

Health and Human Services Committee Meeting, October 29, 2013
Room 209, Cross Office Building, 9am to 5pm

- 9am The Health Insurance Marketplace under the Affordable Care Act
Maine Community Health Options, Chief Executive Officer Kevin Lewis
Anthem Blue Cross Blue Shield, Kristine Ossenfort
- 10am Riverview Psychiatric Center: briefing and discussion with DHHS and interested parties
- 10:20am Mental health services for adults at RAFTS in Lewiston: briefing and discussion with DHHS and interested parties: *Harold Strout Q# 3 pg 1*
- 10:30am Status report on MaineCare participation of Umbrella Mental Health Services and AngleZ Behavioral Health Services; briefing and discussion with DHHS and interested parties *Q# 4 pg 2*
- 10:40am Homeless youth shelter services statewide access issues: briefing and discussion with DHHS and interested parties: *Bob Rowe, New Beginnings Q# 15 pg 5*
- 11:00am Long-term care issues of access in rural areas: briefing and discussion with DHHS and interested parties: *Nathan Brown, Oceanview Nursing Facility Q# 16 pg 5*
- 11:30am Introduction and discussion of budget initiatives spreadsheet: OFPR and OPLA staff
- 12noon Lunch break
- 1pm Specialized dental services: briefing and discussion with DHHS, Community Dental and providers and consumers *Q# 12 pg 4 #13*
- 1:30pm MaineCare auditing of dental clinics: briefing and discussion with DHHS and dental clinic providers *Q# 14 pg 4*
- 2pm Committee discussion of questions to present to the Department of Education regarding the Child Development System to enable DoE to prepare written information for the meeting on December 10. (DoE will not be participating in the meeting on December 10 but CDS will be on the agenda)
Other issues
- 2:30pm MaineCare non-emergency transportation: briefing and discussion with DHHS, brokers, providers and consumers *Q# 8, 9, 10 pg 3*
- 3:30pm Regional transportation systems and their relationships with the new MaineCare non-emergency transportation system: briefing and discussion with DHHS and transportation providers and consumers *Q# 11 pg 3*

Final Interim Meeting: Tuesday, December 10

Information Requests for October 29 Meeting of Health and Human Services Committee

(Questions asked at Meeting on 11th of September in regular font. New questions in italics.)

MaineCare nonemergency transportation

1. Please provide copies of the contracts with the MaineCare nonemergency transportation brokers and indicate the performance standards in each contract.
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.
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?

Head Start

No information requested

Adult day health medical model system

1. Please provide a timeline for reporting to HHS Committee.
2. Please provide a timeline for planning, legislative action and implementation.

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)

Specialized dental care

1. Please provide information on numbers of clients of former Portland Dental Clinic and clients of Dorothea Dix dental services that are MaineCare members and MaineCare eligible.
2. Please provide information on when the contract with Community Dental is likely to be signed and when Community Dental will likely begin to provide services under the contract.

Riverview Psychiatric Center

1. Please provide information on the projected loss of funding from de-certifying the Lower Saco unit and DHHS's plans to address any resulting shortfall.
2. *Please provide information on loss of \$20,000,000 in federal funding and the DHHS appeal, including the process and timeline.*
3. *Please provide information on the DHHS application to certify the 20 beds de-certified in late summer and the process and timeline.*
4. *Please provide information on concerns of the federal DHHS in the Riverview reports during 2013 as required by Public Law 2013, chapter 434, section 13, including question 3 above and plans to implement a recovery and rehabilitation model at Riverview, the hiring and training of staff and any other structural changes.*

Adult mental health services

1. *Please provide information on adult mental health service provided by or through RAFTS in Lewiston and any changes in services or reimbursement.*
2. *Please provide information on MaineCare participation by and reimbursement of Umbrella Mental Health Services and AngelZ Behavioral Health Services.*

Homeless Youth Shelter Services

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.*

Long-term care services access in rural areas

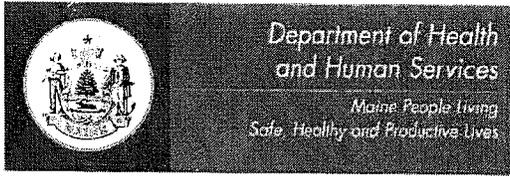
1. *Please provide information on any challenges or changes to long-term care services in rural areas, in particular in Washington, Hancock, Aroostook and Penobscot Counties. Please provide information on developments in the provision of services by Oceanview Nursing Home in Lubec.*

MaineCare auditing of dental clinics

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.*

Regional transportation systems

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.*



Paul R. LePage, Governor

Mary C. Moyhew, Commissioner

Department of Health and Human Services
Commissioner's Office
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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.

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

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.

“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

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.

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

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.

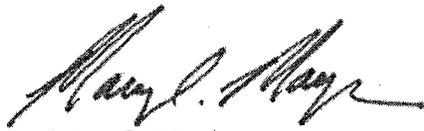
In any event, as a result of the September 17 survey, CMS apparently concluded that Riverview had corrected all of the deficiencies cited during the March and May surveys. The deficiencies cited during the September 17 survey were entirely new, and all related to the Hospital's sharing of resources with 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

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.

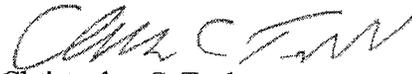
Conclusion

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



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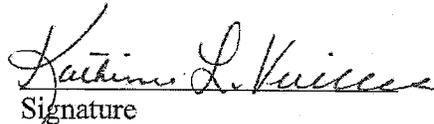
Enclosures (2)

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

JANET T. MILLS
ATTORNEY GENERAL



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TTY USERS CALL MAINE RELAY 711

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October 8, 2013

Senator Dawn Hill, Chair
Representative Margaret R. Rotundo, Chair
Joint Standing Committees
Appropriations and Financial Affairs
State House, Room 228
Augusta, ME 04333

RE: CMS letter of September 27, 2013

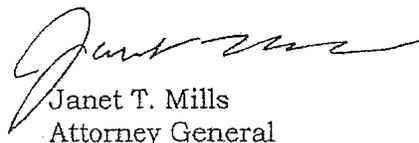
Senator Hill and Representative Rotundo:

I understand the Appropriations Committee wishes to discuss the CMS letter of September 27th (received by us on October 2, 2013) at its meeting this Wednesday, October 9, 2013. This Office is working closely with the Department of Health and Human Services to determine the most appropriate response to this letter which poses both factual and legal issues for us. We are researching the federal regulations on which the findings are based and questioning the legal foundation for those findings. These questions will form the basis for the appeal which we plan to file by the end of the week. The Department may wish to address the alleged deficiencies and pursue a request for recertification at the same time we pursue the appeal, without waiving any legal objections to the CMS decision.

It is truly unfortunate, and certainly unexpected, that the federal government now wants to deprive the state of the very funds we need for vital mental health services which both the state and federal government agree should be provided. With the potential for litigation, discussion of this issue is a delicate matter; and, with CMS employees unable to respond because of the federal shutdown, it has been difficult to get answers to some basic questions. I wish there were more I could share with you but, regretfully, there is not at this time.

Thank you.

Sincerely,


Janet T. Mills
Attorney General

JTM/elf

Resources listed below available in advance of the federal shutdown to State Agencies to provide more information on how a federal shutdown would take place and what the impact would be:

OMB Memo

<http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-22.pdf>

Contingency Plans updated by agency

<http://www.whitehouse.gov/omb/contingency-plans>

**Congressional Research Services: Shutdown of the Federal Government:
Causes, Processes, and Effects**

<http://www.fas.org/sgp/crs/misc/RL34680.pdf>



Adult Mental Health Services

An Office of the
Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Riverview Psychiatric Center
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Tel.: (207) 624-4674; Fax: (207) 287-6123
TTY Users: Dial 711 (Maine Relay)

October 8, 2013

J. William Roberson
Associate Regional Administrator
Director, Northeast Division Survey &
Certification
John. F. Kennedy Federal Building, Room 2350
Boston, Massachusetts 02203

Dear Mr. Roberson,

This letter is to notify you that Riverview Psychiatric Center wishes to be readmitted to the Medicare program. We certify that the reasons for the termination of the previous agreement have been removed and we assure that it will not recur. I have attached a plan of correction documenting the steps that Riverview has taken to correct the deficiencies cited in the letter dated September 27, 2013. The plan of correction includes the precautions that have been taken to assure that these deficiencies will not recur. We have submitted Form CMS-855A, Medicare Enrollment Application –Institutional Providers to the Medicare administrative contractor. Riverview Psychiatric Center is committed to sustaining the terms previously cited in our plan of correction dated August 14, 2013. These include ensuring compliance with:

- Patient rights to include least restrictive interventions
- A safe environment to include adequate emergency equipment and supplies
- Adequate staffing
- Active treatment
- Performance Improvement
- Life Safety Code
- Complete and accurate medical record
- Medical Staff/Medical Director involvement in evaluation care
- The Director of Nursing being qualified by education, training, and experience

This attached Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this request and Plan of Correction is not an admission that deficiencies existed or that any identified deficiencies were cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

Sincerely,

Mary Louise McEwen, BSN, MBA
Superintendent
Riverview Psychiatric Center

cc: Ken Albert, Director of State Licensing
DHHS Commissioner Mary Mayhew

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 204007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW PSYCHIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 ARSENAL STREET AUGUSTA, ME 04330	
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A 000	<p>INITIAL COMMENTS</p> <p>On September 16 - 17, 2013, representatives of the Centers for Medicare & Medicaid Services, Boston Regional Office, and the Maine State Division of Licensing and Regulatory Services conducted a follow-up survey at Riverview Psychiatric Center, a psychiatric hospital. As of August 27, 2013, this hospital is certified for 72 beds (a reduction of 20 beds located on the noncertified "Lower Saco unit"), and census in the hospital on the first survey day was 60 patients. This psychiatric hospital review included an evaluation of the services, facilities and activities of the certified areas to determine the hospital's capacity to provide the services, facilities and supervision required by the applicable general hospital Conditions of Participation and the two special Conditions of Participation for psychiatric hospitals, to its patients.</p> <p>The term hospital used in deficient practice statement and evidence portions of this document refers to the CMS certified sections of the Riverview Psychiatric Center.</p> <p>The terms Institution and Facility used in deficient practice statement and evidence portions of this document refers to Riverview Psychiatric Center in it's entirety, certified and non-certified sections.</p> <p>Evidence in this document was obtained by surveyors from the Maine Division of Licensing and Regulatory Services, and by surveyors from CMS.</p> <p>Riverview Psychiatric Center is not in compliance with 42 Code of Federal Regulation, Part 482, Conditions of Participation for Hospitals. The</p>	A 000	Refer to A043, A308, A385, A392, A494, A506, B136, B146, and B150.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Mary Joise McIver Superintendent 10/10/13

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A 000 A 043	Continued From page 1 following requirements have not been met: 482.12 GOVERNING BODY There must be an effective governing body that is 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 ... This CONDITION is not met as evidenced by: Based on record review and interview, the Condition of Participation for Governing Body is Not Met due to failure 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. Evidence includes: 1. The Condition of Participation at 42 CFR 482.62 Special Staff Requirements for Psychiatric Hospitals is not met. The facility failed to ensure adequate numbers of qualified nursing personnel were available to provide an intensive and comprehensive active treatment program. The Governing Body failed to ensure that only nursing staff employed by the hospital responded to inpatient emergency codes in the hospital and to ensure that the hospital nursing staff did not respond to emergencies outside the hospital. (Refer to B 136) 2. Review of the Riverview Psychiatric Center Advisory Board minutes dated August 15, 2013 was conducted on September 16, 2013. Minutes contained mention of the noncertified portions of	A 000 A 043	See attached, refer to B136 and A506.	

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A 043	Continued From page 2 the hospital regarding correction officer assignments, the pending Plans of Correction for CMS deficiencies and the Quarterly Performance Improvement Team Quarterly report. However, no discussion was found in these notes of how the hospital was operationalizing the decertification of portions of the hospital and managing the certified portion of the hospital. Additionally, under the section of the notes regarding Policies reported " No new policies to present". Administrative staff confirmed on September 16, 2013 that there had been no other meeting of the Advisory Board since May 10, 2013 or subsequent to August 15, 2013. 3. Sharing of Equipment: Review of an RPC (Riverview Psychiatric Center) Incident Report dated August 28, 2013 documented that an EKG machine was removed from the noncertified section of the institution for use by the hospital. This borrowing of equipment was not communicated to staff, who were unaware of its location. 4. The hospital pharmacy maintains a single Pyxis Medication Communication system with Pyxis machines in the hospital and the institution. Staff with access to the Pyxis system can access any machine in the system and would be expected to go to another location, regardless of that locations' certification status, to retrieve a needed item if that item was not available in the Pyxis machine on the unit where it was needed. (Refer to A 506)	A 043		
A 308	482.21 QAPI GOVERNING BODY, STANDARD TAG	A 308	See attached.	

