item is a report on DHHS progress with initiatives authorized in the biennial budget. It is also an opportunity to mention any cost overruns or savings and nay other fiscal issues that might be of interest.

Therese and Nick and Beth, the 2pm and the 2:30 item are all children's services, some involving MaineCare, some OPEGA and some CDS.

Nick and Stefanie and Brian, the 3:30 item is MaineCare NEMT.

Thank you for your assistance with these issues and with the meeting. Jane

Orbeton, Jane

From: Orbeton, Jane
Sent: Thursday, November 21, 2013 2:07 PM
To: Mayhew, Mary; Adolphsen, Nick; Nadeau, Stefanie
Cc: Mullen, Micki
Subject: December 10 HHS Committee meeting

Dear Commissioner Mayhew, Nick and Stefanie,

The chairs of the HHS Committee asked that I invite the Commissioner and Stefanie and Gary Alexander to attend the December 10th meeting of the HHS Committee for a briefing on the contract between DHHS and the Alexander Group regarding MaineCare and welfare in Maine. The chairs have scheduled this briefing for 1:30pm. I do not know how to contact Gary Alexander, so if you could let him know about the briefing and invite him I would appreciate that.

I am hoping that you and Gary Alexander will be able to attend and brief the HHS Committee. If the time needs to be changed, please let me know a better time.

Thank you.
Jane

Orbeton, Jane

From: Broome, Anna
Sent: Friday, November 01, 2013 11:00 AM
To: Adolphsen, Nick; Mayhew, Mary; Mcewen, Marylouise; Nadeau, Stefanie; Cahill-Low, Therese; Sullivan, Brian; Wiley, Jeffrey
Cc: 'mmcraven@roadrunner.com'; 'omc@maine.rr.com'; Orbeton, Jane
Subject: HHS Dec 10th interim meeting requests

Good Morning Commissioner Mayhew, Nick, Mary Louise, Stefanie, Brian, Therese, and Jeff,
Below is the list of questions generated from Tuesday's Health and Human Services Committee meeting for the December 10th meeting.

Riverview:

1. Please provide an update on the appeal.
2. Please provide an update specific to the pre-hearing conference held this week as soon as possible and we will distribute that to the committee.
3. Please provide information on who is doing the advanced training for the RPC staff.

PNMIs:

1. Please provide a briefing on the PNMI situation – the history, audit system, examination of other states with respect to consent decree members, and CMS position on possible options for PNMI reimbursement that may be favored by CMS.

Halcyon House:

1. A possible update on the closeout of the Halcyon House. (Therese Cahill-Low has already been notified.)

Budget spreadsheet initiative:

1. Please provide a progress report on the DHHS policy initiatives in the budget as outlined in the OFPR spreadsheet.

MaineCare Non-Emergency Transportation:

1. Please provide a data report on rides, calls and complaints (similar to the report provided by CTS) broken down by broker and by regional district.
2. Please provide information on the difference between calls to the complaint queue and actual documented complaints.
3. Please provide data on no shows that includes both no shows for the consumer and no shows by the consumer.

Thank you for your assistance.

Anna

Anna Broome
Legislative Analyst
Office of Policy and Legal Analysis
Maine State Legislature
(207) 287-1670

Orbeton, Jane

From: Orbeton, Jane
Sent: Thursday, October 31, 2013 10:54 AM
To: Mullen, Micki
Cc: Adolphsen, Nick; Mayhew, Mary; Nadeau, Stefanie; Albert, Kenneth; Martin, James; Cahill-Low, Therese; Ashcroft, Beth; Mcewen, Marylouise; Sullivan, Brian; Downs, Herb F.
Subject: HHS Committee meeting December 10th request

Dear Micki Mullen,

I am writing to request the attendance at the meeting of the Health and Human Services Committee on December 10th of the Commissioner and officials representing the Department of Health and Human Services and of representatives of the regional transportation brokers for MaineCare. The participation of the department is critical to the efficient and thorough review and discussion of issues by the HHS Committee. I am including information about tentative agendas for both meetings.

For December 10, the tentative agenda includes MaineCare non-emergency transportation, the Riverview Psychiatric Center, MaineCare auditing of school administrative units, DHHS administrative issues (eligibility system upgrades, SIM grant and actuarial study of MaineCare benefits) and children's behavioral health and foster care issues. Since my earlier email with a request for this meeting the following items have been added to the agenda: adult day program medical model progress report, progress report on MaineCare reimbursement of PNMI's, progress report on 2014-15 budget initiatives, and progress report on homeless youth shelter services. Other issues may be added to the agenda.

It would be most helpful if I could hear back from you with permission by November 12th. I look forward to hearing from you.

Thank you for your assistance.
Jane Orbeton
Office of Policy and Legal Analysis

STATE OF MAINE
KENNEBEC, ss.

RECEIVED AND FILED
KENNEBEC SUPERIOR COURT
SUPERIOR COURT
2013 NOV 14 9:05
CIVIL ACTION
DOCKET NO. CV-89-088
MICHELE LUMBERT
CLERK OF COURTS

PAUL BATES, et al.,

Plaintiffs

v.

ORDER

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

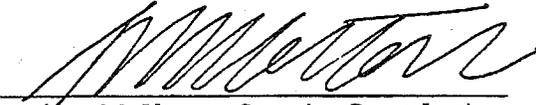
Defendants

Based on the recommendation of the Court Master, and pursuant to a conference with the parties, the Court Master, and the Court on September 27, 2013,

IT IS HEREBY ORDERED:

The authority of the Court Master with respect to Riverview Psychiatric Center as specified in paragraphs 292 through 302 of the Settlement Agreement is hereby reinstated until further order of this Court.

Dated: October 25, 2013


Andrew M. Horton, Superior Court Justice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

_____)	
In the Case of:)	
)	
Riverview Psychiatric Center,)	Date: October 31, 2013
(CCN: 204007),)	
)	
Petitioner,)	
)	
-v.-)	Docket No: C-14-84
)	
Centers for Medicare & Medicaid)	
Services.)	
_____)	

Briefing Schedule

In response to Petitioner's request for an expedited hearing, a conference call was held by telephone with the parties on October 30, 2013. Participating were Christopher C. Taub and Kathy Greason, Assistant Attorney Generals for the State of Maine, on behalf of Petitioner; and Jan B. Brown, Assistant Regional Counsel, on behalf of Centers for Medicare & Medicaid Services (CMS). During the conference the parties agreed that this case could most likely be decided based on the parties' written briefs. The parties further agreed that there are no issues of material fact in dispute. A briefing schedule was developed and the parties were directed that their briefs should address all the issues in the case, including both jurisdictional and substantive issues.

The parties agreed to the following filing deadlines:

1. CMS will file its brief no later than **December 3, 2013**. The brief is not to exceed 25 pages (double spaced).
2. Petitioner will file its brief no later than **January 3, 2014**. The brief is not to exceed 25 pages (double spaced).

3. CMS will file its reply brief no later than **10 days** after receiving Petitioner's brief. The reply brief is not to exceed 10 pages (double spaced).

If the case settles, or at such time as Petitioner no longer wants a hearing, Petitioner should file a written request for dismissal or withdrawal of the hearing request, so that the case can be dismissed in accordance with 42 C.F.R. § 498.68.



Steven T. Kessel
Administrative Law Judge

Served by U.S. Mail and Email

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POLA A. BUCKLEY, CPA, CISA
STATE AUDITOR

MARY GINGROW-SHAW, CPA
DEPUTY STATE AUDITOR
MICHAEL J. POULIN, CIA
DIRECTOR OF AUDIT and ADMINISTRATION

December 4, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Mayhew,

The Office of the State Auditor conducted a limited procedures engagement of a Department of Health and Human Services' vendor who is providing Housing and Direct Care Mental Health Services.

We have completed our report and DHHS personnel has responded to our concerns in writing. Their responses have been incorporated into our report and the report is attached to this letter.

Our report will be available on the Office of the State Auditor website at <http://www.maine.gov/audit/reports.htm>, in the section for Other Reports.

We thank Social Services Director Eileen Cummings, Acting Director of Policy Beth Ketch, Director of Audits Herb Downs, Director of the Rate Setting Unit Colin Lindley, Office of Aging and Disability Services Associate Director Gary Wolcott, and Health Facilities Survey Manager Michael Swan along with members of their staff for their assistance during this engagement.

Sincerely,

A handwritten signature in cursive script that reads "Pola A. Buckley".

Pola A. Buckley, CPA, CISA
State Auditor

Cc: Honorable Margaret Craven, Senate Chair, Health and Human Services Committee
Honorable Richard Farnsworth, House Chair, Health and Human Services Committee
Ricker Hamilton, Deputy Commissioner of Programs, DHHS
Eileen Cummings, Director, Social Services, DHHS
Herb Downs, Director, Division of Audit, DHHS
Beth Ketch, Acting Director of Policy, DHHS
Colin Lindley, Director, Rate Setting Unit, DHHS
Gary Wolcott, Associate Director, Office of Aging and Disability Services, DHHS
Michael Swan, Health Facilities Survey Manager, DHHS

Enclosure

Office of the State Auditor
Report on Limited Procedures Engagement
DHHS Vendor Providing Housing and Direct Care Mental Health Services
Report Issued on December 4th, 2013

Summary

The Office of the State Auditor performed a limited procedure engagement related to a single vendor that provides housing and direct care services to DHHS mental health clients. Our procedures included learning the history of the vendor and the environment in which it operates, understanding the services being provided, and reviewing the State's payments to the vendor. Our audit identified the following areas of concern:

- the resident's share¹ of the cost of housing and direct care services is not being deducted from automated payments to the vendor,
- in a non-transparent fashion, the value associated with room and board, a non-allowable component of the services provided, is incorrectly being charged along with direct care service costs that are eligible for federal financial participation and
- the method of reimbursement for Routine Service Costs warrants review because the vendor claims that their expenditures are underfunded.

Background

The typical client served by the vendor receives food, shelter, and supervision of daily activities such as medication management, and assistance with personal hygiene. The residents are either a Public Ward of the State where DHHS serves as the guardian of last resort or they are under Private Guardianship where a family member, friend, attorney or other interested person serves as guardian. In both cases, a petition is filed with and an appointment of guardianship must be made by the Probate Court.

In the summer of 1989, in response to severe overcrowding and the deaths of patients at the Augusta Mental Health Institute, Maine Advocacy Services filed a class action lawsuit on behalf of specific AMHI residents against the Commissioners of the Department of Mental Health and the Department of Human Services as well as the Superintendent of the Augusta Mental Health Institute (AMHI). The resulting "AMHI Consent Decree" required the defendants to develop, fund and support less restrictive community housing and residential services as an alternative to the institutional setting. As a way of de-institutionalizing patients and also as an alternative to the more costly nursing home setting, Private Non-Medical Institutions (PNMIs) emerged. Presently, there are several categories of PNMIs defined in Chapter III Section 97 of the MaineCare Benefits Manual. Appendix F Non-Case Mix Medical and Remedial Facilities is the section applicable to this vendor. Appendix F facilities are licensed and staffed to provide long term mental health services to clients in three distinct categories:

- those who have suffered brain injury,
- those with developmental disabilities and
- those who are in need of adult protective services.

¹In many cases, the resident has financial resources available to contribute to their cost of care. Programs such as Social Security, Social Security Disability Insurance and Supplemental Security Income are the most common sources of a resident's income. Other private sources may also be available.

Statewide, there are three providers at seven sites licensed to provide adult protective services to about fifty clients. This vendor operates three of the seven separate sites, each with six beds serving a total of eighteen clients.

We are aware that the Center for Medicaid Services (CMS) has expressed concern regarding federal participation in the cost of services being provided by PNMI's. In the case of Appendix F facilities, CMS has expressed concerns over the bundling of prospective rates, non-transparent room and board, and the lack of clinical supervision. A bundled rate exists when a single rate is used to pay for services prospectively² at the time they are provided, regardless of the number of units of service, types of service or the level of practitioners who are providing the service. Room and Board costs are not medical and remedial and therefore not eligible for federal financial participation. Since the State is classifying only an incidental amount of \$1 per day as Room and Board and charging it to the General Fund using a separate object code, it appears that in a non-transparent fashion, federal reimbursement is being collected for unallowable Room and Board costs by improperly classifying them as Direct Care Services. The lack of clinical supervision over paraprofessionals who are providing mental health services calls into question the medical and remedial necessity of the services and therefore the allowability of the services for federal financial participation.