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A 308	Continued From page 3 ... The 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) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to specify services furnished under contract for specific to the hospital. Evidence includes: Several of the hospital contracts for the Fiscal Year (July 1, 2013 to June 30, 2014) were reviewed including "Security Services". These contracts referred to the entire 92 bed institution which existed prior to the acceptable Plan of Correction, and made no distinction between services provided in the hospital and the institution as a whole. These contracts were not revised per the hospital August 29, 2013 Plans of Correction. During an interview on September 17, 2013 at approximately 10:00AM, the facility Superintendent acknowledged that hospital clinical contracts covered both the hospital and the entire institution, and did not specify which services were provided specifically to the hospital.	A 308			
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services.	A 385	Refer to A506, B146, and B150.		

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A 385	<p>Continued From page 4</p> <p>The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by: Based on review of staffing patterns, staff interviews on 9/16/13 and 9/17/13, and documentation review, the hospital failed to ensure that adequate numbers of qualified nursing personnel were available to provide an intensive, safe and comprehensive active treatment program for patients in the hospital.</p> <p>The findings include:</p> <p>1. Review of staffing documentation and staff interview revealed that the hospital failed to delineate hospital nursing staff services as separate from nursing services on the noncertified unit. The 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) who were shared by the hospital and the rest of the institution. The sharing of hospital nursing staff to other parts of the institution has the potential to put hospital patients at risk in terms of safety and in terms of receiving active treatment services. The hospital routinely floated regularly scheduled nursing staff assigned to the hospital, to the noncertified unit. Staff in the hospital responded to all codes in the noncertified unit; staff in the noncertified unit would also respond to codes in the hospital. The use of nursing staff from the noncertified unit to respond to inpatient codes in the hospital is a violation of the Social Security Act at Section 1861 (b) which states that nursing services must be furnished to inpatients and must be furnished by the hospital. The nursing</p>	A 385		

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A 385	Continued From page 5 department maintained a list of "float" nursing staff to cover call-outs and other staffing needs anywhere in the institution as a whole. (Refer to B 146.) 2. There is one supervisory registered nurse (RN) (NOD - Nurse on Duty) who simultaneously covers the hospital and the noncertified unit. This NOD is the only staff person with access to a Night Cabinet for medications needed during pharmacy closure hours and not available through the Pyxis machines. The Nurse on Duty retrieves needed items from the "Night Cabinet" and delivers them to the unit where it is needed, regardless of the unit's certification status. (Refer to B 150 and A 506).	A 385			
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and interview with key personnel on September 16 and 17, 2013, it was determined that the hospital failed to have an adequate number of nursing personnel to provide nursing care to all patients as needed. Evidence includes: 1. During an interview with the Unit Manager of the Upper Saco Unit on September 16, 2013 at approximately 11:00 AM, he stated that he carried a pager and responded to calls for Lower Saco (the noncertified unit) if needed. Additionally, he	A 392	Refer to B146.		

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A 392	Continued From page 6 stated that he was providing training to a new staff member on Lower Saco. 2. During an interview on September 16, 2013 at approximately 12:35 PM, the Chief Financial Officer and Director of Human Resources confirmed that staff from the noncertified unit respond to emergency codes in the hospital, and staff from the hospital respond to emergency codes in the noncertified unit. The hospital and the noncertified unit depend on each others' staff for coverage and assistance during emergency situations. 3. During an interview with Kennebec Unit Nurse 4 on September 16, 2013 at approximately 2:30PM, she/he explained that " we would respond to all codes ... even [the decertified portion of the facility] ..." (Please refer to B 146.)	A 392			
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by: Based on interview, the hospital failed to assure current and accurate records are kept of the receipt and disposition of scheduled drugs. Evidence Includes: During an interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 it was revealed that the pharmacy did not maintain controlled drug records for the specific certified hospital. The Director stated that comingled records are maintained for the entire institution, certified and noncertified sections.	A 494	See attached.		
A 506	482.25(b)(4) AFTER-HOURS ACCESS TO DRUGS	A 506	See attached.		

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A 506	<p>Continued From page 7</p> <p>When 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.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the hospital failed to assure that only hospital personnel have access to medications.</p> <p>Evidence includes:</p> <p>Interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 revealed the pharmacy maintains a "night cabinet" for use by the entire institution, to provide medications needed during pharmacy closure hours and not available through the Pyxis machine. Night cabinet access is limited to the nurse on duty, who is not dedicated to the hospital only, and supervises both the hospital and noncertified unit of the institution. The nurse on duty retrieves needed items from the night cabinet, and delivers them to both the hospital and the rest of the institution.</p>	A 506		

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B 146	<p>482.62(d) NURSING SERVICES</p> <p>The hospital or unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be 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.</p> <p>This STANDARD is not met as evidenced by: Based on interview with administrative and direct care nursing staff on September 16 and 17, 2013, review of nursing staff time sheets between 8/27/13 and 9/2/13, it was determined that the hospital failed to have an adequate number of nursing personnel including Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Mental Health Workers (MHWs) to provide nursing care necessary to provide active treatment and safety of hospital patients. The Hospital failed to have a nursing department separate from the nursing department on the noncertified unit, resulting in hospital nursing staff being reassigned to work a portion or all of a shift outside of the hospital.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. The Hospital failed to insure that nursing staff assigned to a hospital unit or available to float within the hospital were not assigned to respond to codes or work a portion or all of a shift outside of the hospital. <p>During an interview with a SA (State Agency) surveyor, on September 16, 2013 at approximately 11:00 AM, the Unit Manager of the</p>	B 146	See attached.

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B 146	<p>Continued From page 1</p> <p>Upper Saco Unit stated that he carried a pager and responded to calls for Lower Saco Unit (the noncertified unit) when needed. Additionally, he stated that he was providing training to a new staff member on Lower Saco.</p> <p>2. During an interview with the Kennebec Unit Nurse IV (supervisory RN) with a SA and a Regional Office (RO) surveyor on September 16, 2013 at approximately 1:28 PM, the nurse said that nursing staff on all units of the institution respond to all codes in the hospital and on the noncertified unit. She said the overriding principle was: Safety First. She added that staff from the noncertified unit also respond to codes in the hospital. She also stated to the State agency surveyor: "Yes... we do float assigned unit staff to Lower Saco (the noncertified unit)...we have a log". When asked how it is determined who gets assigned to the noncertified unit, she stated that staff are reassigned on a rotating basis. Staff reported that float staff are assigned to the noncertified unit on a rotating basis.</p> <p>3. The Chief Financial Officer and the Director of Human Resources met with SA and RO surveyors on September 16, 2013 at approximately 12:35 PM. They explained the protocol for separation of nursing staff. All hospital units and the noncertified unit have direct care nursing staff assigned specifically to that unit. In addition, the hospital and the noncertified unit has a single list of "float staff" who are assigned to any unit in the institution to replace staff who have called out. The time float staff spends on the noncertified unit is recorded accurately to keep the allocation of nursing staff time on that unit separate from the time staff worked on the hospital units.</p>	B 146			

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B 146	<p>Continued From page 2</p> <p>The Director of Human Resources said the Hospital Nursing Department is not separate from the nursing department on the noncertified unit. The Director of Nurses splits her time between both the hospital and the noncertified unit. She stated that this was true for all department directors including the Medical Director, Social Service and Dietary. The focus of this discussion was on how finances and billing was allocated based on the square foot percentage of the noncertified facility relative to the square footage of both facility's combined or on the basis of the census of the noncertified facility relative to the census of both facilities combined.</p> <p>Administrative staff provided surveyors with a memo re: Lower Saco Staffing, the decertified facility, dated 9/9/13 on 9/16/13. This memo explains: "... the protocol that we will be following to charge any staff time on Lower Saco to that unit. We need to accurately reflect the hours for that unit so that we can show that there is NO commingling of Staff. Any hours worked by nursing staff NOT typically assigned to the LSU will be moved through payroll to that department." Interview with Hospital Human Resources Personnel on September 16, 2013 at approximately 12:40 PM revealed the following; allocation of clinical staff between certified and noncertified portions of the hospital was a function of payroll. Operationally, staff are floated between the psychiatric hospital and the 20-bed noncertified unit adjacent to the hospital. Staff have access between sections via a keycard. There was no recognition that floating staff may impact the individualized active treatment provided to patients in the hospital.</p> <p>4. The facility provided daily staffing sheets as worked for hospital nursing staff for the dates</p>	B 146		

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B 146	<p>Continued From page 3</p> <p>from 8/21/13 through 9/21/13. The staffing sheets from 8/27/13, the date of correction through 9/2/13, the date of termination, were reviewed. These sheets confirmed that nursing staff were floated almost daily outside the hospital to the noncertified unit. There was no documentation that staff assigned to the noncertified unit were reassigned to units in the hospital. For example:</p> <p>a. On Tuesday 8/27/13, on the night shift, an RN assigned to the Upper Saco unit in the hospital, was reassigned to work 4 hours of the shift, 11 PM to 3 AM, on the noncertified unit.</p> <p>b. On Wednesday, 8/28/2013, on the night shift (10:45 PM - 7:15 PM), a MHW assigned to the night shift on the Upper Kennebec Units was reassigned to the noncertified unit for the entire shift. On the same day, on the day shift (6:45 AM - 3:15 PM), an RN scheduled to work on this Upper Kennebec Unit was floated to another unit in the hospital until 2 PM and then assigned to work on the noncertified unit 2 PM to 11 PM. A review of the float staff list for 8/28/2013 indicated that the following float staff were assigned to the noncertified unit: one (1) nursing supervisor on the night shift; one (1) RN and two (2) MHWs on the day shift and one (1) MHW for the night shift. That day, one (1) supervisory nurse and two (2) MHW's on the evening shift and one (1) RN on the day shift were assigned to the hospital.</p> <p>c. On Friday, 8/30/13, an RN assigned to the Upper Saco Hospital Unit was reassigned to the noncertified unit on the day shift.</p> <p>d. On Saturday, 8/31/13, an RN assigned to the Upper Kennebec Hospital Unit, was reassigned for 4 hours on the day shift (7 AM to</p>	B 146		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 204007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW PSYCHIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 ARSENAL STREET AUGUSTA, ME 04330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 146	Continued From page 4 11 AM) to the noncertified unit, and then returned for the rest of shift to the hospital unit. e. On Monday 9/2/13, three members of the hospital nursing staff were reassigned to the noncertified unit for their shift. This included an RN on the Lower Kennebec Hospital Unit, on the evening shift, a MHW normally assigned to Upper Kennebec Hospital unit and and an RN assigned to the day shift on the upper Saco Hospital Unit.	B 146			
B 150	482.62(d)(2) NURSING SERVICES There must be 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. This STANDARD is not met as evidenced by: Based on staff interview and review of staffing documentation, the hospital failed to delineate hospital nursing staff services as separate from nursing services on the noncertified unit. The 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 both facilities. Using hospital staff for coverage on the noncertified unit 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. Findings include: 1. The hospital floated regularly scheduled nursing staff assigned for a shift in the hospital to	B 150	Refer to A506 and B146.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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B 150	<p>Continued From page 5</p> <p>the noncertified unit, to cover call-outs and other nursing needs . Staff in the hospital responded to all codes on the noncertified unit. (Refer to B 146.)</p> <p>2. Interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 revealed the pharmacy maintains a "night cabinet" for use by the entire institution, to provide medications needed during pharmacy closure hours and not available through the Pyxis machine. Night cabinet access is limited to the nurse on duty, who supervises both the hospital and noncertified unit of the facility. The nurse on duty retrieves needed items from the night cabinet, and delivers them to both the hospital and the noncertified unit.</p>	B 150		
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Plan of Correction (POC)	Title of Person Responsible	Completion Date
<p>The following actions were taken by the Governing Body (Advisory Board): The Advisory Board meets regularly and has standing items on the agenda which includes but is not limited to patient rights, safety, staffing, and QAPI. The next meeting's agenda includes all standing items and information on how the hospital is operationalizing the decertification portion of the hospital and managing the certified portion of the hospital. The Advisory Board minutes will clearly reflect the scope of services provided within the distinct part of the hospital to include departmental reporting, policy and procedure approval, as well as contract review/approval specific to the distinct part of the hospital.</p> <p>There is no shared equipment between the distinct part of the hospital and the decertified unit.</p>	Superintendent	10/17/13
MONITORING & TRACKING		
<p>1) All equipment for the distinct part of the hospital is assigned exclusively for use in those units that are within the distinct part of the hospital. Environmental rounds are completed every shift to ensure equipment is not shared. Any discrepancy is immediately reported to the Superintendent or designee.</p>	Superintendent	10/11/13
<p>2) The minutes of the Advisory Board meetings reflect the discussion as stated above in the action plan for operationalizing the management of the decertified unit and the distinct part.</p> <p>3) Any new recommendations as a result of the Advisory Board meeting are immediately reported to the Executive Leadership Committee through email or by the next business day.</p> <p>4) Recommendations are assigned to the department accountable for action steps. The specified department reports through the performance improvement reporting system</p> <p>5) The Performance Improvement report is presented to the Advisory Board</p>	Superintendent	10/17/13
INCORPORATION INTO QAPI PROGRAM		
<p>The Advisory Board recommendations are reported out to the Executive Leadership Committee which meets every two</p>	Superintendent	10/17/13

Riverview Psychiatric Center

CMS POC – October 2013

Tag #A 043

weeks or more often if needed. These recommendations are then incorporated into the overall management plan for the distinct part of the hospital. Any new recommendations are monitored by the department accountable and uniquely reflected in the Performance Improvement reporting system, to include reports to the Advisory Board.		

Plan of Correction (POC)	Title of Person Responsible	Completion Date
<p>The following actions were taken by the Superintendent: All hospital contracts were revised and amended to reflect the Distinct Hospital and the decertified portion of the hospital by each department accountable for the contract. There is a cover sheet on each hospital contract that clearly delineates the allocation of funds for the Distinct and the decertified portion of the hospital. This agenda item is going to be placed on the Governing Body (Advisory Board) standing agenda. An advisory Board meeting will be held on October 17, 2013 to address the changes that have been made to all the contracts at the hospital.</p>	<p>Superintendent</p>	<p>October 9, 2013</p>
MONITORING & TRACKING		
<p>Contracts are updated yearly and reviewed thoroughly at that time to address issues. Each department accountable for the contract reviews and updates on an annual basis.</p>	<p>Superintendent</p>	<p>October 9, 2013</p>
INCORPORATION INTO QAPI PROGRAM		
<p>This item is going to be placed on the Governing Body (Advisory Board) standing agenda. An Advisory Board meeting will be held on October 17, 2013 to address the changes that have been made to all the contracts at the hospital.</p>	<p>Superintendent</p>	<p>October 17, 2013</p>

Plan of Correction (POC)	Title of Person Responsible	Completion Date
<p>The following actions were taken by the Director of Pharmacy to assure current and accurate records are kept of the receipt and disposition of scheduled drugs for the distinct part of the hospital and separated from the decertified unit:</p> <ul style="list-style-type: none"> • Pharmacy will generate controlled drug reports specific for the distinct hospital that delineate all transactions of receipt and disposition of scheduled drugs using CII Safe and Pyxis Knowledge Portal. • The reports shall be maintained to ensure current and accurate records of scheduled drugs is provided. The distinct part of the hospital will have separate record keeping from the decertified unit. • Pharmacy staff education regarding the new recording protocol completed. 	Director of Pharmacy	10/16/13
MONITORING & TRACKING		
<ol style="list-style-type: none"> 1. Monitor reports monthly to determine regulatory compliance is maintained. 2. The reports will be kept for the distinct part of the hospital and the decertified unit separately. 3. Track results of monthly monitoring and share findings with pharmacy staff. 	Director of Pharmacy	10/16/13 and ongoing
INCORPORATION INTO QAPI PROGRAM		
<p>The monitoring of this record keeping, as well as overall pharmacy services, for the distinct part of the hospital will be monitored and reported by way of the hospital performance improvement reporting system.</p>	Director of Pharmacy	Ongoing

Plan of Correction (POC)	Title of Person Responsible	Completion Date
<p>The following actions were taken by the Pharmacy Director to assure that only personnel of the distinct part of the hospital have access to medications:</p> <ul style="list-style-type: none"> • Disabled Global Find function in the electronic medication carts for the entire hospital. • The after hour medication storage is only available to the distinct hospital. • The staff from the decertified unit does not retrieve drugs from the distinct hospital. • Staff education regarding the new practice completed 	Director of Pharmacy	10/16/13
MONITORING & TRACKING		
<ol style="list-style-type: none"> 1. Monitor daily after hours drug distribution reports to ensure compliance with policy 2. Share monitoring results in real time with pharmacy staff and nursing leadership for the distinct hospital. 	Director of Pharmacy	10/16/13
INCORPORATION INTO QAPI PROGRAM		
<p>The monitoring of this record keeping, as well as overall pharmacy services, for the distinct part of the hospital will be monitored and reported by way of the hospital performance improvement reporting system. This is reflected in the Advisory Board minutes for the distinct part of the hospital.</p>	Director of Pharmacy	10/16/13

Plan of Correction (POC)	Title of Person Responsible	Completion Date
<p>The following actions were taken by the Acting Director of Nursing to ensure 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 Director of Nursing only supervises staff in the distinct hospital and is not responsible for requests for care and services outside of the hospital. Unit Managers are assigned to the distinct part of the hospital and are not responsible for requests for care and services outside of the hospital. This hospital nursing department is approved by the governing body and includes the Director of Nurses (DON), a recognized Nurse on Duty (NOD), Registered Nurses, Licensed Practical Nurses, Mental Health Workers and float staff unique to the distinct part hospital for provision of care.</p> <ul style="list-style-type: none"> • Staff from the distinct part does not get assigned to the decertified unit. • Staff from the distinct part of the hospital does not respond to emergency codes in the decertified unit. • Nursing staff do not respond to codes outside the hospital. • Staff education regarding the new staff protocol completed. 	<p>Acting Director of Nursing</p>	<p>October 9, 2013</p>
MONITORING & TRACKING		
<ul style="list-style-type: none"> • Nurse Managers for each unit in the distinct hospital monitors time sheets to ensure that no staff move from the distinct hospital into the decertified unit. • Nurse Managers for each unit in the distinct hospital monitor each code to assure that no staff from the distinct hospital responds to codes in the decertified unit and vice versa. • The staffing complement in each unit is evaluated with a main focus on the individualized active treatment provided to patients in the distinct part of the hospital. 	<p>Acting Director of Nursing</p>	<p>October 9, 2013</p>

Riverview Psychiatric Hospital

CMS POC – October 2013

Tag #B 146

INCORPORATION INTO QAPI PROGRAM		
The process for monitoring time sheets and responses to codes will be reviewed monthly in the nurse leadership meetings.	Acting Director of Nursing	October 9, 2013

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.

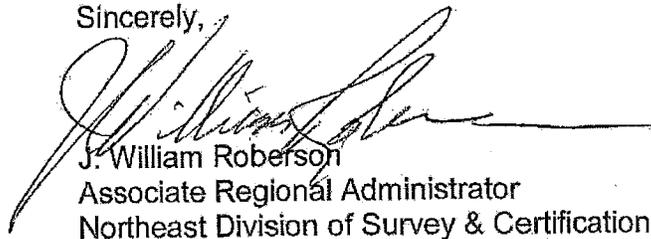
If Riverview Psychiatric Center wishes to be re-admitted to the Medicare program as a provider of psychiatric hospital services, please forward to me a written statement, signed by an authorized official, describing the steps taken to correct the deficiencies that led to the termination of your prior 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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 000	<p>INITIAL COMMENTS</p> <p>On September 16 - 17, 2013, representatives of the Centers for Medicare & Medicaid Services, Boston Regional Office, and the Maine State Division of Licensing and Regulatory Services conducted a follow-up survey at Riverview Psychiatric Center, a psychiatric hospital. As of August 27, 2013, this hospital is certified for 72 beds (a reduction of 20 beds located on the noncertified "Lower Saco unit"), and census in the hospital on the first survey day was 60 patients. This psychiatric hospital review included an evaluation of the services, facilities and activities of the certified areas to determine the hospital's capacity to provide the services, facilities and supervision required by the applicable general hospital Conditions of Participation and the two special Conditions of Participation for psychiatric hospitals, to its patients.</p> <p>The term hospital used in deficient practice statement and evidence portions of this document refers to the CMS certified sections of the Riverview Psychiatric Center.</p> <p>The terms Institution and Facility used in deficient practice statement and evidence portions of this document refers to Riverview Psychiatric Center in it's entirety, certified and non-certified sections.</p> <p>Evidence in this document was obtained by surveyors from the Maine Division of Licensing and Regulatory Services, and by surveyors from CMS.</p> <p>Riverview Psychiatric Center is not in compliance with 42 Code of Federal Regulation, Part 482, Conditions of Participation for Hospitals. The</p>	A 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000 A 043	<p>Continued From page 1</p> <p>following requirements have not been met:</p> <p>482.12 GOVERNING BODY</p> <p>There must be an effective governing body that is 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 ...</p> <p>This CONDITION is not met as evidenced by: Based on record review and interview, the Condition of Participation for Governing Body is Not Met due to failure 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.</p> <p>Evidence includes:</p> <ol style="list-style-type: none"> 1. The Condition of Participation at 42 CFR 482.62 Special Staff Requirements for Psychiatric Hospitals is not met. The facility failed to ensure adequate numbers of qualified nursing personnel were available to provide an intensive and comprehensive active treatment program. The Governing Body failed to ensure that only nursing staff employed by the hospital responded to inpatient emergency codes in the hospital and to ensure that the hospital nursing staff did not respond to emergencies outside the hospital. (Refer to B 136) 2. Review of the Riverview Psychiatric Center Advisory Board minutes dated August 15, 2013 was conducted on September 16, 2013. Minutes contained mention of the noncertified portions of 	A 000 A 043		

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A 043 Continued From page 2
the hospital regarding correction officer assignments, the pending Plans of Correction for CMS deficiencies and the Quarterly Performance Improvement Team Quarterly report. However, no discussion was found in these notes of how the hospital was operationalizing the decertification of portions of the hospital and managing the certified portion of the hospital. Additionally, under the section of the notes regarding Policies reported " No new policies to present.". Administrative staff confirmed on September 16, 2013 that there had been no other meeting of the Advisory Board since May 10, 2013 or subsequent to August 15, 2013.

A 043

3. Sharing of Equipment:
Review of an RPC (Riverview Psychiatric Center) Incident Report dated August 28, 2013 documented that an EKG machine was removed from the noncertified section of the institution for use by the hospital. This borrowing of equipment was not communicated to staff, who were unaware of its location.

4. The hospital pharmacy maintains a single Pyxis Medication Communication system with Pyxis machines in the hospital and the institution. Staff with access to the Pyxis system can access any machine in the system and would be expected to go to another location, regardless of that locations' certification status, to retrieve a needed item if that item was not available in the Pyxis machine on the unit where it was needed. (Refer to A 506)

A 308 482.21 QAPI GOVERNING BODY, STANDARD TAG

A 308

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A 308	<p>Continued From page 3</p> <p>... The 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) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to specify services furnished under contract for specific to the hospital.</p> <p>Evidence includes:</p> <p>Several of the hospital contracts for the Fiscal Year (July 1, 2013 to June 30, 2014) were reviewed including "Security Services". These contracts referred to the entire 92 bed institution which existed prior to the acceptable Plan of Correction; and made no distinction between services provided in the hospital and the institution as a whole. These contracts were not revised per the hospital August 29, 2013 Plans of Correction.</p> <p>During an interview on September 17, 2013 at approximately 10:00AM, the facility Superintendent acknowledged that hospital clinical contracts covered both the hospital and the entire institution, and did not specify which services were provided specifically to the hospital.</p>	A 308		
A 385	<p>482.23 NURSING SERVICES</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services.</p>	A 385		

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A 385	<p>Continued From page 4</p> <p>The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by: Based on review of staffing patterns, staff interviews on 9/16/13 and 9/17/13, and documentation review, the hospital failed to ensure that adequate numbers of qualified nursing personnel were available to provide an intensive, safe and comprehensive active treatment program for patients in the hospital.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of staffing documentation and staff interview revealed that the hospital failed to delineate hospital nursing staff services as separate from nursing services on the noncertified unit. The 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) who were shared by the hospital and the rest of the institution. The sharing of hospital nursing staff to other parts of the institution has the potential to put hospital patients at risk in terms of safety and in terms of receiving active treatment services. The hospital routinely floated regularly scheduled nursing staff assigned to the hospital, to the noncertified unit. Staff in the hospital responded to all codes in the noncertified unit; staff in the noncertified unit would also respond to codes in the hospital. The use of nursing staff from the noncertified unit to respond to inpatient codes in the hospital is a violation of the Social Security Act at Section 1861 (b) which states that nursing services must be furnished to inpatients and must be furnished by the hospital. The nursing 	A 385		

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A 385	Continued From page 5 department maintained a list of "float" nursing staff to cover call-outs and other staffing needs anywhere in the institution as a whole. (Refer to B 146.) 2. There is one supervisory registered nurse (RN) (NOD - Nurse on Duty) who simultaneously covers the hospital and the noncertified unit. This NOD is the only staff person with access to a Night Cabinet for medications needed during pharmacy closure hours and not available through the Pyxis machines. The Nurse on Duty retrieves needed items from the "Night Cabinet" and delivers them to the unit where it is needed, regardless of the unit's certification status. (Refer to B 150 and A 506).	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and interview with key personnel on September 16 and 17, 2013, it was determined that the hospital failed to have an adequate number of nursing personnel to provide nursing care to all patients as needed. Evidence includes: 1. During an interview with the Unit Manager of the Upper Saco Unit on September 16, 2013 at approximately 11:00 AM, he stated that he carried a pager and responded to calls for Lower Saco (the noncertified unit) if needed. Additionally, he	A 392		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 204007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2013
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW PSYCHIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 ARSENAL STREET AUGUSTA, ME 04330
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 392	Continued From page 6 stated that he was providing training to a new staff member on Lower Saco. 2. During an interview on September 16, 2013 at approximately 12:35 PM, the Chief Financial Officer and Director of Human Resources confirmed that staff from the noncertified unit respond to emergency codes in the hospital, and staff from the hospital respond to emergency codes in the noncertified unit. The hospital and the noncertified unit depend on each others' staff for coverage and assistance during emergency situations. 3. During an interview with Kennebec Unit Nurse 4 on September 16, 2013 at approximately 2:30PM, she/he explained that " we would respond to all codes ... even [the decertified portion of the facility] ..." (Please refer to B 146.)	A 392		
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by: Based on interview, the hospital failed to assure current and accurate records are kept of the receipt and disposition of scheduled drugs. Evidence Includes: During an interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 it was revealed that the pharmacy did not maintain controlled drug records for the specific certified hospital. The Director stated that comingled records are maintained for the entire institution, certified and noncertified sections.	A 494		
A 506	482.25(b)(4) AFTER-HOURS ACCESS TO DRUGS	A 506		

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A 506

Continued From page 7

A 506

When 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.