Procedures

We met with DHHS personnel as follows:

- the Office of Aging and Disability Services to gain an understanding of the history of the vendor, the service they provide and the environment in which they operate,
- the Division of Licensing and Regulatory Services to gain an understanding of the licensing and facility survey process,
- the Rate Setting Unit to gain an understanding of the prospective reimbursement methodology,
- the Division of Audit to gain an understanding of the cost report settlement process, and
- the Office of MaineCare Services (OMS) to review the results of our expenditure test.

We toured all three of the vendor's facilities with their Administrator in order to become familiar with the services provided. We also discussed the Administrator's regulatory concerns.

We met with personnel employed by the vendor's bookkeeping service in order to become familiar with their accounting and cost report filing process. We also discussed their concerns regarding the claims processing and reimbursement process.

We examined \$7.5 million paid to the vendor from fiscal year 2008 and ending approximately half way through fiscal year 2013. We tested the population of expenditures paid to the vendor for the period July 1, 2012 to December 30, 2012 for compliance with the daily rate established by DHHS's Rate Setting Unit and for the proper deduction of Cost of Care. Cost of Care is a term used to describe the dollar amount available from sources other than the State that must pay for services being provided to clients prior to Medicaid financial participation.

Results

We gained an understanding of the environment in which this vendor operates as a Private Non-Medical Institution (PNMI) by meeting with staff employed by the Office of Aging and Disability Services.

² Subject to annual cost settlement

From our meeting with the Division of Licensing and Regulatory Services, we learned that this vendor has been providing quality services to clients and has a history of facility surveys that are free of deficiencies. Our less formal observations are consistent with their comments to us.

From our meetings with the Rate Setting Unit, we learned that reimbursement rates for Direct Care Service Costs are driven principally by amounts reflected in the vendor's most recently available Medicaid cost report examined by the DHHS Division of Audit. We obtained their agreement that the \$1.00 daily rate for Room and Board is an arbitrary amount without any basis in the rules for reimbursement, nor is there any foundation for the rate in the vendor's historical costs.

From our meetings with the DHHS Division of Audit, we gained an understanding of the process by which the vendor's Medicaid Cost Reports are examined. We reviewed in detail one audited cost report for one of the vendor's facilities and found that all settlement calculations were consistent with the MaineCare rules for reimbursement.

Based on our walk-through of each of the vendor's three facilities, we were left with the impression that the facilities are clean, secured and well maintained. The facility's Administrator, a dedicated and long serving employee expressed his concerns regarding current reimbursement methodologies. He knew that the State systematically overpays them and that the money must be repaid. He noted that in the past, he has written to DHHS expressing concerns about the fact that, separately from the overpayment issue, the vendor has not been able to recover their operating costs.

From our discussions with the vendor's bookkeeping service, we gained an understanding of the claims and accounts receivable process as well as the process for filing the annual Medicaid cost report. The president of the bookkeeping service company expressed the same concerns as the Administrator regarding the vendor's finances and noted that past attempts to communicate concerns with the Department of Health and Human Services did not result in a response from the State agency.

In our examination of expenditures paid to this vendor between fiscal year 2008 and mid-way through fiscal year 2013, consistent with our expectations, we found that there was no significant change in the annual level of payments made to this vendor for Residential Treatment and Personal Care Services provided to Medicaid eligible clients.

From our test of expenditures paid to the vendor for the first half of fiscal year 2013, we concluded as follows:

- All payments were made based on the correct approved daily rate.
- A total of \$85,785 in Cost of Care was not deducted from payments to the vendor, thus the vendor was overpaid by this amount.

Conclusions and Recommendations

Currently, payments to the vendor are not being reduced by the applicable amount of Cost of Care. We learned that this vendor owed DHHS \$274,213 for overpayment of claims as of April of 2013. We recommend that DHHS initiate a system change the effect of which will allow Cost of Care to be deducted from all payments to the vendor.

For the period fiscal year 2008 through fiscal year 2012, the vendor claims they were underfunded by \$578,077. We recommend that the Department of Health and Human Services meet with the vendor to review their concerns regarding adequate funding.

The last examination and cost settlement performed by the DHHS Division of Audit for this vendor related to fiscal year 2009. We recommend that The Department of Health and Human Services “catch-up” on their annual cost settlements with this vendor.

We thank the dedicated workers employed by the vendor and its agent as well as the many dedicated persons employed by the Department of Health and Human Services for providing their insights and feedback regarding these matters.

Agency Response

Response to Recommendation 1:

Originally, the MIHMS system was not properly designed to collect Cost of Care from PNMIs.

Based on the recommendations of a separate auditor examining Cost of Care for a sample of sixty PNMIs and Nursing Homes, we have requested a MIHMS Change Request (CR) to have cost of care deducted from all lines on a PNMI claim. Work is currently progressing on this CR (#36287) by State and Fiscal Agent systems staff. Once the system has been updated, we will adjust all claims where the COC overpayment has not been paid to the Department by the provider.

We described the current cost of care collection process to the auditor. A designated State employee receives and reviews reports of members with uncollected cost of care for prior months. This individual attempts to work directly with the PNMIs to set up repayment plans or to recoup the money. As the auditor noted, the PNMIs are aware of the overpayment and can refund the money.

Response to Recommendation 2:

The Department does not have a copy of the vendor’s documentation supporting their claim that they have been underfunded by \$578,077. The Department reimburses residential care facilities based on the applicable Principles of Reimbursement. To be allowable for reimbursement, costs must be reasonable and necessary. In addition, reimbursable cost is capped. If the facility incurs cost in excess of their cap, the excess cost is not allowable for reimbursement.

We would refer the provider back to Chapters II and III of the MaineCare Benefits Manual for an explanation of covered services and determination of reimbursement. In addition, as noted in Chapter 115, Principles of Reimbursement for Residential Care Facilities – Room and Board Costs, “Reimbursement for specified room and board costs shall be provided on a “reasonable cost-related basis” rather than by simply reimbursing the provider’s costs. In determining what is a reasonable cost-related basis, all payments must relate to the care of the member and be based on the “reasonable cost.” Reasonable costs include all allowable, necessary and proper costs incurred in rendering room and board to members who are receiving Medical and Remedial Services under the MaineCare program, subject to the Principles relating to specific items of revenue and cost. Costs may not be shifted from Medical and Remedial Services to room and board.”

Response to Recommendation 3:

The Department has a strategy to “catch up” on all of its cost report audits. Audit of the vendor’s cost reports is part of that strategy. The vendor’s audits should be complete by June 30, 2014.

Information requests for Department of Education and Department of Health and Human Services regarding Child Development Services for meeting of HHS Committee on December 10, 2013

1. Please provide information on any policy changes made in order to come into compliance with the 2012 OPEGA report on Child Development Services. (DoE, DHHS)
2. With regard to consideration of changes detailed in question 1 above, please provide information on the involvement of children's mental health and CDS services providers in the process of considering change and in implementation of the change. (DoE, DHHS)
3. Please provide specific information on the rates of identified intellectual disabilities that require CDS services among children 0 to 3 years and 3 to 5 years. Please provide similar data on rates of identified autism and other developmental disabilities.
4. Please provide information on progress in mainstreaming children 3 to 5 years who have received CDS services.
5. Please provide information on collaboration between DHHS and DoE on Section 28 and Section 64 services.
6. Please provide information on the adoption of rules by DHHS and DoE on deemed status for the certification of early childhood education programs.

FY	VENDOR NAME	FUND	APPROP	APPROP_TITLE	ENCUMBERED AMOUNT	ENCUMBERED DATE	EXPENDITURES TO DATE	EXPENDITURE DATE
2014	THE ALEXANDER GROUP LLC	10 GF	12901	OFFICE OF MAINECARE SERVICES	\$124,560	9/30/2013	\$11,560	11/7/2013
2014	THE ALEXANDER GROUP LLC	13 FEF	12901	OFFICE OF MAINECARE SERVICES	\$124,560	9/30/2013	\$11,560	11/7/2013
2014	THE ALEXANDER GROUP LLC	10 GF	14201	OFFICE OF THE COMMISSIONER	\$330,315	9/30/2013	\$50,537	11/7/2013
2014	THE ALEXANDER GROUP LLC	14 OSR	14201	OFFICE OF THE COMMISSIONER	\$276,645	9/30/2013	\$43,232	11/7/2013
2014	THE ALEXANDER GROUP LLC	15 FBG	13801	TANF BLOCK GRANT	\$69,120	9/30/2013	\$6,471	11/7/2013
TOTAL					<u>\$925,200</u>		<u>\$123,360</u>	

FFTA



Foster Family-based Treatment Association

September 12, 2013

Dear Members of the Health & Human Services Committee,

Thank you for inviting us to present our concerns before the HHS Committee on Wednesday, September 11, 2013, and for the detailed and thoughtful questions the Committee members posed to us. As you requested, I am writing to you provide you with information about the number of foster homes recruited by Treatment Foster Care agencies over the last five years. The FFTA is also discussing what other data we might be able to gather that would be helpful to the Committee. Please note that the Treatment Foster Care agencies have been sending extensive data to the DHHS on a monthly basis for several years and I have attached the data tracking form for your review.

In the 5 year period from June 2008 to June 2013, FFTA member agencies recruited and trained 126 new treatment level foster homes. This represents an average addition of one new TFC home every two weeks and accounts for a significant number of the homes that are currently providing Treatment Foster Care for Maine's children.

I would also like to take this opportunity to clarify a couple of issues from Wednesday's meeting:

- **Why we requested to appear before the Committee Wednesday:** Based on comments made by the DHHS in our monthly meetings with them, we believed the DHHS would be presenting to the Committee either 1) the "White Paper," and/or 2) their proposed redesign in anticipation of an RFP this Fall, neither of which we have been privy to. Last November (2012), the DHHS asked us to engage in discussion with them about the current foster care system, in terms of what works, what could be improved, etc., as they felt there were some service gaps. We started that discussion in our November meeting with them. We had a brief phone meeting in December due to inclement weather; the DHHS cancelled the meetings for January, February, and March. At the April meeting, in the last 5 minutes, Therese came in to the meeting and told us that there would be an RFP out in the Fall to redesign the foster care system, with implementation of a new system by January 2014. She said that treatment foster care as we know it would no longer exist, and that effective July

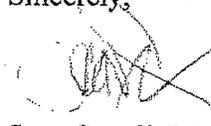
2013, the DHHS would take over payment to all TFC foster parents – she provided no details. To date, payment has not changed. At subsequent meetings, the DHHS told us that they could **listen** to anything we might want to say about the foster care system, but they could no longer **share** anything about the “redesign” because the RFP was in development. Until yesterday, we did not know that the DHHS intended to share the “White Paper” with us later this month. We have heard nothing further about an RFP.

- TFC agencies do recruit homes to provide treatment level foster care, and DHHS also recruits “regular” foster homes. Some regular foster homes begin their fostering experience with a TFC agency because they have work or personal experience that qualifies them to provide treatment level care. (TFC agencies do the home studies for all the homes we recruit.) Foster Parents in Maine, whether regular or treatment level, are independent contractors. That means they can decline any child that is presented to them for placement. Placement decisions are complex, not the least of which is the potential impact on children already in the home.
- The TFC model does not include “emergency placements” due to the critical placement considerations and matching that must be made to maintain stability in the TFC home. Rider E of our contract with the DHHS states: **“Emergency placement will not be made in treatment foster homes due to the need for careful assessment and planning.”** The DHHS has primary responsibility to find an emergency placement in a regular foster home as the first step to protect children who have been removed from their homes under emergency situations.

TFC agencies do not want **one** child/youth in a shelter, at a DHHS office, or “couch surfing” while waiting for a foster care placement, let alone the 35 youth that Therese mentioned in her statement before the Committee. We all agree that there is a shortage of all levels of foster homes. We simply ask that the DHHS not forget the 379 children that are safe and sound in the homes of caring, professional treatment foster parents. That alone is a testament to the TFC model.

We thank the Committee for hearing our concerns and for your ongoing efforts on behalf of Maine’s children.