This STANDARD is not met as evidenced by:
Based on interview, the hospital failed to assure that only hospital personnel have access to medications.

Evidence includes:

Interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 revealed the pharmacy maintains a "night cabinet" for use by the entire institution, to provide medications needed during pharmacy closure hours and not available through the Pyxis machine. Night cabinet access is limited to the nurse on duty, who is not dedicated to the hospital only, and supervises both the hospital and noncertified unit of the institution. The nurse on duty retrieves needed items from the night cabinet, and delivers them to both the hospital and the rest of the institution.

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B 146	<p>482.62(d) NURSING SERVICES</p> <p>The hospital or unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be 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.</p> <p>This STANDARD is not met as evidenced by: Based on interview with administrative and direct care nursing staff on September 16 and 17, 2013, review of nursing staff time sheets between 8/27/13 and 9/2/13, it was determined that the hospital failed to have an adequate number of nursing personnel including Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Mental Health Workers (MHWs) to provide nursing care necessary to provide active treatment and safety of hospital patients. The Hospital failed to have a nursing department separate from the nursing department on the noncertified unit, resulting in hospital nursing staff being reassigned to work a portion or all of a shift outside of the hospital.</p> <p>The findings included:</p> <p>1. The Hospital failed to insure that nursing staff assigned to a hospital unit or available to float within the hospital were not assigned to respond to codes or work a portion or all of a shift outside of the hospital.</p> <p>During an interview with a SA (State Agency) surveyor, on September 16, 2013 at approximately 11:00 AM, the Unit Manager of the</p>	B 146		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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B 146	<p>Continued From page 1</p> <p>Upper Saco Unit stated that he carried a pager and responded to calls for Lower Saco Unit (the noncertified unit) when needed. Additionally, he stated that he was providing training to a new staff member on Lower Saco.</p> <p>2. During an interview with the Kennebec Unit Nurse IV (supervisory RN) with a SA and a Regional Office (RO) surveyor on September 16, 2013 at approximately 1:28 PM, the nurse said that nursing staff on all units of the institution respond to all codes in the hospital and on the noncertified unit. She said the overriding principle was: Safety First. She added that staff from the noncertified unit also respond to codes in the hospital. She also stated to the State agency surveyor: "Yes... we do float assigned unit staff to Lower Saco (the noncertified unit)...we have a log". When asked how it is determined who gets assigned to the noncertified unit, she stated that staff are reassigned on a rotating basis. Staff reported that float staff are assigned to the noncertified unit on a rotating basis.</p> <p>3. The Chief Financial Officer and the Director of Human Resources met with SA and RO surveyors on September 16, 2013 at approximately 12:35 PM. They explained the protocol for separation of nursing staff. All hospital units and the noncertified unit have direct care nursing staff assigned specifically to that unit. In addition, the hospital and the noncertified unit has a single list of "float staff" who are assigned to any unit in the institution to replace staff who have called out. The time float staff spends on the noncertified unit is recorded accurately to keep the allocation of nursing staff time on that unit separate from the time staff worked on the hospital units.</p>	B 146		
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B 146	<p>Continued From page 2</p> <p>The Director of Human Resources said the Hospital Nursing Department is not separate from the nursing department on the noncertified unit. The Director of Nurses splits her time between both the hospital and the noncertified unit. She stated that this was true for all department directors including the Medical Director, Social Service and Dietary. The focus of this discussion was on how finances and billing was allocated based on the square foot percentage of the noncertified facility relative to the square footage of both facility's combined or on the basis of the census of the noncertified facility relative to the census of both facilities combined.</p> <p>Administrative staff provided surveyors with a memo re: Lower Saco Staffing, the decertified facility, dated 9/9/13 on 9/16/13. This memo explains: "... the protocol that we will be following to charge any staff time on Lower Saco to that unit. We need to accurately reflect the hours for that unit so that we can show that there is NO commingling of Staff. Any hours worked by nursing staff NOT typically assigned to the LSU will be moved through payroll to that department." Interview with Hospital Human Resources Personnel on September 16, 2013 at approximately 12:40 PM revealed the following; allocation of clinical staff between certified and noncertified portions of the hospital was a function of payroll. Operationally, staff are floated between the psychiatric hospital and the 20-bed noncertified unit adjacent to the hospital. Staff have access between sections via a keycard. There was no recognition that floating staff may impact the individualized active treatment provided to patients in the hospital.</p> <p>4. The facility provided daily staffing sheets as worked for hospital nursing staff for the dates</p>	B 146		

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B 146 Continued From page 3
from 8/21/13 through 9/21/13. The staffing sheets from 8/27/13, the date of correction through 9/2/13, the date of termination, were reviewed. These sheets confirmed that nursing staff were floated almost daily outside the hospital to the noncertified unit. There was no documentation that staff assigned to the noncertified unit were reassigned to units in the hospital. For example:

a. On Tuesday 8/27/13, on the night shift, an RN assigned to the Upper Saco unit in the hospital, was reassigned to work 4 hours of the shift, 11 PM to 3 AM, on the noncertified unit.

b. On Wednesday, 8/28/2013, on the night shift (10:45 PM - 7:15 PM), a MHW assigned to the night shift on the Upper Kennebec Units was reassigned to the noncertified unit for the entire shift. On the same day, on the day shift (6:45 AM - 3:15 PM), an RN scheduled to work on this Upper Kennebec Unit was floated to another unit in the hospital until 2 PM and then assigned to work on the noncertified unit 2 PM to 11 PM. A review of the float staff list for 8/28/2013 indicated that the following float staff were assigned to the noncertified unit: one (1) nursing supervisor on the night shift; one (1) RN and two (2) MHWs on the day shift and one (1) MHW for the night shift. That day, one (1) supervisory nurse and two (2) MHW's on the evening shift and one (1) RN on the day shift were assigned to the hospital.

c. On Friday, 8/30/13, an RN assigned to the Upper Saco Hospital Unit was reassigned to the noncertified unit on the day shift.

d. On Saturday, 8/31/13, an RN assigned to the Upper Kennebec Hospital Unit, was reassigned for 4 hours on the day shift (7 AM to

B 146

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B 146	Continued From page 4 11 AM) to the noncertified unit, and then returned for the rest of shift to the hospital unit. e. On Monday 9/2/13, three members of the hospital nursing staff were reassigned to the noncertified unit for their shift. This included an RN on the Lower Kennebec Hospital Unit, on the evening shift, a MHW normally assigned to Upper Kennebec Hospital unit and and an RN assigned to the day shift on the upper Saco Hospital Unit.	B 146		
B 150	482.62(d)(2) NURSING SERVICES There must be 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. This STANDARD is not met as evidenced by: Based on staff interview and review of staffing documentation, the hospital failed to delineate hospital nursing staff services as separate from nursing services on the noncertified unit. The 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 both facilities. Using hospital staff for coverage on the noncertified unit 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. Findings include: 1. The hospital floated regularly scheduled nursing staff assigned for a shift in the hospital to	B 150		

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B 150	<p>Continued From page 5</p> <p>the noncertified unit, to cover call-outs and other nursing needs . Staff in the hospital responded to all codes on the noncertified unit. (Refer to B 146.)</p> <p>2. Interview with the pharmacy director at approximately 12:00 PM on September 16, 2013 revealed the pharmacy maintains a "night cabinet" for use by the entire institution, to provide medications needed during pharmacy closure hours and not available through the Pyxis machine. Night cabinet access is limited to the nurse on duty, who supervises both the hospital and noncertified unit of the facility. The nurse on duty retrieves needed items from the night cabinet, and delivers them to both the hospital and the noncertified unit.</p>	B 150		

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: 204007

August 29, 2013

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

**Re: Acceptable Plan of Correction as of 08/27/2013 for
Survey ID: ZYLS11 & V4Q411, 03/29/2013 & 05/10/2013**

Dear Ms. McEwen:

I am pleased to inform you that the Riverview Psychiatric Center's plan of correction for its Medicare deficiencies, and the time schedule for completion of the plan, August 27, 2013, has been found acceptable.

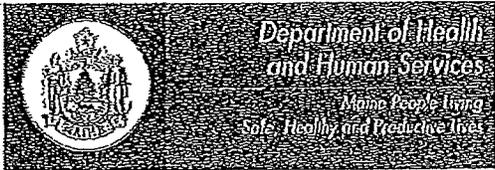
Based on information submitted by Riverview Psychiatric Center, the plan of correction has been completed as of August 27, 2013. Failure to correct Condition-level deficiencies will result in termination of the Medicare provider agreement, as stated in our letter of June 4, 2013. CMS will conduct an unannounced revisit survey to verify compliance with the Medicare Conditions of Participation. The revisit survey will also review whether your facility meets Federal requirements for certification as a distinct part psychiatric hospital. Please refer to our August 14, 2013 notice regarding appeal rights for termination effective September 2, 2013 if your facility is not found to have corrected Condition-level deficiencies.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

Daniel Kristofa, Branch Manager
Certification & Enforcement Branch

cc:
Maine Department Of Health And Human Services
CMS Central Office



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Licensing and Regulatory Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
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Toll Free (800) 791-4080; TTY Users: Dial 711 (Maine Relay)

VIA EMAIL AND US MAIL

August 15, 2013

Mr. Daniel Kristola
Centers for Medicare & Medicaid Services
JFK Federal Building, Suite 2325
Boston, MA 02203-0003

Mr. Kristola,

I am compelled to express my sincere concern about the telephone conference that was arranged by your Office yesterday with Mr. Roberson to discuss Riverview Psychiatric Center. As an initial matter, please understand my perception that the integrity of our State / Federal relationship has been challenged not so much by what you and your team said, rather by what you failed to say in the presence of Mr. Roberson: A posture that I will not soon forget.

Not once during our meeting did you or a member of your team acknowledge the effort of Riverview, the Commissioner of the Department of Health and Human Services, or the efforts of this Agency to facilitate a compliant response to the deficiencies cited by my Office (DLRS). In fact, you affirmatively stated that other than our assertions that progress is being made, you have nothing in your office to demonstrate progress by Riverview. Such an assertion is patently untrue. Two progressive plans of correction, and a third – in draft – have been filed with CMS. Further, there have been two teleconferences, one as recently as last week, involving DLRS, Riverview (including the DHHS Commissioner, Mary Mayhew), and representatives from both CMS regional and central offices. In addition to the acknowledgement by CMS that similar challenges are being experienced by other psychiatric hospitals across the United States, we had extensive dialogue around status reports and technical assistance for Riverview personnel. Further, you will please recall that at the end of the most recent technical assistance call in which DHHS Commissioner Mayhew participated, CMS, by way of Alice Bonner who was on the call with you, pledged ongoing technical support to Riverview and the State of Maine. To assert, and or to remain silent when your superiors assert that "no progress" has been made, can only be perceived by me as disingenuous and an acquiescence to factual inaccuracies. The rapid change in posture by CMS is, among other things, perplexing.

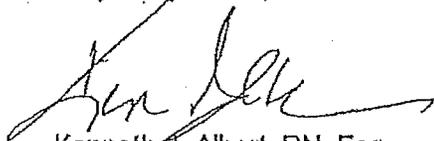
Your team has expressed, on more than one occasion, a concern and guidance that the Maine State Agency (DLRS) should carefully monitor any bias it may have related to Riverview, another State entity. I have expressed appreciation for such a concern, but have indicated that DLRS has – and will always – manage such responsibilities with integrity, and in the same manner that we would manage such processes with any other federally certified hospital in Maine. To mitigate the potential for a compromised survey, CMS made the decision to include federally contracted surveyors with the Maine survey team when it conducted a full federal survey at Riverview. A review of the Statements of Deficiencies drafted by both the state and federal surveyors clearly reveal that all surveyors took their responsibilities to ensure compliance with Medicare Conditions of Participation very seriously and without bias. The consistencies between the reports, which were drafted and filed by each survey team independently, are clear evidence of my assertions. Despite these realities, you failed to inform Mr. Roberson of our efforts to ensure integrity in the process when he unabashedly – and insultingly – admonished DLRS for not taking a more aggressive technical assistance and enforcement posture with Riverview to bring them into compliance sooner. This inconsistent messaging from regional and central offices was further compounded when your team failed to own the guidance (directive) given Maine to be very careful about the nature and scope of involvement by DLRS in the development of a plan of correction by Riverview. Again, a perplexing turn of events.

Based on our experience with CMS, and given a one-on-one conversation I had with you just minutes before our conference call yesterday, DLRS believes it presented a cogent and reasonable proposal - and subsequent request - seeking authorization from CMS to extend the Riverview termination track for an additional two weeks to allow for Riverview to continue its forward progress on the development of an acceptable Plan of Correction. We have, in recent history, made similar successful requests of CMS for other Maine hospitals who have demonstrated ongoing effort toward compliance. In the instant case, the granting of such a request would neither have compromised statutory timeframes, nor would it have - in my professional opinion - compromised the health or safety of patients at Riverview Psychiatric Center. Despite the presentation of a litany of initiatives in motion by Riverview and the State of Maine, along with the attestation of my Office that Riverview is nearing completion of an acceptable Plan of Correction, Mr. Roberson opined that public notice might somehow "motivate" a response by Riverview and the State of Maine. While I was a bit stunned by the lack of logic in such an assertion, and the complete disregard of existing efforts, I was even more taken aback by Mr. Roberson's assertion that the position being taken by CMS is motivated - at least in part - by the need for the federal government to "manage the money". While I struggle to figure out the implications of the need to "manage the money" on the survey and certification process, I don't struggle at all with my understanding of the role required of my Office, which is to enforce compliance with the Medicare Conditions of Participation.

Despite the apparent disagreement between our respective offices, I sincerely hope that we can work together in this regard, as I am confident that Riverview Psychiatric Center can - and will - demonstrate compliance. And like any other hospital, I strongly believe that Riverview should be given every opportunity afforded under the law to do so.

At the end of the day, please rest assured that my Office will continue to conduct the business of CMS in Maine with integrity. After all, the State of Maine shares with CMS the legitimate interest of ensuring the health and safety of our citizens. I trust we can focus on that as we move forward.

Very Truly Yours,



Kenneth J. Albert, RN, Esq.
Director, Division of Licensing and Regulatory Services

KJA/lc

cc: Mary Mayhew, Commissioner, Department of Health and Human Services
All Hill-Lash, Acute Care Supervisor, DLRS, DHHS
Phyllis Powell, Assistant Director, Medical Facilities, DLRS, DHHS
Michael Swan, Health Facility Survey Manager, DLRS, DHHS
William Boeschstein, Chief Operating Officer, DHHS
Renee Guignard, Assistant Attorney General, Attorney General's Office
William Roberson, Associate Regional Administrator Director, CMS
Alice Bonner, CMS

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 Arsenal Street
Augusta, ME 04330

Re: CMS Certification Number: 204997
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 §488.53(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

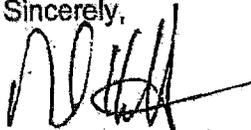
It is important that you send a copy of your request for hearing to this office to the attention of:

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

DANIEL E. WATHEN
Of Counsel

77 Winthrop Street
Augusta, ME 04330

PH 207.622.6311
FX 207.623.9367
dwathen@pierceatwood.com
pierceatwood.com

July 18, 2013

Michele Lumbert, Clerk
Kennebec County Superior Court
95 State Street
Augusta, ME 04330

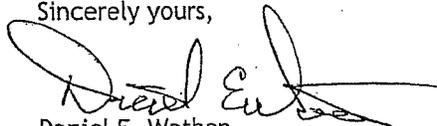
Re: Paul Bates, et al. v. Commissioner, Department of Health and Human Services, et al.
Docket No. CV-89-088

Dear Michele:

Enclosed please find for filing the Court Master's Progress Report running from January 16, 2013, to June 30, 2013, in the above-captioned matter.

Thank you for your attention to this letter and enclosure.

Sincerely yours,



Daniel E. Wathen

DEW/wt
Enclosure
cc/w/enc:

Justice Andrew M. Horton
Katherine Greason, AAG
Phyllis Gardiner, Esq.
Helen Bailey, Esq.

STATE OF MAINE
KENNEBEC, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

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

Defendants

COURT MASTER'S PROGRESS
REPORT PURSUANT TO
PARAGRAPH 299

The following report covers the period from January 16, 2013 to June 30, 2013.

Riverview Psychiatric Center

Although Riverview Psychiatric Center is not presently supervised by the Court, given its importance to the overall mental health system, there are significant developments that should be noted. As discussed in the last two progress reports, Riverview has been challenged by a substantial increase in the number of forensic admissions since 2012. The imbalance between forensic and civil clients persists and worsens. The situation is aggravated further by the fact that client-specific security concerns on Lower Saco, the most acute forensic wing of the hospital, has in recent months required the full time presence of two correctional officers around the clock and a reduction in the overall capacity of the wing. The substantial increased security costs are funded from the hospitals existing budget.

Since March 1, 2013, the hospital has experienced two serious security situations on the Lower Saco Unit which have led to two "substantial allegation surveys" by the Center for Medicare & Medicaid Services ("CMS") and the Licensing Division of the Maine Department of Health and Human Services ("DHHS") acting as the State Survey Agency. One incident involved a client assaulting a member of the staff and the second involved jeopardy to the health and safety of patients arising from the actions of correctional officers providing unit security. In both instances, the CMS surveys have been conducted promptly and thoroughly, and CMS has issued a detailed list of deficiencies. The hospital has submitted a plan of correction for consideration by CMS and took immediate steps to remove the causes of patient jeopardy. CMS has an effective remedy for correcting deficiencies, it has both the authority and the intention to suspend payment for Medicare services unless the deficiencies are addressed to its satisfaction.

When I recommended in 2011 that this Court suspend active supervision of Riverview, I noted that other adequate mechanisms exist to monitor Riverview's operations. Among the mechanisms mentioned were the survey procedures of CMS and the Licensing Division of DHHS. I have examined the reports of the surveys conducted by CMS, the plans of correction submitted by Riverview, and I have discussed the incidents with the Superintendent of the hospital. Although the deficiencies noted in the CMS surveys could constitute a violation of the

Consent Decree and serve as the basis for requesting reinstatement of active supervision under the terms of this Court's December 8, 2011 order, I do not at this time make such a request. At this point, CMS has yet to act upon the plan of correction, and it is too early to judge the adequacy and effectiveness of its response.

The Maine Legislature considered bills submitted by the administration to alleviate the increased demand for forensic services at Riverview. The Legislature enacted LD 1433 that allows, but does not require, the State Forensic Service to observe an incarcerated person at a correctional facility, rather than at Riverview, for evaluation purposes. A more comprehensive approach was presented in LD 1515 that would provide mental health services in a correctional facility, rather than Riverview, for persons transferred from jail, persons charged with crimes seeking mental evaluations and adults found incompetent to stand trial. Essentially, this bill would create a mental health unit in a correctional facility and reserve the increasingly limited forensic capacity at Riverview for clients who have been found not criminally responsible. LD 1515 received approval in both the House and Senate but carried a fiscal note of more than \$3,000,000 per year and, in the end, was not funded by the Appropriations Committee. The bill remains with the Committee.

The budget of the hospital remains adequate but barely so. In my last progress report, I noted that the hospital needs for FY 13 included \$1,085,944 for an audit of Disproportionate Share Funding ("DSH"). This amount was provided in the Department's budget. The Legislature, however, took no steps to address the potential loss of future DSH funding that will result from an increased forensic population.

The funds for ACT team services for FY 14 and 15 were provided in the amount requested, namely \$216,857 per year. \$50,000 was provided in FY 14 for sidewalk repairs and upgrading the hospital duress system. The funds requested for replacing an obsolete electronic medical records platform were not provided but the budget contains authorization to transfer available balances from Riverview personal services appropriations for that purpose. I am advised that the available balances may be sufficient to cover the cost of a new system. Finally, staffing at the hospital remains adequate although the coverage and assignment of the nursing staff is included in the operational deficiencies noted by CMS.

Developments in Community Mental Health

The availability of the much needed funding for additional mental health services in the community, particularly for those ineligible for MaineCare, continues to presents a mixed and shifting picture. In approaching the biennial budget, DHHS requested an additional \$4,664,250 for additional mental health services for each of the two years. The Governor's proposed budget included \$2,000,000 for FY 14 but nothing for FY 15. While the budget was pending before the Legislature, the Attorney General designated \$2,700,000 from a settlement with Janssen/Risperdal for mental health services for FY 14. At this point, it appeared that DHHS might be fully funded for the first year of the biennium and have a golden opportunity to demonstrate the effect of adequate funding on waitlists for mental health services. Ultimately, however, the Legislature accepted the funds designated by the Attorney General but rejected the \$2,000,000 proposed by the Governor, leaving DHHS with \$2,700,000 for a single year. To its credit, the Department now proposes to make available carryover non-lapsed funds from FY 12 and 13 in the total amount of \$2,015,000 for additional mental health services for FY 14, thereby

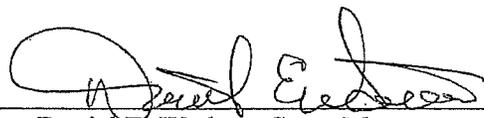
recapturing the opportunity to demonstrate the effect of adequate funding on waitlists in the coming fiscal year.

The most persistent and glaring example of non-compliance with the Consent Decree is the Department's failure to promptly provide timely community integration services ("CI") for those with severe and persistent mental illness. Essentially, CI involves the assignment of a caseworker to assist and guide the client in constructing an individual service plan and accessing needed services that are available within the community. CI is the most basic form of mental health service and the gateway to all other forms of mental health treatment. As I have mentioned before, the Department entered into a binding agreement in 1990 that class members would have a caseworker assigned within 2 days of a request if hospitalized and 3 days if not hospitalized. Non-class members were to have one assigned within 7 days. **Six months ago, I reported that there were a total of 387 people on a wait list for assignment of a case worker and on average they were experiencing a wait of more than 40 days, with some waiting up to 300 days. Today, the situation is worse. 543 people, both class members and non-class members including those who are MaineCare eligible and those who are not, are now on the waitlist and they are waiting an average of 58 days, with some waiting for more than 350 days.** Clearly, the trend is in the wrong direction, although it may be influenced to some extent by the funding uncertainty that accompanies the budget process and the end of the fiscal year.

The challenge for the Department and its Office of Substance Abuse and Mental Health Services ("SAMHS") is real but it should be manageable. Within the last year, SAMHS has improved its capacity for tracking and monitoring waitlists. Beginning July 1, 2013, SAMHS will enhance the information exchange with state staff and service providers by providing a weekly list by agency of the number of consumers on the waitlist and a week by week comparison to calendar year 2012. In addition, it will post on its website APS reports, and waitlists by provider and service. SAMHS has a process improvement project underway with a pilot group of six providers and has included performance measures in all of its provider contracts. These changes are designed to produce improved contract management. With full funding available for FY 14, SAMHS has a unique opportunity to reduce the waitlists for services and demonstrate its ability to achieve a reasonable degree of compliance with the Consent Decree, thereby providing a track record to persuade the Legislature to fully fund mental health services in FY 15 and beyond. This fiscal year could be a year of accomplishment.

In the coming months, I will continue to meet with the SAMHS staff on a monthly basis and will report on progress.

Dated: July 18, 2013


Daniel E. Wathen, Court Master

Department of Health and Human Services

DHHS → Audit → Program Integrity

+ A | - A | Wed 23 Oct 2013

Program Integrity

Program Integrity (PI) is responsible for monitoring and safeguarding the MaineCare Program against fraud, abuse and waste. It conducts analysis of MaineCare billings to detect utilization patterns or trends that may indicate fraud, abuse or waste. Based on data analysis or referrals/complaints received from other state agencies, health care providers or members, PI may perform retrospective audits/reviews of MaineCare Providers and members to validate the allegations of fraud, abuse or waste.