Sincerely,



Sean Scovil, LCSW, Chair
Foster Family-based Treatment Association
40 Summer Street
Bangor ME 04401
(207) 945-4240
SScovil@comcareme.org

Treatment Foster Care Data Tracking

2013

line

- | | | |
|----|---------------|--|
| 1 | August | Report month |
| 2 | | Agency name |
| 3 | | Office location |
| 4 | | Person completing report |
| 5 | | Total number of therapeutic beds |
| 6 | | # available beds |
| 7 | | # of children in placement |
| 8 | | Admissions |
| 9 | | Discharges |
| | | # adopted outside agency |
| | | # to crisis |
| | | # to hospital |
| | | # to kin |
| | | # to residential |
| | | # adopted by foster parents |
| | | # level goes down within home |
| | | # reunified to birth family |
| | | # disrupted from home |
| | | # ran away/missing |
| | | # transferred to another TFC agency |
| | | # other |
| | | # aged out |
| 10 | | # referrals received |
| 11 | | # referrals declined for any reason |
| 12 | | # calls handled by on-call staff within agency |
| 13 | | # calls to outside crisis services |
| 14 | | # ER visits for medical |
| 15 | | # ER visits for non-medical reasons |
| 16 | | # calls to law enforcement |
| 17 | | # calls to law enforcement that result in an arrest/ summons |
| 18 | | # restraints |
| 19 | | # children involved in restraints |

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Orbeton, Jane

From: At Your Service Taxi <barharbortaxi@gmail.com>
Sent: Tuesday, November 26, 2013 12:55 PM
To: Orbeton, Jane
Subject: Being a provider for CTS
Attachments: editorial.docx

Please forward my comments to committee members. Thank you

Clare Bingham

I have been reading with interest the many articles and editorials about CTS and the administration of the MaineCare Transportation program. My small family business is one of the many transportation providers in Hancock and Washington counties. When I first heard about the transition that was coming for servicing this program from WHCA to CTS, I was apprehensive. I had been working with Washington County Community Agency (WHCA) for the past eight years and everything ran smoothly. I knew my clients well and the staff at WHCA and I had a good relationship.

That being said, the contract was awarded to CTS because of the Federal mandate and other reasons well known at this point and we all took months to adjust our systems to this decision. Now I am reading that there is a chance that CTS may lose the contract. I believe changing systems at this early point would be a waste of time and money.

There has been a lot of focus on CTS and their administration of the program, but there may be a piece you are forgetting. The MaineCare transportation service is only as good as the all the providers who actually perform the services. To have good services in Maine you will need the cooperation of all of the individual providers which takes time to earn.

Being directly involved, in the beginning, I heard a lot of the frustration this transition caused to the clients I normally drove. What I haven't heard in the discussion to potentially end the contract is that if the contract is changed all of the providers in the state will have to again learn a whole new system and integrate it into our own systems. It will take months just to go through the application process and sign individual contracts with each provider.

We began this process in early June, I attended meetings with other taxi services, ambulance companies and other transportation services from across the state to learn about this new company, CTS, what we were expected to do. To add to the learning curve, the decision was made to launch the new system in August, arguably one of the busiest months of the year for taxi service. I honestly didn't have a lot of time to devote to learning the new Trapeze System and how to go through a portal to get clients assigned to me. Because of this, it took me a few months to decide whether or not I wanted to sign a contract with CTS and commit to learning this new program.

But over the past few months I have taken the time to learn about the new system and the staff at CTS and I can report a vast improvement from August to now. I don't think the learning curve for providers or the staff at CTS can be underscored enough. They needed us to understand the Trapeze System, and we needed them understand our territories and what we could and couldn't provide. I can say from my prospective that

between August and today that has happened and things are running much more smoothly.

For example, in August I would receive several calls for services that didn't make sense for my company to perform. This was very frustrating for me and the CTS call center. However, I have found that one of the best strengths of CTS is their dispatchers. At first they were clearly overwhelmed, but they always listened and over time they have all learned what to call us for and now we rarely get calls for trips outside our territory.

I have also learned about the staff at CTS and who to call with what questions. Every time I have attended a meeting or asked a question directly, the staff at CTS has listened and made adjustments to the program to fit the situation at hand. For my part, I have learned the Trapeze System and have now integrated it fully into our reservation system. After learning the new system, I can say it is an improvement over what had been done in the past. I have a lot more information to work with as far as upcoming trips and I am able to plan much further out, and the reporting requirements and billings are much more straightforward.

I don't know about the politics of the situation or what should or should not have been done. I do want to point out that even if there is a more perfect system out there, (and I can only hope that would have been vetted out before now), the time and money spent to completely change to another system at this point may not be taking into consideration that all of the providers would have to relearn another new system. A new company will still face the same learning curve and the time it will take to build the necessary collaborations with the hundreds of providers across the state. Not to mention all of the clients who will also have to be reeducated in how to set up their transportation needs.

As far as my experience in Hancock and Washington County, the services through CTS have improved significantly over the past few months; I believe that instead of starting over you should consider giving CTS a fair chance at success.

Clare Bingham Broad
President
CJTL, Inc
At Your Service Taxi
Mount Desert, ME



STATE OF MAINE
OFFICE OF THE STATE TREASURER
39 State House Station, Augusta, ME 04333-0039
www.maine.gov/treasurer

NERIA R. DOUGLASS
State Treasurer
KRISTI L. CARLOW
Deputy State Treasurer

To: Members, Joint Standing Committee on Appropriations and Financial Affairs
Members, Joint Standing Committee on Health and Human Services
Fr: State Treasurer Neria R. Douglass
On: December 1, 2013
Re: 2013 Tobacco Settlement Payments Report

Mandated Report: The State Treasurer is required to report the status of Maine's Tobacco Settlement Payments each December to the Joint Standing Committees on Appropriations and Financial Affairs and Health and Human Services. The report must summarize the activity in any funds or accounts directly related to the Fund for a Healthy Maine. See 22 M.R.S.A s. 1511(8).

EXECUTIVE REVIEW

In 1998, Maine, along with 45 other states and 6 U.S. Territories became creditors of Participating Cigarette Manufacturers (PMs) pursuant to a Master Settlement Agreement (MSA) made between the states and many cigarette manufacturers settling lawsuits brought by these states and territories. Florida, Minnesota, Texas and Mississippi had already reached individual agreements with the tobacco industry. The MSA exempted participating cigarette manufacturers from liability to the state governments arising from the claims alleged in the states' lawsuits, and provided those state governments with compensation for smoking related medical costs and the states' other monetary claims, and with funding to help reduce smoking in the United States through a national foundation. The MSA also limited the marketing and advertising practices of the cigarette manufacturers to further protect public health.

Maine's continuing receipt of Tobacco Settlement Payments hinges on three (3) key factors:

1. Enforceability: The continuing enforceability of the manufacturers' Master Settlement Agreement payment obligations.
2. Financial Capacity: The continuing financial capacity of the OPMs and SPMs to make timely Master Settlement Agreement payments.
3. Legal Actions: Legal actions which delay or alter Master Settlement Agreement Payment obligations.

PAYMENTS FORMULA AND REVENUE PROJECTION PROCESS

ELIGIBILITY: Maine has the right to always receive 0.7693050% of the Annual Payments that are expected to be paid in perpetuity pursuant to the MSA. In addition, Maine will also receive 1.3281978% of the Strategic Contribution Payments during the years 2008 through 2017. Maine is eligible for these supplemental payments as a result of its early involvement in the work which resulted in the MSA. Payments are due in April each year.

PAYMENTS FORMULA: Annual settlement payments are driven by two key annual adjustments, the 1) inflation adjustment and the 2) volume of cigarettes sold nationwide. Under the Inflation Adjustment, the base annual payments will increase annually by the greatest of 3% or CPI, (Consumer Price Index). Under the

Volume Adjustment, the MSA tobacco payments due from the manufacturers are either reduced or increased depending on whether the Original Participating Manufacturers' national sales volumes for a given sales year are less than or greater than, respectively, the national cigarette sales volumes for 1997. Maine's Tobacco Settlement Payments are directly related to the shipments of cigarettes nationwide, without regard to increases or decreases in Maine cigarette sales.

REVENUE PROJECTION PROCESS: The Treasurer's Office organizes a meeting of the Maine Attorney General's Office, the State Budget Office and the Legislature's Office of Fiscal and Program Review in advance of the Spring Revenue Forecasting Committee meeting in order to reach consensus on the revenue forecast. That meeting agenda includes a review of an econometric model available from the National Association of Attorneys General that projects domestic consumption of cigarettes. Each meeting also discusses the likely impacts on Maine's payments stream of any disputes pending under the MSA. These disputes, and the timing and direction of their outcomes, present significant volatility to the revenue stream projection process.

Under the MSA, a participating tobacco company may be entitled to a reduction in its annual payment obligation for the Non-participating Manufacturer Adjustment if two (2) things are determined in its favor: First, an economic firm determines that the disadvantages imposed upon it by the MSA were a significant contributing factor in its loss of market share to non-participating manufacturers (NPMs), and; Second, recovery of this NPM Adjustment amount from an individual state is dependent on a) whether the state had a qualifying statute governing NPM escrow deposits in place during the relevant sales year and b) whether the individual state diligently enforced that qualifying statute.

Once the PMs dispute the calculated amount they owe by claiming entitlement to the NPM Adjustment, they have three options under the MSA. They may pay the contested amount to the State anyway, as Phillip Morris did for sales years 2003-2009, or the PM may place the amount in a disputed payment account, which R.J. Reynolds did for sales years 2003-2010 (excepting sales year 2006, for which it withheld the NPM Adjustment amount), and which Phillip Morris did for the first time with its April 2011 payment. To date R.J. Reynolds has escrowed more than \$2.1 billion into the disputed payments account for the NPM Adjustment for those sales years. Finally, the PMs may simply withhold the entire amount they dispute from their annual payments, and many PMs have done this.

Beginning in sales year 2003 (and expected for every sales year thereafter), the PMs have claimed that they are entitled to an NPM Adjustment, which would result in a decrease in the amount the PMs owe under the MSA for any year in which the PMs' argument succeeds. The 2003 NPM Adjustment dispute as it pertains to Maine went to a final arbitration hearing in September 2012, and on September 11, 2013 the Panel issued its ruling finding in Maine's favor. Specifically, the Panel found that Maine did enforce its qualifying statute during sales year 2003 and that the PMs, therefore, are not entitled to the NPM Adjustment for that year. We estimate that the state will receive approximately \$5.5 million as a credit for those amounts that had been withheld or placed in the Disputed Payments Account attributable to the PMs' claimed NPM Adjustment for sales year 2003. The timing of this credit to Maine is unknown as a result of several factors, including when the Independent Auditor will issue instructions as to payment source(s) and timing, whether any states will contest those instructions, and whether those states found to have been non-diligent for sales year 2003 will contest the Panel's decision as to several global issues affecting all states in the arbitration.

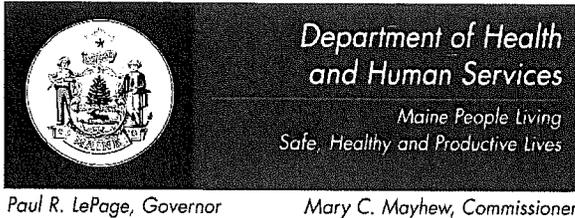
TOBACCO SETTLEMENT PAYMENTS AND INVESTMENT EARNINGS

The State of Maine has received \$739,987,776 to date in Tobacco Settlement payments. Each payment is deposited into the Fund for a Healthy Maine (FHM) where it is held in the Treasurer's Cash Pool. All investment earnings on these funds are deposited back into the FHM.

ESTIMATED FUTURE TOBACCO SETTLEMENT PAYMENTS

(BASED ON DECEMBER 2013 RECOMMENDATION TO THE REVENUE FORECASTING COMMITTEE)

	FY 13 (Actual)	FY 14	FY 15	FY 16	FY 17
Base Payments	50,986,658	41,825,854	41,379,781	40,938,466	40,501,857
Strategic Contribution Payments		8,617,031	8,525,131	8,434,210	8,344,259
Racino Revenue		4,259,143	4,430,980	4,475,290	4,520,043
Income from Investments	5,657	3,754	5,090	13,485	17,949
Offset	0	0	0	0	0
TOTAL FHM Revenue	55,992,315	54,705,782	54,340,982	53,861,451	53,384,108



Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707
Fax (207) 287-3005; TTY: 1-800-606-0215

December 10, 2013

To: Senator Margaret M. Craven, Chair
Representative Richard R. Farnsworth, Chair
Members of the Joint Standing Committee on Health and Human Services

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: DHHS Response to questions regarding the Riverview Psychiatric Center for December 10th meeting with HHS.