Authority

- **Authority:** PI's authority to conduct reviews and administer sanctions is described in the MaineCare Benefits Manual (MBM), Chapter 1, § 1, General Administrative Policies and Procedures (word*)
- **Audits:** The Division's authority to monitor MaineCare payments through audits and post-payment reviews is described in MBM Chapter 1, § 1.16 (word*)
- **Utilization Review:** MBM Chapter 1, § 1.17 (word*) details the responsibilities for conducting utilization review and the authority to request and receive medical records and other supporting records as needed.
- **Surveillance:** MBM Chapter 1 § 1.1 (word*) lists PI's responsibilities for monitoring the MaineCare Program through continuous sampling of claims which can include extrapolation, and evaluation of necessity and quality of services. It also provides authority to make referrals to licensing boards and registries when appropriate, and to refer cases to the Healthcare Crimes Unit in instances of suspected fraud.
- **Grounds for Sanctioning and/or Recouping:** MBM Chapter 1 § 1.19-1 (word*) lists the grounds from which PI may impose sanctions or request recoupment of funds.
- **Sanction Actions, Impositions, Scope and Notification:** MBM Chapter 1, § 1.19-2, 1.19-3 and 1.19-4 (word*) describe the type of sanctions that PI may invoke, factors to be considered when imposing a sanction, the scope of the sanctions, and the notification requirements.

*free viewer or to request a hard copy

Credits

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Orbeton, Jane

From: Adolphsen, Nick <Nick.Adolphsen@maine.gov>
Sent: Friday, October 04, 2013 4:31 PM
To: Orbeton, Jane
Subject: RE: NET Update - On Behalf of Commissioner Mayhew

State and Federal for the entire fiscal year.

From: Orbeton, Jane [mailto:Jane.Orbeton@legislature.maine.gov]
Sent: Friday, October 04, 2013 3:12 PM
To: Adolphsen, Nick
Subject: RE: NET Update - On Behalf of Commissioner Mayhew

Thanks. The brokerage contract amounts, are they state GF and federal FF? Are these amounts per year? Per month? Jane

From: Adolphsen, Nick [mailto:Nick.Adolphsen@maine.gov]
Sent: Friday, October 04, 2013 2:59 PM
To: Orbeton, Jane
Subject: RE: NET Update - On Behalf of Commissioner Mayhew
Importance: High

Hi Jane,

Please see answers noted below.

Nick

From: Orbeton, Jane [mailto:Jane.Orbeton@legislature.maine.gov]
Sent: Wednesday, October 02, 2013 3:31 PM
To: Adolphsen, Nick
Cc: Broome, Anna; Margaret Craven; Farnsworth, RepRichard; Gattine, RepDrew
Subject: RE: NET Update - On Behalf of Commissioner Mayhew

Thank you.

I have a few questions:

1. What is "service level" in the call center?
Response: Service level is defined as percent of calls answered within 60 seconds which is the contractual requirement.
2. Do you know why CTS scheduled trips dropped from 111,531 in August to 52,146 in September? Does this worry you? Where did the other 59,000 scheduled trips from the prior month go to? How many trips did DHHS estimate CTS would be scheduling each month? And when I look at those numbers, 30,424 in the week of September 14 looks consistent with 111,531 a month but even higher. Are you sure that you have full month figures for August and September and that they are correct?
Response: Responded in a prior email
3. Could we have a copy of the corrective action plan when CTS submits it?
Response: Yes

4. Could we have copies of the letters to all 3 brokers, informing of deficiencies or asking for corrective action plan?

Response: Attached

5. December 1 for substantial progress seems far away. Did DHHS establish benchmarks for November 1 or another interim date?

Response: We will be monitoring the progress on a week to week basis based on the actions in the corrective action plans.

6. What is the amount of each contract with the 3 brokers and on what schedule are they paid?

Response: Brokers are paid on a capitated per member per month at the beginning of each month for the number of MaineCare eligible members in each region for that month.

DHHS District	Contract Transit Region	Provider	Dollar Amount
1 York	8	LogistiCare Solutions LLC	\$ 5,100,000
2 Cumberland	6	Coordinated Transportation Solutions	\$ 5,200,000
3 Western	7	Coordinated Transportation Solutions	\$ 8,800,000
4 Midcoast	5	Coordinated Transportation Solutions	\$ 3,100,000
5 Central	4	Coordinated Transportation Solutions	\$ 5,000,000
6 Penquis	3	Penquis CAP, Inc.	\$ 7,800,000
7 Downeast	2	Coordinated Transportation Solutions	\$ 2,700,000
8 Aroostook	1	Coordinated Transportation Solutions	\$ 3,500,000
			\$ 41,200,000

Thank you.

I appreciate your assistance. Jane

From: Adolphsen, Nick [mailto:Nick.Adolphsen@maine.gov]

Sent: Tuesday, October 01, 2013 5:07 PM

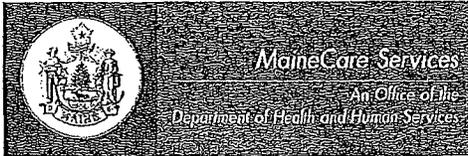
To: Cain, SenEmily; Carey, RepMichael; Chase, RepKathleen; Clark, Tyler; Flood, SenPatrick; Frey, RepAaron; Hill, SenDawn; Jorgensen, RepErik; Keschl, RepDennis; Rochelo, RepMegan; Rotundo, RepMargaret; Sanborn, Linda; Winsor, RepTom; Cassidy, RepKatherine; Craven, SenMargaret; Dorney, RepAnn; Farnsworth, RepRichard; Gattine, RepDrew; Lachowicz, SenColleen; Malaby, RepRichard; McElwee, RepCarol; Peterson, RepMatthew; Rep. Bear (bearlaw2@yahoo.com); Sanderson, RepDeborah; senatorhamp@gmail.com (senatorhamp@gmail.com); Sirocki, RepHeather; Stuckey, Peter

Cc: Dawson, Maureen; Nolan, Christopher; Orbeton, Jane; Lusk, Holly E; Newman, Kathleen; Nadeau, Stefanie; Mayhew, Mary

Subject: NET Update - On Behalf of Commissioner Mayhew

As you are aware, the Department has launched a new delivery system for Non-Emergency Transportation services for MaineCare members. The new brokerage system has been implemented in response to concerns raised by the federal government.

The Department is clearly disappointed with the experiences during implementation. It is not acceptable for MaineCare members to miss rides to critical medical appointments and vital community services. We have been



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 287-2674
Fax (207) 287-2675; TTY (800) 423-4331

September 30, 2013

VIA EMAIL AND REGULAR MAIL

Mr. Brian Thibeau
Penquis Community Action Program
262 Harlow Street
Bangor, ME 04401

BThibeau@penquis.org

Re: Non-Emergency Transportation Services contracts between the Maine Department of Health and Human Services and Penquis dated August 1, 2013 (the "Contract")

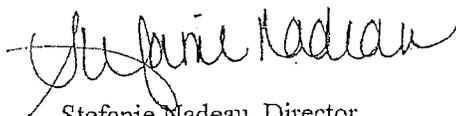
Dear Mr. Thibeau:

While Penquis has clearly made significant efforts over the last few weeks to ensure that it is satisfying its requirements under the above-referenced contract regarding the delivery of Non-Emergency Transportation services to MaineCare members in Region 3 for the State of Maine, please note that the following requirement must be improved upon:

1. Penquis may not yet have an adequate network of transportation providers, and it lacks a reasonable number of available drivers and wheelchair accessible vehicles. Based on the data provided by Penquis, it appears that, since August 1, 2013, Penquis has missed approximately 1,100 trips. As you know, each and every one of those missed trips is unacceptable, and the Contract requires that no trips shall be missed, unless cancelled due to emergency weather conditions. Pursuant to the Contract, Rider A, Sec. III (M)(9), we expect that Penquis will promptly establish a network of transporters to deliver NET services to members that is sufficient to provide adequate access to all covered services, pursuant to the Contract, Rider A, Sec. III (H)(8).

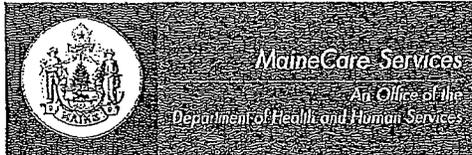
As you know, Non-Emergency Transportation services are an integral part of providing necessary MaineCare services to members throughout the State of Maine. I hope that this letter helps you understand our area of concern, and I look forward to discussing this issue and its resolution with you.

Sincerely,



Stefanie Nadeau, Director
Office of MaineCare Services
242 State Street
Augusta, Maine 04333
(207)-287-2093
stefanie.nadeau@maine.gov

cc: Mary Mayhew, Commissioner, Department of Health & Human Services
Kevin Wells, General Counsel, Department of Health & Human Services
Brian Sullivan, Manager, NET, Office of MaineCare Services
Roger Bondeson, Director of Operations, Office of MaineCare Services
Dori Harnett, Assistant Attorney General



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

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 287-2674
Fax (207) 287-2675; TTY (800) 423-4331

September 30, 2013

VIA EMAIL AND REGULAR MAIL

Mr. David White
Coordinated Transportation Solutions, Inc.
P.O. Box 2547
Lewiston, ME 04241-2547

dwhite@ctstransit.com

Re: Non-Emergency Transportation Services contracts between the Maine Department of Health and Human Services and Coordinated Transportation Solutions dated August 1, 2013 (the "Contract")

Dear Mr. White:

This letter shall serve as notice to Coordinated Transportation Solutions (CTS) that it has repeatedly failed to provide the services required by the Contract referenced above, whereby CTS agreed to broker Non-Emergency Transportation (NET) services to MaineCare and Children's Health Insurance Program (CHIP) members in Regions 1, 2, 4, 5, 6, and 7 for the State of Maine. CTS has failed in its service to MaineCare members by: failing to secure an adequate transportation network, failing to provide prompt and competent service at its call center. As a result, thousands of MaineCare members have missed, or been late, for appointments and, in some instances, gone without necessary medical services, among other things. CTS's performance failures also have a ripple effect throughout the State, causing caretakers to miss work and causing medical providers to lose revenue, to note just a couple of examples.

In response to this notice, the Department demands that CTS provide Corrective Action Plans, through "Root Cause Analysis" Reports, setting forth, in detail: (i) the root cause for each unsatisfactory element of performance; (ii) the actions taken, or to be taken by, CTS to improve performance to a satisfactory level; and, (iii) an improvement timeline, detailing when CTS expects improvement to reach a satisfactory level, with intermediate improvement goals noted. Please note that the Department expects significant measurable improvement of the deficient services identified below to occur **no later than December 1, 2013**. A Root Cause Analysis Report shall be done for each region and shall be based on CTS's data. CTS shall specify the corrective actions it expects to take in each Region. The Corrective Action Plans must be completed and submitted to the Department **within five business days** of the date of this notice, pursuant to the Contract, Appendix B.

The required services that CTS has failed to provide to the standards outlined in the Contract (each of which must be addressed, in detail, in the Root Cause Analysis Reports) include, but are not limited to:

1. **CTS does not have an adequate network of transportation providers, and it also lacks available drivers and wheelchair accessible vehicles.**

Pursuant to the Contract, Rider A, Sec. II (H)(8), CTS is required to establish a network of transporters to deliver NET services to members that is sufficient to provide adequate access to all covered services. Based on your self-reported data, since the NET system went live on August 1, 2013, CTS has missed over 4,000 trips. Each and every one of those missed trips is unacceptable, and the Contract requires that no trips shall be missed, unless cancelled due to emergency weather conditions. Contract, Rider A, Sec. III (M)(9). The significant number of missed trips reflects that CTS has not secured an adequate network of transportation providers.

2. CTS has failed to adequately receive and process members' requests, and has failed to arrange for NET services in numerous instances.

Pursuant to the Contract, Rider A, Sec. III (H)(4), CTS is responsible for receiving and processing requests for NET services, and for arranging for the provision of those services, for members who reside in the Regions listed above. Examples of CTS's unsatisfactory performance in this regard are reflected by its call center performance. CTS must maintain a call center with adequate capacity for members in its Regions to conveniently schedule needed transportation, per Contract, Rider A, Sec. III (H)(12)(a). The call center shall have a monthly abandonment rate of no more than 5%, per Contract, Rider A, Sec. III (M)(9). Based on your data, the call center abandonment rate has been between 15% and 58% between August 1, 2013 and September 14, 2013. In addition, 90% of member calls are required to be answered by a live CTS representative within 60 seconds, per Contract, Rider A, Sec. III (M)(9). Average wait times have been between three (3) minutes and almost 24 minutes, based on the data CTS has reported, to date.

3. CTS has failed to adequately handle schedule changes, driver No-Shows, and late running vehicles.

Pursuant to the Contract, Rider A, Sec. III (H)(6), CTS is required to develop procedures to accommodate scheduling changes, no-shows and late running vehicles. The Department has received numerous complaints from its members regarding CTS's failure to adequately schedule their transportation, handle changes to the schedules, and problems with how CTS deals with no-shows and late trips. CTS has exacerbated this issue through failing to properly communicate with members. When trip pickups were not on time, or if trips were not provided at all, CTS has failed to contact members to inform them about this fact, which is contrary to the requirements set forth in Rider A, Section III(H)(10)(f) of the Contract.

4. CTS has failed to: (a) establish mechanisms to ensure that the transporters comply with the timely access requirements; and (b) take adequate action following the failures to comply with timely access.

Pursuant to the Contract, Rider A, Sec. III (H)(10) and 42 C.F.R. § 438.206(c), CTS's transportation network shall meet the various minimum "timely access to service" delivery standards. As reflected by CTS's data, numerous trips have been late or missed all together, preventing MaineCare members from timely accessing their necessary medical services. The Contract sets forth clear guidelines regarding what are considered "timely" performance for each leg of a trip provided by CTS, and the Department expects those requirements to be met. Contract, Rider A, Sec. III (M)(9).

In addition, CTS has failed to adequately monitor and enforce the transporter requirements, and it has failed to take responsibility for the performance of services it delegates to the transporters. CTS shall be held responsible for the transporters' performance for any functions it delegates to any transporter, pursuant to Section III (I)(7) of the Contract.

5. CTS's consumer complaint rate is much too high.

Based on CTS data, since CTS began providing NET services on August 1, 2013, it has received over 3,300 complaints from members, and this does not include the numerous complaints received separately by the Department. It is imperative that CTS immediately improve upon its customer satisfaction performance measure.

6. CTS has failed to provide the documentation and monthly reporting required by the Contract.

Please see our letter, dated September 24, 2013, which sets forth the specific documents and reports that are required.

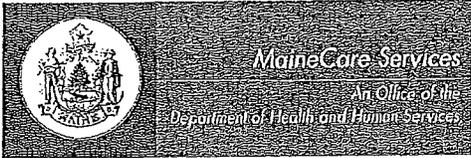
In sum, CTS has not provided transportation services as required by the Contract. While there has been some improvement over the last few weeks, information provided to the Department demonstrates that CTS has not responded quickly enough to identified deficiencies, and has not provided sufficient resources to remedy the deficiencies. NET services are an integral part of providing necessary MaineCare services to members throughout the State of Maine. Please note that, upon issuance of this notice, the Department shall also put CTS's bond holder on notice of its performance failures. **Finally, please be advised that if CTS does not submit the required Corrective Action Plans within five business days or does not achieve significant measureable improvement toward the Corrective Action Plans by December 1, 2013, then the Department may choose to exercise any or all of its contractual and regulatory rights including, but not limited to, accessing the performance bond, issuing sanctions pursuant to the MaineCare Benefits Manual Chapter 1, Section 1.19, and terminating any or all of CTS's contract for NET services.**

Sincerely,



Stefanie Nadeau, Director
Office of MaineCare Services
242 State Street
Augusta, Maine 04333
(207)-287-2093
stefanie.nadeau@maine.gov

cc: Mary Mayhew, Commissioner, Department of Health & Human Services
Kevin Wells, General Counsel, Department of Health & Human Services
Brian Sullivan, Manager, NET, Office of MaineCare Services
Roger Bondeson, Director of Operations, Office of MaineCare Services
Dori Hamett, Assistant Attorney General



Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2674
Fax (207) 287-2675; TTY (800) 423-4331

September 30, 2013

VIA EMAIL AND REGULAR MAIL

Mr. Bob Harrison
Logisticare Solutions, L.L.C.
86 York Street, Suite 2
Kennebunk, ME 04043

roberth@logisticare.com

Re: *Non-Emergency Transportation Services contracts between the Maine Department of Health and Human Services and Logisticare dated August 1, 2013 (the "Contract")*

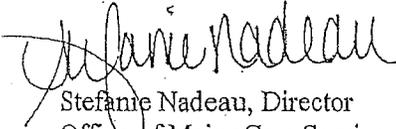
Dear Mr. Harrison:

While Logisticare has clearly made significant efforts over the last few weeks to ensure that it is satisfying its requirements under the above-referenced contract regarding the delivery of Non-Emergency Transportation services to MaineCare members in Region 8 for the State of Maine, please note that the following requirements must be improved upon:

1. Logisticare may not yet have an adequate network of transportation providers, and it lacks a reasonable number of available drivers and wheelchair accessible vehicles. Based on the data provided by Logisticare, it appears that, since August 1, 2013, Logisticare has missed approximately 500 trips. As you know, each and every one of those missed trips is unacceptable, and the Contract requires that no trips shall be missed, unless cancelled due to emergency weather conditions. Pursuant to the Contract, Rider A, Sec. III (M)(9), we expect that Logisticare will promptly establish a network of transporters to deliver NET services to members that is sufficient to provide adequate access to all covered services, pursuant to the Contract, Rider A, Sec. III (H)(8).
2. The Department has received formal complaints from its members regarding Logisticare's failure to adequately schedule their transportation, handle changes to the schedules, and problems with how Logisticare deals with no-shows and late trips. These problems have been exacerbated through failure to properly communicate with members. When trip pickups were not on time, or if trips were not provided at all, Logisticare has failed to contact members to inform them about this fact, contrary to the requirements set forth in Rider A, Sec. III (H)(10)(f) of the Contract.

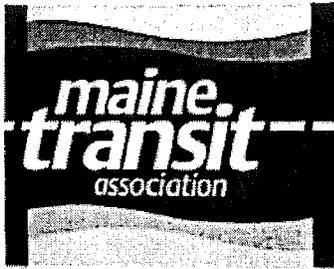
As you know, Non-Emergency Transportation services are an integral part of providing necessary MaineCare services to members throughout the State of Maine. I hope that this letter helps you understand areas of concern, and I look forward to discussing these issues and their resolution with you.

Sincerely,



Stefanie Nadeau, Director
Office of MaineCare Services
242 State Street
Augusta, Maine 04333
(207)-287-2093
stefanie.nadeau@maine.gov

cc: Mary Mayhew, Commissioner, Department of Health & Human Services
Kevin Wells, General Counsel, Department of Health & Human Services
Brian Sullivan, Manager, NET, Office of MaineCare Services
Roger Bondeson, Director of Operations, Office of MaineCare Services
Dori Harnett, Assistant Attorney General



Maine Transit Association
c/o General Manager
Downeast Transportation, Inc.
P.O. Box 914
Ellsworth, Maine 04605

October 2, 2013

Senate Chair Dawn Hill
House Chair Peggy Rotundo
Appropriations and Financial Affairs Committee
5 Statehouse Station
Augusta, ME 04333

Re: Non Emergency Transportation Brokerage

Dear Committee Members:

The purpose of this letter is to update you on the continuing challenges posed by the new transportation brokerage system, which went into effect on August 1, 2013. We also offer our recommendation for a way forward that will better serve the needs of MaineCare recipients.

I serve as the General Manager of Downeast Transportation in Ellsworth and as the President of the Maine Transit Association (MTA). The Maine Transit Association is a professional association providing leadership, resources, support, and technical assistance to transit agencies throughout Maine. Our members provide a variety of services including regularly scheduled local and inter-city bus service, demand-response services statewide, inter-city commuter programs, and ferry service. When we speak of "transit," we are referring to transportation services available to the general public. Each year our members provide more than 7 million trips totaling over 60 million miles.

Our members include the state's 10 regional transportation providers (RTPs). Until the shift to the MaineCare transportation brokerage system on August 1, 2013, the RTPs managed transportation in their service areas. Maine had an integrated, efficient transportation system that had been in place for 30 years.

The new brokerage system divides Maine into 8 regions. In the region served by Penquis, Region 3 - Penobscot and Piscataquis counties, the new brokerage is working well. Penquis was previously the transportation provider in that region and, building on those resources and knowledge, has been able to provide high quality service as a broker.

Unfortunately, that is not true for the other 7 regions in the state. In fact, the system is working far worse than we expected and the situation is not improving. The new system is consistently failing to meet the needs of MaineCare recipients.

Of the 7 poorly served regions, Logisticare is the broker for Region 8 in York County and Coordinated Transportation Solutions (CTS) is the broker selected for the remaining 6 regions. The problems MaineCare clients have encountered are myriad and include:

1. Spending hours on hold and being unable to book a ride
2. Booking a ride that never shows up
3. Having a ride show up much earlier or later than scheduled.
4. Drivers having difficulty finding a destination or the client's home.

There are many scary stories. You can only imagine the fear and uncertainty these problems cause for those, such as dialysis and chemotherapy patients, who know their very life depends on a ride. For example, over Labor Day weekend CTS did not schedule trips on Labor Day for dialysis patients in Kennebec and Somerset Counties. That morning KVCAP, the provider in the region, received a call from the dialysis clinic asking why patients were not showing up. KVCAP quickly determined what had happened and worked frantically to arrange rides. All but one patient ultimately made it for dialysis. Unfortunately, that one patient ended up in the hospital on Wednesday.

Since the brokerage began, providers are seeing fewer trips than for the same period in 2013. Unfortunately, this probably means that eligible MaineCare recipients who require help are not receiving it. However, only the brokers have full information on service provided during the past two months. We would encourage the Committee to request this information from DHHS.

The regional providers exist to serve those without access to transportation, including MaineCare patients. Thus far, CTS and Logisticare have made it almost impossible for us to fulfill our mission. Problems we have encountered include:

1. Ride requests delivered with little or no advance warning, such as an hour or less. We have even received requests for rides that should have happened in the past.
2. We accept a ride from the broker, but when our driver shows up, someone else is already there to provide the same ride.
3. We accept a ride from the broker, but when our driver shows up, we learn the client has called the broker and canceled, but we were never informed.
4. We decline a ride request from the broker, inform them pursuant to their policies, but the broker does not process the decline. When the client calls to ask about their ride, we receive an angry call from the broker wondering why we haven't made the pick-up.
5. Broker and provider computer systems are not communicating effectively, requiring a significant investment of time to manually check each and every ride.

We have spoken with representatives of groups who work with MaineCare patients, such as the Maine Association of Community Service Providers and the Maine Area Agencies on Aging, and they are all experiencing these problems with the clients they serve.

We are now in the 10th week of this experiment. I would like to report that things are improving and that we have faith in the brokers and DHHS to make this system work. Unfortunately, I cannot. By early September, the situation had improved somewhat from early August, but we have not seen sustained improvement since then. The number and the significance of the problems we are encountering lead us to question whether this system will ever work.

At this point, the Maine Transit Association recommends this Committee urge the Department of Health and Human Services to do the following:

1. Closely review the brokers performance in each and every region. As discussed above, we think Region 3 is in good shape. The other regions all are experiencing significant problems, but some are worse than others..
2. In those regions where the broker is not performing anywhere near the RFP standards, DHHS should pull the contract pursuant to the terms of the RFP.
3. For those regions, DHHS should seek CMS' permission to operate in that region under the administrative model, at least for a few months.
 - a. That model, which is in use in Vermont, allows DHHS to contract with a provider to offer and manage MaineCare transportation services. This is similar to the situation in Maine before August 1.
 - b. This change will allow MaineCare recipients to receive the trips they need.
 - c. It will mean a reduction in federal reimbursement for services from the Medicaid rate of 62.57% to the administrative rate of 50%.
 - d. The administrative model is a CMS approved alternative to the brokerage.
4. DHHS can then explore alternative models that will allow Maine to receive the full MaineCare match.
 - a. This may mean rebidding the brokerage under a revised RFP that will help prevent the service problems that are currently being seen.
 - b. Several providers do intend to bid if the state re-issues the RFP. Given the positive performance of Penquis, that may be the best option for the state and MaineCare recipients.

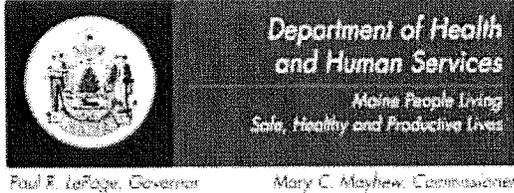
The members of MTA are disappointed that the MaineCare Transportation Brokerage is in such a poor condition. We are distressed that our clients, Maine residents we served well for many years, are now suffering with an unreliable, needlessly complex system. We are asking for the Committee's help in moving DHHS to address these problems as outlined above.