1. What progress is DHHS making in the appeal of decertification of RPC?

Response: As can be seen in an email sent to the Committee on November 12, all briefs will have been filed by mid-January 2013. At that point, a hearing will be scheduled.

2. Please provide copies of the appeal document and any other documents filed by DHHS and CMS.

Response: The appeal was sent directly to Legislative leadership by the Attorney General's Office on October 15, and is included in this packet as Attachment A

3. What is the timeline for the appeal and a decision by CMS on the appeal?

Response: DHHS filed the appeal on October 11, 2013. CMS filed its brief on December 3, 2013. The DHHS brief is due no later than January 3, 2014. The CMS reply is due 10 days after the DHHS brief is filed. The parties expect that the Administrative Law Judge (ALJ) will make a decision within a month thereafter, although there is no obligation for him to do so.

4. If this appeal is not successful is there another level of appeal?

Response: If the ALJ rules against DHHS, DHHS may appeal to the (US HHS) Departmental Appeals Board within 60 days. If dissatisfied with a decision of the DAB, DHHS may appeal to federal court.

5. If there is another level of appeal does DHHS intend to appeal?

Response: Yes

6. If DHHS files another level of appeal what is the timeline for a decision at that level?

Response: The DAB would set the timeline for decision at that level, as would the federal court at that level.

7. What progress is DHHS making in its application for recertification of RPC?

Response: We received a call from CMS regarding our application on November 18th. They had questions that we clarified and we resubmitted the application on November 21st.

8. Please provide copies of the application and any other documents filed by DHHS.

Response: Copies of the application for recertification were sent to the Committee on October 16.

9. Please provide copies of any correspondence between DHHS and CMS on the application.

Response: Additional correspondence as well as the revised application is attached. Attachment B

10. What is the timeline for a decision by CMS on the application?

Response: No timeline has been provided by CMS.

11. If the application is not successful is there a right to appeal?

Response: There is a right to request reconsideration, and then the same appeal rights (ALJ, DAB, federal court) as for the termination.

12. If there is a right to appeal or reapply does DHHS intend to appeal?

Response: Yes

13. If DHHS files an appeal or reapplication what is the timeline for a decision at that level?

Response: Timelines would be set by the bodies before which any appeals are taken.

14. How is DHHS paying for the costs of operating RPC at this time?

Response: Riverview continues to draw down appropriated General Fund dollars and Federal Disproportionate Share dollars, as it normally would.

15. With the loss of federal funding when will DHHS fully spend or encumber its appropriated and allocated funding for RPC?

Response: The Federal funding has not been disallowed.

16. What changes has DHHS made to staffing or training at RPC as a result of enactment of Public Law 2013, chapter 434?

Response: Please see Attachment C

17. Has the enactment of Public Law 2013 chapter 434 had any effect on staffing and training, employees, patients, admissions or discharges at RPC? If so please provide details.

Response: Admissions and discharges have not changed as a result of PL2013, Chapter 434. For information related to staffing, training, employees and patients, please see Attachment C

Attachment A



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
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Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

October 11, 2013

VIA FIRST CLASS MAIL AND EXPRESS DELIVERY

Department of Health and Human Services
Departmental Appeals Board – MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

Re: *Appeal of Involuntary Termination of Riverview Psychiatric Center's
Medicare Provider Agreement
CMS Certification Number: 204007*

Dear Sir/Madam:

Pursuant to 42 C.F.R. Part 498, the State of Maine's Department of Health and Human Services ("DHHS") appeals the decision of the Center for Medicare and Medicaid Services ("CMS") terminating Riverview Psychiatric Center's ("Riverview") Medicare provider agreement. DHHS requests a hearing before an Administrative Law Judge. Further, because of the significant adverse consequences the termination decision may have on the health and welfare of Riverview's patients, DHHS requests that the hearing be expedited.

Background

In March and May of 2013, DHHS's Division of Licensing and Regulatory Services¹ conducted surveys at Riverview and found a number of deficiencies. Among the deficiencies were issues relating to the presence of correctional officers, and their use of tasers and handcuffs, at Riverview. By letter dated June 4, 2013, CMS notified Riverview that as a result of these deficiencies, it was terminating Riverview's Medicare provider agreement effective September 2, 2013. CMS notified Riverview that it could avoid termination by submitting an acceptable Plan of Correction ("POC").

CMS rejected initial POCs submitted by Riverview on June 14 and July 18. On August 16, 2013, DHHS submitted a revised POC. As result of discussions with CMS personnel, and the rejection of previous POCs, it was clear that CMS would not accept any POC that would permit the presence of correctional officers. Accordingly, at the advice of CMS personnel, Riverview decertified twenty beds at its forensic unit, where the patients posing the most significant safety issues are housed. This resulted in Riverview having two separate parts – a "distinct part" 72-bed

¹ The Division of Licensing and Regulatory Services performs surveys on behalf of CMS under a written agreement pursuant to 42 U.S.C. § 1395aa.

Attachment A

*Appeal of Involuntary Termination of Riverview Psychiatric
Center's Provider Agreement
CMS Certification Number: 204007
Page 2*

unit that would participate in the Medicare program (the "Hospital"), and a twenty-bed forensic unit (the "Noncertified Part") that would not participate in the Medicare program. Federal law expressly permits a psychiatric hospital to designate a "distinct part" and apply for Medicare participation of that portion only. 42 U.S.C. § 1395x(f). By separating into two parts, Riverview could allow the presence of correctional officers at the Noncertified Part (the forensic unit) without risk of being out of compliance with any Medicare requirements applicable to the Hospital.

By letter dated August 29, 2013, CMS accepted DHHS's POC. It stated that it would conduct a "revisit survey" to determine whether "your facility meets Federal requirements for certification as a distinct part psychiatric hospital." CMS further stated that a "[f]ailure to correct Condition-level deficiencies will result in termination of the Medicare provider agreement." CMS also referred to Riverview's appeal rights if the facility were "not found to have corrected Condition-level deficiencies."

CMS conducted the revisit survey on September 17, 2013. None of the deficiencies noted during the March and May surveys was noted during the September 17 survey. Presumably, then, CMS found that Riverview had corrected all such deficiencies.² However, CMS did note other deficiencies, all of which related to the sharing of staff, equipment, and other resources between the Hospital and the Noncertified Part. None of these was a "Condition-level deficiency" warranting termination of Riverview's provider agreement. Further, there is nothing in federal law or regulation that prohibits the sharing of resources between a Medicare-certified distinct part and other parts of a facility.

Nevertheless, by letter dated September 27, 2013, CMS advised Riverview that it had "concluded that it will not re-open and revise its initial determination to terminate Riverview Psychiatric Center's Medicare provider agreement." CMS further stated that the termination would be retroactive to September 2, 2013, even though at that time, Riverview had been operating under a POC accepted by CMS.

Bases for Appeal

A primary basis for this appeal is that CMS's decision to terminate Riverview's Medicare provider agreement was based on the erroneous legal conclusion that there can be no sharing of staff, equipment or other resources between the Medicare-certified distinct part of a facility and the separate non-certified part. CMS cites no legal support for such a conclusion, and there is none.³

² Because CMS apparently found that Riverview corrected all of the deficiencies noted during the March and May surveys, DHHS understands that there is no need to appeal whether CMS erred in finding those deficiencies, whether those deficiencies warranted termination of Riverview's Medicare provider agreement, or whether CMS erred in rejecting Riverview's initial POCs addressing those deficiencies. In the event that CMS claims that the March and May deficiencies are somehow relevant to this appeal, DHHS reserves the right to seek review of these issues.

³ In fact, interpretative guidance published by CMS expressly allows for sharing of services. It states that "[i]t is rare that a distinct part of a hospital is completely self-contained" and that "in most instances, the distinct part shares with the rest of the institution such central support services as dietary, housekeeping, maintenance, administration and supervision, and some medical and therapeutic services." State Operations Manual, Chapter 2, § 2048C. It

Attachment A

*Appeal of Involuntary Termination of Riverview Psychiatric
Center's Provider Agreement*
CMS Certification Number: 204007
Page 3

While it is possible that by sharing resources, a Medicare-certified distinct part might leave itself without sufficient resources to provide adequate care for its patients, there is no evidence of such a result here. At no time did any sharing result in the Hospital having insufficient staff and equipment to provide adequate care, and CMS did not find otherwise. Accordingly, CMS's decision to terminate Riverview's Medicare provider agreement should be vacated and the agreement reinstated.

Even if CMS was correct in determining that the Hospital was out of compliance because it shared resources with the Noncertified Part, it should not have terminated Riverview's provider agreement retroactive to September 2, 2013. Rather, it should have given Riverview an opportunity to submit a POC to address the new alleged deficiencies cited during the September 17 survey.⁴

Specific Issues for Appeal

While the overriding issue is whether the Hospital was somehow precluded from sharing resources with the Noncertified Part, the following are specific issues that may need to be addressed.

Issue 1: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.12.

Section 482.12 provides, in relevant part, that a hospital must have "an effective governing body legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body." The Hospital fully complied with these requirements, and CMS's determination to the contrary is erroneous. CMS's determination is apparently based on its finding that the governing body failed "to govern the hospital in delineating certified and non-certified sections of the institution and assuring separation of services of the certified portions of the facility as required." In support of this finding, CMS noted that 1) the governing body failed to ensure that only Hospital staff responded to emergencies in the Hospital and did not respond to emergencies at the Noncertified Part; 2) minutes from a meeting of the Riverview Psychiatric Center Advisory Board (the "Board") reflect discussion of issues relating to the Noncertified Part, but do not reflect discussion of "how the hospital was operationalizing the decertification of portions of the hospital and managing the certified portion of the hospital" and instead note that there were "[n]o new policies to present;" 3) the Hospital

continues: "The primary consideration in evaluation of shared services is whether the sharing can be done without sacrifice to the quality of care given the patients in the distinct part and without endangering their health and safety." *Id.* Here, CMS did not address this consideration, and instead concluded that the Hospital was out of compliance merely because it shared services. Under CMS's own interpretative guidance, this conclusion was erroneous.

⁴ In fact, CMS's September 27, 2013 letter notifying Riverview that its provider agreement was being terminated was a new "initial determination" triggering the sixty-day appeal period. *See* 42 C.F.R. §§ 498.3(b), 498.40. Out of an abundance of caution, and because DHHS seeks prompt resolution of this matter, it is nevertheless filing this appeal now.

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“borrowed” an EKG machine from the Noncertified Part; and 4) a single Pyxis Medication Communication System serves both the Hospital and the Noncertified Part.

As an initial matter, none of these findings supports the conclusion that the Hospital did not have “an effective governing body legally that is responsible for the conduct of the hospital.” Nor do these findings even support an allegation that the governing body failed to ensure that the Hospital was operating in compliance with all applicable regulations. While CMS faults the governing body for not “assuring separation of services of the certified portions of the facility as required,” CMS does not, and cannot, cite to any such requirement. Indeed, as noted above, CMS’s own interpretative guidance states that “in most instances,” services will be shared, and that such sharing is acceptable so long as it does not sacrifice the quality of care or endanger the health and safety of patients in the distinct part. *See n.3 supra*. As is discussed in more detail below with respect to Issues 3, 4, 7 and 8, there is no evidence that the Hospital was ever understaffed or that sharing of services ever impacted the Hospital’s quality of care. In the absence of such a finding, the facts that staff from one part respond to emergencies on the other part, that separation was not discussed at a Board meeting, that the Hospital once “borrowed” a piece of equipment, and that a single medication dispensing system serves both the Hospital and the Noncertified Part, are of no relevance. The Hospital fully complied with Section 482.12.

Issue 2: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.21.

In relevant part, Section 482.21 provides that a “hospital’s governing body must ensure that the program reflects the complexity of the hospital’s organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.” The Hospital fully complied with these requirements, and CMS’s determination to the contrary is erroneous. CMS’s determination is apparently based on its finding that the facility had entered into various service contracts which “referred to the entire 92 bed institution . . . and made no distinction between services provided in the hospital and institution as a whole.” CMS further found that “[t]hese contracts were not revised per the hospital August 29, 2013 Plans of Correction.” CMS does not explain how the fact that the facility contracted for certain services facility-wide somehow means that the Hospital did not have a compliant quality assessment and performance improvement program. And, there was nothing in the August POC stating that contracts would be revised as CMS alleges. The Hospital fully complied with Section 482.21.

Issue 3: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.23.

Section 482.23 requires that a hospital “have an organized nursing service that provides 24-hour nursing services,” and requires that the nursing services “be furnished or supervised by a registered nurse.” The Hospital fully complied with these requirements, and CMS’s determination

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to the contrary is erroneous. CMS's determination is apparently based on its findings that 1) nursing staff, including supervisory nursing staff, were "shared" between the Hospital and the Noncertified Part of the facility; and 2) a single nurse supervised both the Hospital and the Noncertified Part of the facility. CMS cites no legal support for the proposition that "sharing" of staff, or having a single person supervise both the certified and Noncertified Parts of a hospital, is prohibited. Moreover, CMS apparently made no finding that the Hospital was actually understaffed. Rather, CMS found only that the "sharing" of staff had the "potential" to result in understaffing. In fact, the "sharing" of staff never resulted in the Hospital being understaffed. The Hospital fully complied with Section 482.23.

Issue 4: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.23(b).

Section 482.23(b) requires that a hospital have adequate numbers of nurses and other personnel to provide nursing care to all patients as needed, and that staffing be such to ensure "the immediate availability of a registered nurse for bedside care of any patient." The Hospital fully complied with these requirements, and CMS's determination to the contrary is erroneous. CMS's determination is apparently based on its findings that 1) a Unit Manager carried a pager and sometimes responded to calls from the Noncertified Part and was training a new staff member at the Noncertified Part; and 2) staff from the Hospital sometimes responded to emergencies on the Noncertified Part, and staff from the Noncertified Part sometimes responded to emergencies at the Hospital. The Hospital was not left understaffed when its staff responded to calls from the Noncertified Part, and CMS made no finding to the contrary. Nor does the fact that staff from the Noncertified Part sometimes responded to emergencies at the Hospital somehow mean that the Hospital was understaffed.⁵ The Hospital fully complied with Section 482.23(b).

Issue 5: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.25(a)(3).

Section 482.25(a)(3) requires that "current and accurate records must be kept of the receipt and disposition of all scheduled drugs." The Hospital fully complied with this requirement, and CMS's determination to the contrary is erroneous. CMS's determination is apparently based on its finding that drug records for both the Hospital and the Noncertified Part were "comingled" and that the "pharmacy did not maintain controlled drug records for the specific certified hospital." However, there is nothing in Section 482(a)(3) that requires such segregation of records, or that by "comingling" records, a hospital is somehow not maintaining current and accurate records. The Hospital did maintain current and accurate records of the receipt and disposition of all scheduled drugs and thus fully complied with Section 482.25(a)(3).

⁵ Given that safety and welfare of patients is presumably CMS's overriding concern, it is odd that it faults Riverview for having reciprocal emergency responses from its two distinct parts.

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Issue 6: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. § 482.25(b)(4).

Section 482.25(b)(4) requires that “[w]hen a pharmacist is not available, drugs and biologicals must be removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with Federal and State law.” The Hospital fully complied with this requirement, and CMS’s determination to the contrary is erroneous. CMS determined that the facility’s pharmacy maintained a “night cabinet” to provide medications when the pharmacy is closed and when the medications are not available through the Pyxis system. CMS further found that night cabinet access was limited to the on-duty nurse. Nevertheless, CMS concluded that the Hospital was in violation of Section 482.25(b)(4) because the on-duty nurse provided medications from the night cabinet to both the Hospital and the Noncertified Part. There is nothing in Section 482.25(b)(4) that prohibits such a practice, however. The Hospital ensured that only properly authorized personnel can access drugs and biologicals when the pharmacy is closed and thus fully complied with Section 482.25(b)(4).

Issue 7: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. §482.62(d).

Section 482.62(d) requires that a hospital have a “qualified director of psychiatric nursing services” and “adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient.” The Hospital fully complied with this requirement, and CMS’s determination to the contrary is erroneous. CMS’s determination is apparently based on its findings that 1) nursing staff assigned to the Hospital sometimes responded to codes or were assigned to work in the Noncertified Part; and 2) the Director of Nurses “splits her time” between the Hospital and the Noncertified Part. However, CMS made no finding that the assignment of staff from the Hospital to work in the Noncertified Part ever resulted in the Hospital having insufficient staff. Rather, CMS found only that such a practice “may impact” patient treatment. In fact, the assignment of Hospital staff to the Noncertified Part never resulted in the Hospital having insufficient staff, and the Hospital thus fully complied with Section 482.62(d).

Issue 8: Whether CMS erred in concluding that the Hospital failed to comply with 42 C.F.R. §482.62(d)(2).

Section 482.62(d) requires that a hospital have “adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient’s active treatment program.” The Hospital fully complied with this requirement, and CMS’s determination to the contrary is erroneous. CMS’s determination is apparently based on its findings that 1) “[t]he nursing department including the Director of Nursing, some supervisory nursing staff (NOD) as well as other nursing staff including Registered Nurses (RNs) and Mental Health Workers (MHWs) were shared” by the Hospital and the Noncertified Part; 2) staff from the Hospital were sometimes assigned to work in the Noncertified Part; and 3) the “night cabinet” maintained by the pharmacy served both the Hospital and the Noncertified Part, and the nurse in

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charge of the cabinet supervised both the Hospital and the Noncertified Part. None of these findings supports the conclusion that the Hospital failed to maintain adequate nursing staff. Indeed, CMS stated only that using staff to cover both the Hospital and the Noncertified Part "can result in nursing staff being unable to provide active treatment to all patients in the hospital, and put hospital patients at risk from a safety perspective as well." It did not conclude such a result actually occurred. Nor does CMS point to any prohibition on Hospital staff working at the Noncertified Part. The sharing of staff and the night cabinet never resulted in the Hospital having inadequate staff, and the Hospital thus fully complied with Section 482.62(d)(2).

Issue 9: Even if the Hospital failed to comply with any applicable regulations, whether any such non-compliance was sufficient to support termination of the Hospital's provider agreement.

As is set forth above, the Hospital contends that it was fully compliant with all applicable regulations, and that CMS's findings to the contrary are without factual support and are based on the erroneous legal conclusion that the Hospital was prohibited from sharing resources with the Noncertified Part. In the event that it is concluded that the Hospital did fail to comply with any applicable regulation, such noncompliance was insufficient to support termination of the Hospital's provider agreement. The Hospital was in substantial compliance with Title XVIII of the Social Security Act and its implementing regulations. CMS did not find that any noncompliance jeopardized or adversely affected the health or safety of patients. Nor did CMS identify any condition-level deficiencies or any deficiencies affecting the quality of care. In these circumstances, CMS should have simply worked with Riverview to correct the alleged deficiencies, and there was no basis for CMS to terminate the Hospital's Medicare provider agreement.

Issue 10: Whether CMS violated applicable statutes, regulations, or principles of substantive and procedural due process, or otherwise acted improperly, by terminating Riverview's Medicare provider agreement retroactive to September 2, 2013 for alleged deficiencies cited during the September 17, 2013 survey.

When CMS accepted Riverview's POC on August 29, 2013, it advised Riverview that its provider agreement would be terminated if it failed to correct "Condition-level" deficiencies. None of the deficiencies cited during the September 17 survey rose to "Condition-level." While CMS faulted the Hospital for sharing resources with the Noncertified Part, this sharing did not limit the Hospital's capacity to furnish adequate care, nor did it jeopardize or adversely affect the health or safety of patients.

In any event, as a result of the September 17 survey, CMS apparently concluded that Riverview had corrected all of the deficiencies cited during the March and May surveys. The deficiencies cited during the September 17 survey were entirely new, and all related to the Hospital's sharing of resources with the Noncertified Part. Even though CMS was well aware that Riverview would be creating a distinct part Hospital, CMS never advised Riverview that resources could not be shared. There is nothing in federal law or regulation suggesting that sharing of resources is prohibited. Indeed, CMS's own interpretive guidance states that such sharing is

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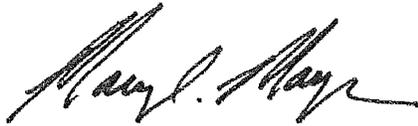
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permissible. In these circumstances, CMS was required to give Riverview an opportunity to avert termination by submitting a POC to address the new deficiencies identified by CMS during the September 17 survey, and CMS erred when it terminated Riverview's provider agreement retroactive to September 2.

Conclusion

For the reasons set forth above, CMS had no basis for terminating Riverview's Medicare provider agreement, and the agreement should be immediately reinstated.

Sincerely,



Mary C. Mayhew
Commissioner
Maine Department of Health and Human Services



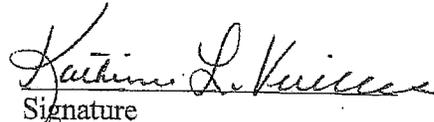
Christopher C. Taub
Assistant Attorney General
Maine Attorney General's Office
#6 State House Station
Augusta, ME 04333-0006
207-626-8565
Christopher.C.Taub@maine.gov
Counsel to DHHS

Enclosures (2)

CMS Notification dated September 27, 2013
CMS Notification dated August 14, 2013

Certificate of Service

I, hereby, certify that on this, the 11th day of October, 2013, I sent copies of the above letter and attachments by both First Class Mail and Email to Daniel Kristola, Branch Chief, Northeast Consortium, Division of Survey and Certification, John F. Kennedy Federal Building, Room 2325, Boston, MA 02203, Daniel.Kristola@cms.hhs.gov.



Signature

Attachment A

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203



Northeast Division of Survey & Certification

CMS Certification Number (CCN): 204007

September 27, 2013

Ms. Mary Louise McEwen, Superintendent
Riverview Psychiatric Center
250 Arsenal Street
Augusta, ME 04330

**Re: Involuntary Termination of Medicare Provider Agreement Effective
September 2, 2013**

Dear Ms. McEwen:

Riverview Psychiatric Center was involuntarily terminated effective September 2, 2013, based on the hospital's failure to comply substantially with Title XVIII of the Social Security Act (the Act) and implementing regulations of the Secretary of Health and Human Services specified at 42 C.F.R. Part 482 (See letters dated April 17, 2013, June 4, 2013, and August 14, 2013 and Statements of Deficiencies dated March 29, 2013, and May 10, 2013). The Centers for Medicare and Medicaid Services (CMS) and the Maine Department of Health and Human Services, Division of Licensing and Regulatory Services (State agency – SA) conducted a re-visit on September 17, 2013, to determine whether promised corrective actions had been completed and substantial compliance had been achieved by August 27, 2013. Findings made during this re-visit are reported in the enclosed Statement of Deficiencies, dated September 17, 2013. CMS has reviewed these findings and concluded that it will not re-open and revise its initial determination to terminate Riverview Psychiatric Center's Medicare provider agreement. Accordingly, the termination action remains effective as of September 2, 2013.

Please refer to CMS' correspondence dated August 14, 2013 for information about requesting a hearing before an Administrative Law Judge of the Departmental Appeals Board under the procedures specified at 42 C.F.R. Part 498.

A provider that wishes to be re-admitted to the Medicare program must demonstrate its ability to maintain compliance. A Medicare provider agreement will not be accepted unless CMS finds 1) that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and, 2) that the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R. §489.57.

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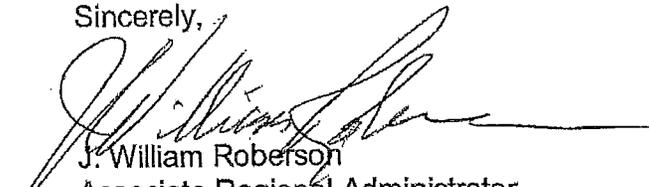
If Riverview Psychiatric Center wishes to be re-admitted to the Medicare program as a provider of psychiatric hospital services, please forward to me a written statement, signed by an authorized official, describing the steps taken to correct the deficiencies that led to the termination of your prior agreement, and the precautions that have been taken to assure that these deficiencies will not recur.

In addition, you are required to enroll with the Medicare Administrative Contractor by completing the Form CMS-855A, Medicare Enrollment Application-Institutional Providers. Any questions concerning this form should be directed to Carlene Vitello at (781)741-3213 (prior to October 18, 2013) or Bobbi Jo Luciano at (207) 253-3322 (after October 18, 2013).

In addition to enrollment and being in substantial compliance with the CoPs, to receive payments under Medicare, you must meet the requirements of Title VI of the Civil Rights Act of 1964. Title VI prohibits discrimination on grounds of race, color, or national origin in any program or activity receiving Federal financial assistance. The Office for Civil Rights is responsible for determining whether a health facility meets the requirements of Title VI. If you are denied participation in the Medicare program, notification will be forwarded to that effect together with the reasons for the denial and information about your right to appeal the decision.

If you have any questions concerning this notice, please contact me at (617)565-3310.

Sincerely,

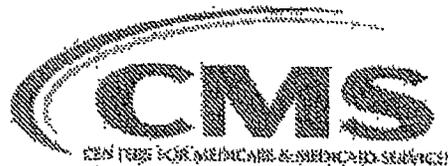


J. William Roberson
Associate Regional Administrator
Northeast Division of Survey & Certification

Enclosure: Form CMS-2567, Statement of Deficiencies

cc:
SA
SMA
AO
MAC
CMCHO-Boston

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203



Northeast Division of Survey & Certification

August 14, 2013

Ms. Mary Louise McEwen, Superintendent
Riverview Psychiatric Center
250 Arsenial Street
Augusta, ME 04330

Re: CMS Certification Number: Z04007
Survey ID: V4Q411, 05/10/2013

Dear Ms. McEwen:

Section 1865 of the Social Security Act (the Act) provides that entities accredited by a CMS-recognized national accreditation organization may be "deemed" to meet the Medicare health and safety conditions. Section 1864 of the Act authorizes the Secretary of Health and Human Services (the Secretary) to enter into an agreement with a State agency (SA) to conduct surveys of such "deemed status" entities participating in the Medicare program when the Secretary finds a survey appropriate because of substantial allegations of deficiencies which, if found to be present, would adversely affect health and safety of patients. If, in the course of such a survey, a psychiatric hospital is found to have deficiencies with respect to compliance with one or more of the Conditions of Participation (CoPs), the Centers for Medicare & Medicaid Services (CMS) is required in accordance with 42 CFR §488.7(d) to remove its deemed status. CMS may keep the psychiatric hospital under SA Medicare survey jurisdiction until its significant Medicare deficiencies have been corrected and it is determined to be in compliance with all Medicare CoPs. Alternatively, if timely correction is not made, in accordance with Section 1866(b)(2)(B) of the Act and 42 CFR §488.7(d) and §489.53(a)(1), a "deemed status" psychiatric hospital that fails to comply substantially with Title XVIII of the Act and its implementing regulations may be subject to termination of its Medicare provider agreement. Please also see 42 CFR §488.28.

On March 29, 2013, the Maine Department of Health and Human Services (State agency) conducted a substantial allegation survey of Riverview Psychiatric Center. In a letter dated April 17, 2013, CMS notified Riverview Psychiatric Center that the psychiatric hospital was not in compliance with the Medicare CoPs for psychiatric hospitals. Because of the existence of significant deficiencies, effective March 29, 2013, survey jurisdiction was transferred to the SA.

On May 10, 2013, the SA conducted a full Medicare survey of your psychiatric hospital. In a letter dated June 4, 2013, CMS notified Riverview Psychiatric Center that

immediate jeopardy was identified but removed during the survey. In addition, during the survey, it was determined that Riverview Psychiatric Hospital was not in compliance with the following Medicare CoPs:

- 42 CFR §482.11 - Compliance with Federal, State and Local Laws**
- 42 CFR §482.12 - Governing Body**
- 42 CFR §482.13 - Patient's Rights**
- 42 CFR §482.21 - Quality Assessment and Performance Improvement**
- 42 CFR §482.22 - Medical Staff**
- 42 CFR §482.41 - Physical Environment**
- 42 CFR §482.61 - Special Medical Record Requirements for Psychiatric Hospitals**
- 42 CFR §482.62 - Special Staff Requirements for Psychiatric Hospitals**

In a notification dated July 5, 2013, the SA notified Riverview Psychiatric Center that the plans of correction were not acceptable for the surveys conducted on March 29, 2013 and May 10, 2013. Subsequently, Riverview Psychiatric Center submitted revised plans of correction. CMS notified Riverview Psychiatric Center on July 29, 2013 that the revised plans of correction were not acceptable.

Because Riverview Psychiatric Center is not in compliance with the Medicare CoPs and has failed to submit acceptable plans of correction, CMS will terminate the Medicare provider agreement between Riverview Psychiatric Center and the Secretary, effective September 2, 2013.

The Medicare program will not make payment for services furnished to patients who are admitted on or after September 2, 2013. For inpatients admitted prior to September 2, 2013, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after September 2, 2013. You should submit, as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your facility on September 2, 2013 to Elaine Soong, DHHS/CMS, JFK Federal Building, Room 2325, Boston, MA, 02203 to facilitate payment for these individuals.

We will publish a public notice in the *Kennebec Journal*.

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. §498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of your receipt of this letter.

Your request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Such a request may be made to the following address:

Department of Health & Human Services
Departmental Appeals Board – MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request for hearing to this office to the attention of:

Daniel Kristola, Branch Chief
Northeast Consortium, Division of Survey and Certification
John F. Kennedy Federal Building, Room 2325
Boston, Massachusetts 02203

If Riverview Psychiatric Center submits acceptable plans of correction immediately for the surveys conducted on March 29, 2013 and May 10, 2013, the SA and the CMS psychiatric hospital contract surveyors may conduct a revisit survey to determine whether compliance has been achieved. This should not be interpreted as an extension to the termination date of September 2, 2013.

If you have any questions, please contact me at (617)565-4487.

Sincerely,



Daniel Kristola, Branch Manager
Certification & Enforcement Branch

cc:
SA
TJC
CMS Central Office

Attachment C

Riverview Psychiatric Center Update:

Recertifying Beds; Recovery Model; Staffing

Recertifying 20 Beds on the Lower Saco Unit

We have identified the following steps that need to be completed in order to ensure the safety of staff and clients as we recertify the 20 beds on the Lower Saco unit:

Create and Hire Four Acuity Specialists

Riverview Psychiatric Center (RPC) worked with the Bureau of Human Resources to create the acuity specialist positions. The positions were posted on November 8 through November 22nd per union contract. The applications are being screen and the interviews should begin in early December.

Provide Additional De-Escalation Training for Staff on Lower Saco

RPC has identified training that will increase the skills of staff in de-escalation techniques. Twelve individuals will be attending a 'train the trainer' three day class the week of January 6th and they will train additional staff.

Establish the Mental Health Unit at Maine State Prison

RPC continues to work with the Department of Corrections to establish this unit, with a goal of completing this project by mid-February. The all-day meetings between the two departments are held biweekly.

Place a Resource Officer from the Capital Police in the RPC Lobby

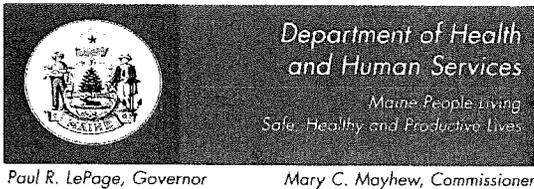
The Department of Public Safety is working with RPC to create additional Capital Police positions that will be assigned to the hospital. Positions have been approved and are now being created by the Bureau of Human Resources.

Recovery and Rehabilitation Model at Riverview

RPC has created a process improvement team to re-engage and re-train staff on the recovery model. On November 21, Patricia Deegan, a national expert on recovery-oriented practice, provided two staff training sessions at RPC. She also provided consultation to the RPC Leadership and Advisory Board teams.

Staff Recruitment and Retention

The hospital continues to struggle with recruiting nurses and psychologists. RPC submitted salary review information to the Bureau of Human Resources and has asked for an official review of the salary structure for both classifications. Due to the emergency need for registered nurses, the hospital has contracted with one agency to provide per diem nurses. The contract was approved on November 18th and the Nursing Department is awaiting applications for screening and interviewing.



Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

December 10, 2013

To: Senator Margaret M. Craven, Chair
Representative Richard R. Farnsworth, Chair
Members of the Joint Standing Committee on Health and Human Services

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: DHHS Responses to questions regarding DHHS Children's Services, the Administrative and MaineCare PNMI Reimbursement and Alexander Group Contract for December 10th HHS Committee Meeting

Children's Services:

1. Please provide a schedule for meetings and progress on the Section 28 rate setting changes.

Response: The Department has continued to meet internally and is in the process of developing an initial draft of recommendations for the review of the Commissioner.

DHHS administrative issues

2. Please provide detailed information on each of the following DHHS administrative matters: the SIM grant, MaineCare eligibility system upgrades, and the actuarial study of MaineCare benefits for the purposes of reimbursement level determination under the Affordable Care Act.

Response:

- SIM Grant: Please see response to questions 5 and 6
- MaineCare Eligibility System Upgrades: Please see Attachment A as provided to the Health Exchange Advisory Commission.
- Actuarial Study of MaineCare benefits: The study is still in progress

3. With regard to the SIM grant please provide information on the initiatives to be studied or implemented and the timeline for accomplishment.

Response: Please see Attachment B and the SIM grant Operational Grant Plan at the following link:
<http://www.maine.gov/dhhs/oms/sim/operational-plans/Maine-SIM-OPS-PLAN-v19.pdf>

4. With regard to the SIM grant please provide information on how each initiative to be implemented will impact the delivery of services by DHHS, the provision of services by community social service providers and access to services by all Maine residents, by clients of DHHS and by members of MaineCare.

Response: Please see Attachment B and the link above

MaineCare reimbursement of PNMI's

5. Please provide a detailed update of the progress that DHHS is making with regard to reimbursement of PNMI's.

Response:

Appendix B: The Department is working internally and with CMS to finalize the development of an acceptable rate methodology and begin the drafting of a State Plan Amendment. The primary concern of CMS is that we are able to clearly observe what services were provided under the rate methodology.

Appendix C: The State Plan Amendment was submitted in July and the Department is currently working with CMS to respond to their formal requests for additional information. Simultaneously, the Department is working internally to begin the rules redrafting work required by the changes outlined in the State Plan Amendment. Additionally, we are meeting with providers to ensure that changes are reasonable and appropriate. Please see Attachment C for further information related to Appendix C.

Appendix D: The Department is working internally to construct an appropriate plan for the redesign of Appendix D services.

Appendix E: The Department is working to identify the true needs of this population to ensure all needs are appropriately addressed for both providers and patients as we begin to work on formulating final policy changes.

Appendix F:

- **Mental Health:** There are two facilities containing a total of 32 beds statewide that fit this category of provider. We are currently meeting directly with providers and assessing their needs and the specific needs of the population to determine the appropriate path forward.
- **Brain Injury:** The Department anticipates the Waiver application should be finished and submitted to CMS in the beginning of January. The Section 18 Rule will be drafted in December and sent to the AG's office for review in the beginning of January. We have established a NF eligibility project timeline and workgroup related to necessary changes. Additionally, the Department has had an extensive Stakeholder process which will continue until the waiver is finally submitted.
- **I/DD:** The Department has been meeting with the Maine Association of Community Service Providers (MACSP) and other PNMI providers outside of MACSP membership each month to continue discussions on the creation of a new model to replace I/DD PNMI's. There are currently 203 (+/-) individuals living in I/DD PNMI's. The Department and the provider association are exploring alternative models of care that will sustain services for this group of people. In partnership, we have completed independent assessments of each member and we are currently completing time studies. We will have a proposed model ready for review in January 2014. The Department is considering several solutions in order to achieve successful transition of the I/DD PNMI's. Solutions may include use of Section 21 (for those already on the program), Section 29 (for those already on the program) and the creation of a new state-plan service through use of a composite rate. We plan to continue meeting with providers and MACSP on a monthly basis until an appropriate solution has been identified.
- **Adult Protective:** The Department has met with the three service providers individually and as a group to continue discussions about the current state and future plans for PNMI, Appendix F Adult Protective Services facilities. Providers have given detailed information about the services they provide and the needs of the individuals receiving those services. Additional assessment has been ongoing as well through use of the *Adult Needs and Strengths Assessment (ANSA)*, which is an assessment of needs,

strengths, and level of care. The Department has gained a better understanding of the real costs of providing this model of service, as well as greater insight and appreciation for the service needs of the individuals they serve. We are currently assessing next steps for appropriate changes to these services.

6. What is the status of any application to federal CMS from DHHS on PNMI reimbursement?

Response: Please see response for question 5

7. What is the timeline for a decision from CMS?

Response: State Plan Amendments can take several months depending on the complexity of the changes.

8. What is the status of DHHS-provider discussions for each type of PNMI?

Response: See question 5

9. What is the impact of the PNMI status quo payment system and any proposed payment systems on the 2014-2015 biennial budget?

Response: We are still assessing potential additional costs.

10. Do the plans or applications submitted to CMS have an impact on PNMI or persons living in PNMI?

Response: Yes

DHHS contract with the Alexander Group

11. Please provide a copy of any contracts with the Alexander Group or Gary Alexander.

Response: The contract was provided to the Speaker's office on November 19th and is included here as Attachment D.

12. What services and at what cost and on what schedule for completion has DHHS contracted for with the Alexander Group?

Response: Please see Attachment D

13. What contracting procedures were used in developing and signing the contract with the Alexander Group?

Response: The statute and rules references noted below provide guidance for developing contracts – the contract for the Alexander Group was developed consistent with these regulations.

Title 5: ADMINISTRATIVE PROCEDURES AND SERVICES

Part 4: FINANCE

Chapter 155: PURCHASES

Subchapter 1-A: RULES GOVERNING THE COMPETITIVE BID PROCESS

<http://www.mainelegislature.org/legis/statutes/5/title5sec1825-B.html> (Attachment E)

And:

DAFS/BGS Division of Purchases
Basic Contracting and Commodity Procurement Guidelines

<http://www.maine.gov/purchases/files/BasicContractingandCommodityProcurementGuidelines2013.rtf> (Please see Attachment F)

14. With regard to each deliverable under the Alexander Group contracts please provide detailed information on the responsibilities of the contractor and the purpose of the inquiry.

Response: Please see the responsibilities as outline by the contract. (Attachment D)

15. With regard to each deliverable under the Alexander Group contracts please provide a schedule and the means for communication with the Legislature and the public when the Alexander Group completes the applicable report.

Response: There is no formal plan at this time.

The Role of Maine DHHS In the Health Exchange

Background

On October 1, 2013, Maine and all states must be ready to participate in a Health Exchange that will assist people who qualify to purchase government-subsidized health insurance as required by the Affordable Care Act.

Maine's Model

Maine has chosen to use the Federally Facilitated Marketplace vs. run a State-Based Exchange.

In this model:

- Final Medicaid eligibility determination is retained at the state level;
- Modified Gross Income (MAGI) eligibility rules will be adopted by January 1, 2014 to be in compliance with ACA.

A Brief Description of MAGI Rules

MAGI is Adjusted Gross Income as determined by income tax, plus any other income or tax-exempt interest a person receives. Assets are not included in eligibility determination. A family's size is based on the number of personal exemptions claimed on the applicant's tax form.

One key difference in the MAGI rules is the type of income that is currently disregarded when determining eligibility. For example, some child support payments and the first \$90 of earned income are disregarded in Maine. This will no longer be allowed in the MAGI rules.

In addition, many items that are counted in calculating gross income currently will not be counted under MAGI, because they are excluded as income when filing federal income tax.

These rules are extremely complex and DHHS eligibility staff have undergone intense training regarding the implementation of these rules.

Processing Applications

It should be clear that the Office for Family Independence is responsible only for Medicaid eligibility determination.

- When a person applies at the FFM by going to www.healthcare.gov, the application will be assessed to determine if the applicant may be eligible for Medicaid;
- Applicants that are deemed potentially eligible for Medicaid by the FFM will have their information transferred to Maine for a final determination;

Attachment A

- If deemed ineligible for Medicaid, a notification will be sent to the applicant as well as the FFM and the application will be transferred back to the FFM.

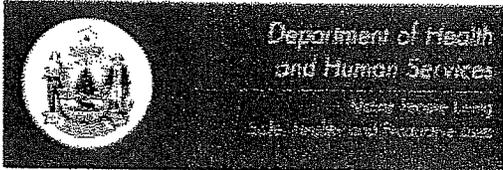
If an applicant applies for Medicaid via the State's online portal, in person, via phone, fax or via a Navigator, the application will be reviewed against the existing rules to determine Medicaid eligibility.

- If eligible for Medicaid, the applicant will be enrolled;
- If ineligible, the account will be transferred to the FFM and they will assist with the selection of a Qualified Health Plan and determine eligibility for subsidies.

Support Available to Applicants

- An 800 number will be posted at www.healthcare.gov (the FFM site) and the State Web portal (My Maine Connection);
- A menu-driven phone system will give those who are calling three options, based on scripts that have been developed:
 - 1) Inquiries regarding the purchasing of health insurance will be directed to www.healthcare.gov which will connect the called to the FFM Call Center;
 - 2) Inquiries about a particular health insurance or dental insurance provider will be transferred directly to the Bureau of Insurance;
 - 3) Inquiries about Maine's online Medicaid application or questions about Medicaid eligibility will be transferred to DHHS staff.
- In addition, the Federal government has provided funding to states like Maine who have adopted the FFM model for people called 'Navigators,' who are positioned in agencies across the state to help support those who are seeking to apply for health insurance coverage under ACA.

Attachment A



Paul R. LaPage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

October 18, 2013

To: Senator Margaret M. Craven, Senate Chair, Maine Health Exchange Advisory Committee
Representative Sharon Anglin Treat, House Chair, Maine Health Exchange Advisory Committee
Members of the Maine Health Exchange Advisory Committee

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: Maine Health Exchange Advisory Committee
Questions for the Department of Health and Human Services to be provided in writing for
October 21, 2013 meeting

1. How many people are currently applying for Medicaid each month? How many are approved and how many people are denied each month by Medicaid category?

Response: The Department is currently gathering and verifying this data and will forward it when it is available.

2. Are there measures in place to assess the readiness of DHHS for the marketplace's open enrollment period and taking/making referrals between the marketplace and Medicaid program? How is the Department assessing its readiness?

Response:

Our current process between the Federally Facilitated Marketplace (FFM) and the State of Maine is an implementation of contingency plans, both at the State and Federal levels. There is a process which the Center for Medicare and Medicaid Services (CMS) refers to as Account Transfer (AT) which is not yet in production at the Federal or State levels.

Currently Maine citizens that apply at the Federally Facilitated Marketplace (FFM) are assessed for potential eligibility for MaineCare. If the assessment indicates that the applicant is not MaineCare eligible they can continue on and shop for a Qualified Health Plan (QHP) and subsidies at the FFM. If the assessment indicates that the applicant is potentially eligible for MaineCare they are notified and their contact information is entered into a file. That file is then made available to the State of Maine on a weekly basis which we are able to download for the purpose of obtaining a sense of the volume we can expect. There is limited applicant information within the file and is insufficient to process against our eligibility rules. Our first file made available to download was scheduled to be on 10/8/2013, but was not made available by CMS until 10/17/2013. The file contained 107 records of applicants applying at the FFM and were assessed as potentially MaineCare eligible.

If a Maine citizen applies for MainCare within the State of Maine we process the application against our current eligibility rules and if they are eligible they are enrolled. If they are deemed

Attachment A

ineligible we hold the application to run against the new Modified Adjusted Gross Income (MAGI) rules which we plan to have available by 10/28/2013. If they are identified as eligible for MaineCare after processing against the MAGI rules, we will pend that applicant to become enrolled in MaineCare on 1/1/2014. If they are determined to be ineligible after processing against our current and MAGI rules, they will be notified and we will hold that application until 11/15/2013 when we will have our Account Transfer process from the State of Maine to the FFM implemented and they will be able to shop for a Qualified Health Plan (QHP) and potential subsidies.

When the designed production technical AT process is in place (11/15/2013) the State of Maine will receive all 'full' applications received at the FFM from 10/1/2013 to current date. Once received by the State we will process against our current eligibility rules and if determined eligible they will be enrolled in MaineCare. If they are determined ineligible we will hold until we can process the application against our Modified Adjusted Gross Income (MAGI) rules (10/28/2013) to make a final eligibility determination. If determined eligible they are notified and placed in pend status for MaineCare enrollment on 1/1/2014. If determined ineligible they are notified and their 'account' will be transferred back to the FFM to shop for a Qualified Health Plan (QHP) and potential subsidies.

The State of Maine processes and technologies in place and those planned for the 10/28/2013 and 11/15/2013 deployments have and are currently going through rigorous user acceptance, integration and regression testing internally and with CMS.

3. What systems are in place to ensure a seamless application process regardless of what door (Marketplace v. DHHS) people apply?

Response:

There are multiple ways for a Maine citizen to apply for MaineCare through DHHS. We have an online application known as My Maine Connection (MMC) which guides the applicant through a series of questions and collects all applicant data required to determine eligibility for our current rules. We collect MAGI supplemental data that will be made available to our frontline eligibility specialists by 10/28/2013. Consumers can also apply over the phone, fax, mail and 'walk-in'. If the consumer walks in they have the option of utilizing a kiosk to apply online via MMC or apply face to face with an eligibility specialist. Those that choose to apply manually (non MMC application) will have all of the data collected necessary to process against the new MAGI rules when implemented on 10/28/2013. We also have an application verification process, approved by CMS, which could require the applicant to produce income verification documents.

If the applicant is determined to be ineligible for MaineCare they will receive notification and then would follow the process outlined in question 2 response.

4. How will people be transferred from DHHS to the Marketplace and/or Navigators, certified application counselors?

Response:

See above process in question 2 response. The Navigators are currently assisting with State of Maine consumers with the FFM application process only. Our frontline eligibility specialists have all contact information for the Navigators and all groups identified as resources for State of Maine consumers that request assistance with the FFM application process.

Attachment A

5. What data, if any, is DHHS collecting related to its obligation to refer people to the Marketplace?

Response: DHHS is collecting required data that includes, tax filing status, annual income, tax dependency, minimal essential health coverage, etc. Please see attached supplemental data sheet (Attachment A).

6. Will DHHS track whether people are churning on and off of Medicaid and the Marketplace? How will you track this data?

Response: DHHS has data that can track the number of individuals who come onto MaineCare and who go off. We will also be able to track the number of accounts sent to the FFM as a result of ineligibility for MaineCare.

7. Given existing infrastructure, what would be needed in order to deliver real-time processing of eligibility information and facilitate entry to the Marketplace immediately if a person is deemed ineligible for MaineCare?

Response: The State of Maine is currently in the process of planning 'phase 2' of the Business Process and IT Modernization project which will include real-time processing of a consumer's application and notification. If the consumer is determined to be ineligible for MaineCare then the account transfer process to FFM will occur as described above. The changes required will include tighter dynamic integration between MMC and our systematic eligibility rules process. There will also be an emphasis placed on consumer self-service which will drive more technology application processing which will allow for real-time decisions and notification.

8. What lessons have been learned through DHHS experience with the Private Insurance Purchase Program (PIP) and its implications for the Marketplace and/or possibility of a Basic Health Plan? What's been the retention rate of members on the PIP? How have average costs to DHHS per PIP member [premium plus any medical wrap expenses] compared to the average MaineCare costs per member [not including long term care or other non-medical costs].

Response: There are 1,345 members on PHIP.

	371.15	(PMPM wo/TPL)
-	<u>169.73</u>	(PMPM w/TPL)
=	201.42	(cost savings)
X	<u>1,345</u>	(# of MaineCare members)
=	\$270,909.90	
-	<u>\$157,000.00</u>	(average monthly cost of premiums)
=	\$113,909.90	(cost savings per month)

9. For those who are due to lose coverage given the Medicaid eligibility reductions, what has been their utilization of medical services as measured by physician services, hospital services, ED utilization, pharmacy, total medical costs, etc. This information could be helpful in examining the richness and sufficiency of the benchmark plan in existence for QHPs.

Response: See Attachment B

10. What considerations, if any, have been given to the application of SIM work to Marketplace (Exchange) infrastructure, the benchmark plan, and QHPs in general?

Attachment A

Response: SIM work has not focused on the Marketplace infrastructure but more on the delivery of quality healthcare services and payment.

Attachment A

MEDICAID APPLICATION SUPPLEMENT			
COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.			
APP LAST NAME:	APP FIRST NAME:	MI:	
FEDERALLY RECOGNIZED TRIBE MEMBERS			
Names of those with Indian Health Service Coverage:			
Does Not Receive Indian Health Service Coverage, but is eligible:			
OTHER MEDICAL INSURANCE <small>(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)</small>			
Name:	Company:		
Policy:	Type:		
EMPLOYER INSURANCE <small>(HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSURANCE (NOW OR IN THE NEXT THREE MONTHS))</small>			
Name:	SSN:	Minimal essential coverage?	
Date when eligible to enroll:	Coverage plan premium:		
Employer Name:	Employer EIN:		
Employer Address:			
Employer Phone:	Employer Email:		
Employer Insurance Name:	Employee Contact Info:		
TAX INFORMATION, APPLICANT <small>(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)</small>			
A. Will you file Income Tax Next Year (If yes, please answer questions A-C; if no, skip to question D):			
B. Will you file jointly with spouse:	Name of spouse:		
C. Will you claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will you be claimed as a dependent on someone's tax return:	Name of filer:		
DEDUCTIONS, APPLICANT <small>ENTER AMOUNTS FOR ALL THAT APPLY</small>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
SIGNATURE			
I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.			
Signature of applicant:			
Date:			

v. 10/01/2013

Attachment A

TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #1 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
TAX INFORMATION, NAME OF PERSON #2 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

v. 10/01/2013

Attachment A

COMBINED TOTAL - 101% TO 133% OF FPL PLUS CHILDLESS ADULT WAIVER

SERVICE CATEGORY	PATIENTS	VISITS	DOLLARS
1010 Facility Inpatient Non Acute	3	8	\$12,124.84
1020 Facility Inpatient Long Term Care	19	29	\$98,279.92
1030 Facility Inpatient Maternity	1,294	1,874	\$3,931,588.49
1050 Facility Inpatient Medical	10,005	32,533	\$37,109,333.19
1210 Facility Outpatient Surgery	4,387	5,815	\$7,815,238.22
1220 Facility Outpatient ER	10,244	18,744	\$5,009,075.48
1230 Facility Outpatient Diagnostic Services	3,536	5,228	\$899,450.90
1231 Facility Outpatient Dialysis	16	137	\$59,895.67
1232 Facility Outpatient DME	23	26	\$496.25
1233 Facility Outpatient Home Health	87	296	\$61,594.47
1234 Facility Outpatient Pharmacy	5,960	9,250	\$568,950.99
1235 Facility Outpatient PT, OT, Speech Therapy	1,817	3,942	\$255,128.31
1236 Facility Outpatient Specialty Drugs	367	1,005	\$1,253,808.94
1237 Facility Outpatient Supplies and Devices	1,144	1,863	\$83,679.46
1238 Facility Outpatient Transportation	152	196	\$71,364.97
1299 Facility Outpatient Other	27,119	100,584	\$8,634,295.36
2010 Physician Specialty Inpatient	12	21	\$2,750.06
2020 Physician Non-Specialty Inpatient	3,837	10,091	\$2,371,722.90
2115 Physician Specialty Outpatient Surgery	108	140	\$31,195.25
2120 Physician Specialty ER	13	14	\$302.64
2125 Physician Specialty Office Visits	1,043	1,787	\$79,441.91
2139 Physician Specialty Outpatient Other	389	673	\$47,579.35
2155 Physician Non-Specialty Outpatient Surgery	4,711	6,132	\$1,875,198.55
2160 Physician Non-Specialty ER	14,879	26,744	\$1,111,416.92
2165 Physician Non-Specialty Office Visits	22,414	70,782	\$3,189,411.23
2199 Physician Non-Specialty Outpatient Other	9,144	18,171	\$766,544.00
2225 Professional Office Visits	12,388	25,850	\$1,174,037.84
2227 Professional Chiropractic Services	1,675	7,796	\$157,679.13
2230 Professional Diagnostic Services	6,886	12,034	\$567,780.87
2231 Professional Dialysis	20	125	\$7,570.35
2232 Professional DME	897	2,752	\$450,598.97
2233 Professional Home Health	32	298	\$130,629.61
2235 Professional PT, OT, Speech Therapy	2,235	8,183	\$256,878.70
2236 Professional Specialty Drugs	144	455	\$196,809.11
2237 Professional Supplies and Devices	2,601	5,925	\$647,248.76
2238 Professional Transportation	4,440	41,692	\$3,098,740.44
2240 Professional Injections	2,846	5,813	\$698,035.08
2299 Professional Services Other	11,351	17,944	\$1,316,073.36
3010 Mental Health Inpatient	1,048	2,395	\$1,631,903.24
3025 Mental Health Office Visits	4,605	9,371	\$468,357.90
3030 Mental Health Other Outpatient	11,557	87,765	\$10,789,235.58
3050 Substance Abuse Inpatient	734	3,281	\$2,957,530.93
3065 Substance Abuse Office Visits	878	3,903	\$227,389.76

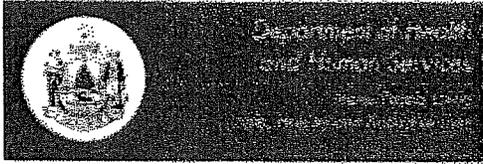
Attachment A

COMBINED TOTAL - 101% TO 133% OF FPL PLUS CHILDLESS ADULT WAIVER

SERVICE CATEGORY	PATIENTS	VISITS	DOLLARS
3070 Substance Abuse Other Outpatient	4,042	60,662	\$6,696,400.79
4051 Laboratory Outpatient Chemistry Tests	15,425	31,795	\$1,320,269.23
4055 Laboratory Outpatient Pathology	9,310	12,106	\$401,534.79
4099 Laboratory Outpatient Other	19,776	46,175	\$935,604.96
4561 Radiology Outpatient CT Scans	3,206	3,898	\$579,627.81
4562 Radiology Outpatient Mammograms	4,711	6,235	\$231,293.54
4563 Radiology Outpatient MRIs	4,545	5,490	\$1,116,154.48
4564 Radiology Outpatient Nuclear Medicine	1,119	1,222	\$217,136.83
4566 Radiology Outpatient Therapeutic Radiology	85	317	\$282,086.50
4567 Radiology Outpatient Ultrasounds	8,072	13,475	\$1,080,009.91
4568 Radiology Outpatient X-Rays	11,950	18,841	\$514,338.73
4599 Radiology Outpatient Other	1,474	1,679	\$76,763.68
5070 Prescription Specialty Drugs	424	1,635	\$2,935,453.10
5075 Prescription Drugs Retail	34,611	382,690	\$22,567,249.96
8090 Dental	4,081	7,262	\$1,722,962.05
GRAND TOTAL	309,891	1,145,149	\$140,793,254.26

NOTE: The PATIENTS column is an unduplicated count of persons who utilized a particular service - it is NOT a count of members.

Attachment A



Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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 TTY Users: Dial 711 (Maine Relay)

To: Senator Margaret M. Craven, Senate Chair
 Representative Sharon Anglin Treat, House Chair
 Members of the Maine Health Exchange Advisory Committee

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: Maine Health Exchange Advisory Committee questions to the Department of Health and Human Services.

1. Please provide an update on the # of referrals DHHS has received from the Federally-facilitated marketplace (FFM) for individuals assessed as potentiality eligible for MaineCare. How many individuals have been determined eligible and enrolled for coverage under current eligibility rules and under eligibility rules beginning January 1, 2014? How many individuals have been determined ineligible for MaineCare and referred back to the FFM for enrollment in a qualified health plan?

Response: CMS is unable to send the application/account transfers at this time. They are sending a weekly file to FFM/assessment states which provides a name and an address of those individuals they have assessed that may be MaineCare eligible. Thus far, Maine has received 733 unique households consisting of 1477 individuals that have applied at the FFM and were assessed as potentially eligible for MaineCare; approximately 21% of these applications refer to an inconsistency in citizenship and income between the self-attested application answers and FFM data sources that ultimately will require the State to reconcile once the FFM is fully functional on its Account Transfer capabilities. Due to the lack of the application/account transfer at this time from CMS, we are unable to process this information until CMS is technically prepared to transfer the required MAGI application for which a specific date has not yet been provided (ballpark estimate is end of November'13 / December'13)

For applications taken by the Department; determined eligible for MaineCare under MAGI rules after being determined ineligible under non-MAGI existing rules. These cases will be opened January 1, 2014.

Oct-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	7	9
MG20	MAGI Children age 19 '&' 20	3	3
MGCC	MAGI Cub Care	2	2
MGPC	MAGI Parent/Caretaker Relatives	5	5

Nov-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	9	10
MG20	MAGI Children age 19 '&' 20	4	4

Attachment A

MGPC	MAGI Parent/Caretaker Relatives	9	11
MGPR	MAGI Pregnant and Postpartum Women	1	1

Dec-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	42	54
MG20	MAGI Children age 19 '&' 20	41	42
MGCC	MAGI Cub Care	22	33
MGPC	MAGI Parent/Caretaker Relatives	116	134
MGPR	MAGI Pregnant and Postpartum Women	3	3

Determined ineligible for MaineCare under MAGI rules and under non-MAGI existing rules. Will be sent to the FFM.

Oct-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	16	20
MG20	MAGI Children age 19 '&' 20	4	4
MGCC	MAGI Cub Care	8	10
MGPC	MAGI Parent/Caretaker Relatives	24	35
MGPR	MAGI Pregnant and Postpartum Women	3	3
MGU1	MAGI Children under 1	1	1

Nov-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	23	28
MG20	MAGI Children age 19 '&' 20	8	8
MGCC	MAGI Cub Care	14	16
MGPC	MAGI Parent/Caretaker Relatives	42	62
MGPR	MAGI Pregnant and Postpartum Women	3	3
MGU1	MAGI Children under 1	1	1

Dec-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	114	155
MG20	MAGI Children age 19 '&' 20	20	22
MGCC	MAGI Cub Care	58	70
MGPC	MAGI Parent/Caretaker Relatives	413	574
MGPR	MAGI Pregnant and Postpartum Women	11	11
MGU1	MAGI Children under 1	2	2

Attachment A

2. Please provide an update on the anticipated implementation of MAGI rules (10/28/13) and the Account Transfer (AT) process (11/15/13). Have any issues been identified that may delay implementation? See DHHS response to Question #2 in October 18th memo.

Response: The MAGI Rules were successfully deployed on 11/4/13 and the Account Transfer deployment date will be prior to the end of the year, but we will not have a date until the final design is complete. We were asked to change direction in our priority by CMS from focus on SOM - FFM to FFM - SOM. We have since re-prioritized to our original based on CMS not being prepared to transfer full application data to the states.

3. Please provide a timeline or benchmark dates for implementation of the Business Process and IT Modernization project. See DHHS response to Question #7 in October 18th memo.

Response: We are in the early stages of planning and have developed and received DHHS Executive Management Team consensus on strategic guiding principles and prioritization criteria. We will be conducting workshops over the next several weeks with various subject matter experts across the DHHS offices and technology resources. These workshops are intended to develop the initial scope and milestones for the initiative which will inform the Expedited Advance Planning Document (EAPD) we plan to submit to CMS by 1/30/14. A detailed implementation roadmap based on prioritization is targeted preliminarily for end of Q2'14.

4. Please provide demographic information on the 1345 individuals enrolled in the PHIP program. What is the retention rate for those enrolled in PHIP coverage? See DHHS response to Question #8 in October 18th memo.

Response: Will provide at a later date.