Sincerely,

Paul G Murphy

Paul Murphy, President
Maine Transit Association

paul @ exploreacadia.org



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)

Non-Emergency Transportation

Background:

- **2009:** Maine's current system authority and structure under the State Plan was out of compliance with federal regulations. CMS began working with the Office of MaineCare Services to identify the aspects of the NET system that were out of compliance.
- **November 2010:** CMS notified DHHS that Maine's Non-Emergency Medical Transportation system was not compliant with federal requirements. At this time, the Department investigated options presented by CMS, and determined that an at-risk brokerage model would be most advantageous. This model will result in greater accountability for the provision of accessible, cost effective, reliable, quality transportation for MaineCare members who lack alternate means of transport to MaineCare covered services. After discussions with stakeholders, DHHS opted for a regional system, utilizing the existing 8 Maine DOT transit regions.
- **March 2011:** The Department communicated to CMS about our intention to restructure NET under a single, statewide, risk-based Prepaid Ambulatory Health Plan (PAHP).
- **July 2011:** In collaboration with the Governor's Office and MaineDOT, we decided to restructure NET as a regional system of risk-based PAHP brokerages that aligned with the current eight Maine DOT transit districts.
- **2011 – 2102:** MaineCare worked with CMS to create a 1915(b) waiver, which was approved by CMS allowing MaineCare to utilize the risk-based PAHP.
- **August 2012:** MaineCare released a Request for Proposals and received bids for all regions from four national transportation companies, and two bids from existing providers for the region they service.
- **January 2013:** MaineCare completed a rigorous review of all proposals pursuant to state procurement rules, and announced the following awardees:
 - Penquis CAP of Bangor Maine was awarded Region 3 (Piscataquis and Penobscot Counties)
 - Logisticare LLC of Atlanta, GA was awarded Region 8 (York County and part of southern Oxford County.)
 - Consolidated Transportation Solutions of Ansonia CT was awarded the six remaining regions.
- **February – March 2013:** MaineCare negotiated with Awardees and entered into contracts.
- **April-July 2013:** Awardees prepared for operations, including acquiring office space and employees, and negotiating subcontracts with transportation providers within their regions. Some negotiations were protracted, and agreements for these contracts were not reached until mid-July.
- **July 22, 2013:** Brokers began call center operations.
- **August 1, 2013:** The new Brokerage model for MaineCare NET was implemented.

Challenges:

The launch has not gone as planned and the performance has been both frustrating and unacceptable. There have been problems across the state, including the inability to get through to the broker, as many constituents have experienced, and missed rides. In particular, rural areas have been impacted by the loss of volunteer drivers, who have resigned for various reasons.

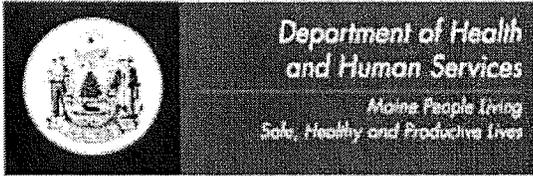
Solutions:

The Department is holding the brokers accountable. We have worked with them to increase staff in their call centers in an effort to decrease wait time. Staff in the Office of MaineCare Services have been logging long hours in their Member Services and Transportation divisions to provide support to the brokers in order to minimize the amount of missed rides. Some of the brokers have brought vans and drivers to Maine in order to more effectively meet the needs of MaineCare members. We are holding check-in sessions twice daily with the brokers and are continually reviewing contingency plans to assure that their performance improves.

We remain vigilant in holding the brokers accountable for the provision of rides to Medicaid recipients. Both the State of Maine and the transportation brokers are committed to resolving current issues and concerns so that the transportation needs of all MaineCare members are being met.

Contact:

If a constituent has missed a ride or cannot reach a broker, please direct them to our toll-free number, **1-800-977-6740**. Additionally, please do not hesitate to contact Nick Adolphsen at nick.adolphsen@maine.gov if you have additional questions or concerns. He can coordinate follow-up from our staff at the Office of MaineCare Services.



Paul E. LeFarge, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
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TTY Users: Dial 711 (Maine Relay)

Non-Emergency Transportation

Update: October 1, 2013

Summary

There have been significant improvements made in the Non-Emergency Transportation system since launch on August 1, 2013. In particular, the number of missed rides has been reduced dramatically by all three brokers, Coordinated Transportation Solutions (CTS), Logisticare and Penquis Community Action Program. The call center performance of each broker has also improved since launch of the program. Some highlights in improvement on missed rides:

Broker	August Missed (per week avg)	September Missed (per week avg)	Current missed rides %
Penquis (1 district)	245	73	1.45%
Logisticare (1 district)	107	29	0.54%
CTS (6 districts)	824	394	1.30%

While improvements have been made in providing daily rides to thousands of MaineCare members, there are still challenges, some significant, remaining in the brokerage system. There are three key issues that the Department continues to evaluate that need improvement:

- Technical interaction between the Brokers and the transportation providers continues to be problematic.
- The volume of missed rides has been dramatically reduced, however rides are still being missed.
- Call center operations and performance while improved, are not satisfactory.

In order to build upon the improvements that have been made, and ensure the Non-Emergency Transportation system is operating at a high level of performance, the Department is taking action steps to ensure Brokers are performing as required by the contract.

To address the technical challenges, the diverse computer systems are being modified to become compatible. To this end, the Department has facilitated a number of meetings with the Brokers and providers, including both operational and technical staff, to work through these issues. There has been progress made in this area of focus.

Brokers have taken a variety of actions to reduce the volume of missed rides, including purchasing vehicles to assist in meeting demand. In areas where call center performance has been lacking, staff has been added by Brokers to address the issue of call wait times or disconnects.

Additionally, on September 30, 2013, the Department sent letters to all three Brokers identifying areas of deficiency in their performance that must be corrected to meet contractual standards. Specifically, CTS was instructed to provide a formal Corrective Action Plan to the Department, identifying specific actions they will take to correct their deficiencies within a reasonable time. This plan is due to the Department by close of business October 7, 2013.

Broker Specific Metrics

Below is information regarding performance improvements for specific Brokers:

Penquis: Penquis continues to recover from the loss of volunteer drivers. Missed trips have dropped from an average of 245 per week in August to 73 per week in September (month to date), which amounts to 1.45% of trips missed.

Penquis' call center statistics all fall within contractual requirements, with a Service Level of 91% (Contract requires the percent of calls answered within 60 seconds must be at 90%) and an Abandoned Call Rate of 3% (Contract requires that the abandoned rate be no more than 5%).

Logisticare: Logisticare improved their performance in September. In August, they averaged 107 missed trips per week, which was reduced to an average of 29 missed trips per week in September, (month to date). Logisticare has missed 0.54% of trips scheduled in September.

Logisticare continues to successfully handle call volume to contractual specifications. Their Service Level goals on their Reservations Line are at 95%, "Ride Assist" Line (94%), and Facility Line (91%) (Contract requires the percent of calls answered within 60 seconds must be 90%). Their Abandon Rate also meets requirements for the month (Contract requires the abandoned rate be no more than 5%).

CTS: CTS is demonstrating improvement in problem areas they saw in August.

On the call center side, CTS has added significant staffing in September (a total of 27 agents have entered production in the last month), with the most recent class beginning to take calls on September 23. While it is unlikely that they will reach contractual metrics in September due to the large number of agents who only began taking calls late in the month, we've seen the following improvements:

- Service Level was 12% in August. Month to date in September, it was 48%, and continues to climb. At current trends, they will end September at approximately a 60% Service Level.
- Abandon rate is also considerably improved. In August, half of the callers to CTS' centers hung up before reaching a live agent, waiting an average of 7:16 before disconnecting. In September, that number had dropped to 20%, with the average wait time before disconnecting of 3:38. For the most recent week (September 18-24), the abandoned call rate is 5%; the contractual requirement.
- The average time a caller waits has dropped significantly, as well. In August, the average caller waited approximately 16 minutes before reaching an agent. In September to date, that dropped to 5:16, and in the last week it has been 43 seconds.

CTS has also demonstrated improvement in trip delivery; however, it must be noted that these numbers are based on estimates as CTS waits for transportation providers to submit their invoices and trip logs to verify these stats. CTS' methodology for these estimates has been consistent, so any variance to actual performance should likewise be consistent, making the trends they demonstrate relatively accurate.

In general, CTS continues to provide more trips week over week and September was significantly improved over August. In August, CTS missed 3,295 trips of 111,531 scheduled; a percentage of 2.95%. In September, they report having missed 843 trips of 52,146 scheduled for a percentage of 1.62%. For the week of 9/14, they missed 394 trips, despite having 30,424 trips scheduled; a percentage of 1.3%. In short, they are delivering more trips, and missing fewer.

Contact

If a constituent has missed a ride or cannot reach a Broker, please direct them to our toll-free number, **1-800-977-6740**.

How will MaineCare's new transportation system differ from the current system?



	Current System	Planned
Brokers	<ul style="list-style-type: none"> • 10 FSRTPs across 8 transit districts. 	<ul style="list-style-type: none"> • Up to 8 brokers aligned with transit districts. Open to for-profit, non-profit or governmental entities.
Competition	<ul style="list-style-type: none"> • FSRTPs are designated by MaineDOT. 	<ul style="list-style-type: none"> • Any interested bidder must compete for the brokerage.
Risk	<ul style="list-style-type: none"> • Brokers paid fee for service. State at risk. 	<ul style="list-style-type: none"> • Brokers must manage within a per member per month capitated rate.
Federal Match	<ul style="list-style-type: none"> • Cannot continue to receive FMAP for many services. 	<ul style="list-style-type: none"> • May receive full FMAP.
Member Access	<ul style="list-style-type: none"> • Problems with consistent member access to after-hours and weekend appointments and urgent care. 	<ul style="list-style-type: none"> • Bidders must demonstrate the ability to provide 24/7 access in order to qualify as a PAHP.
Accountability	<ul style="list-style-type: none"> • The State has no authority to restrict payment or terminate the relationship if an FSRTP fails to meet quality standards. 	<ul style="list-style-type: none"> • The State will tie payment to specified quality benchmarks and may terminate the contract with a broker for non-compliance.
Transportation Options	<ul style="list-style-type: none"> • The State may only reimburse bus passes in Portland and Bangor. 	<ul style="list-style-type: none"> • Brokers will be encouraged to utilize all public transit options statewide, such as ZOOM, the Kennebec Explorer, City Link, and the Bath Shuttle Bus.
Reimbursement	<ul style="list-style-type: none"> • Providers, volunteers, family, friends and members all receive fixed reimbursement rates for providing transportation. 	<ul style="list-style-type: none"> • Rates will be negotiable with the Broker.

NET Expenditures in SFY 2013

By Provider

Provider Name	SFY 2013
ALLIED MEDICAL SERVICE	233,054.40
AROOSTOOK REGIONAL TRANSPORTATION SYSTEM, INC.	2,969,701.64
C3 TRANSPORT, LLC	576,213.36
CHELSEA R. MACINNES	132,372.23
COASTAL TRANS, INC.	1,252,371.13
COMMUNITY CONCEPTS INC	5,555,114.07
DELTA AMBULANCE CORPORATION	79,668.96
FREEPORT TRANSIT, INC.	112,878.58
KVCAP TRANSPORTATION	5,193,438.41
MERMAID TRANSPORTATION CO, INC.	231,910.31
PENQUIS C.A.P., INC.	5,737,241.32
PLEASANT RIVER AMBULANCE SERVICE	1,286.18
REGIONAL TRANSPORTATION PROGRAM, INC	4,205,608.14
STERLING AMBULANCE	42,303.31
UNITED AMBULANCE	1,385,325.14
WALDO COMMUNITY ACTION PARTNERS	1,198,040.26
WASHINGTON HANCOCK COMMUNITY AGENCY, INC.	1,938,188.23
WEST TRANSPORTATION, INC.	59,193.20
WESTERN MAINE COMMUNITY ACTION, INC.	7,863.06
WESTERN MAINE TRANSPORTATION SERVICES	1,808,655.77
YORK COUNTY COMMUNITY ACTION CORPORATION	3,119,179.70
Grand Total	35,839,607.40

Performance Indicators and Statistics
Penquis Transportation Brokerage

	August	September	October MTD	TOTAL / AVG CTD	
Trips Scheduled (excludes reimbursement)	23,785	23,262	22,920	69,967	TOTAL
Trips Missed (no transporter available)	969	283	308	1,560	TOTAL
% Trips Missed (no transporter available)	4.07%	1.22%	1.34%	2.23%	
Complaints	3	1	0	4	TOTAL
Calls to Complaint Line (Total)	57	37	N/A	94	TOTAL
Number of MaineCare Eligible Members	39,171	38,892	38,808	38,957	Average
Call Center - Abandon %	4.80%	3.20%	2.00%	3.33%	Average
Call Center - Service Level (Ans within 1 min)	87.30%	90.80%	96.40%	91.50%	Average
Call Center - Avg Speed to Answer	0:00:43	0:00:33	0:00:19	0:00:32	Average
Call Center - Call Offered	9,414	8,509	8,199	26,122	TOTAL



Charles Newton
 President-Chief Executive Officer
 Corporate Services Department

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 262 Harlow Street, P.O. Box 1162, Bangor, ME 04402
 cnewton@penquis.org • www.penquis.org

Senator Craven, Rep Farnsworth & members of the HHS Committee. My name is Koriene Low; I am the Director of Transportation & Corporate Technology for Community Concepts.

Community Concepts, Inc. is a community action agency located in Western Maine. We have provided transportation via a network of agency vehicles and volunteers since 1983. This program has grown over the years and resulted in successfully transporting over 9000 Mainecare members per year for over 300,000 trips per year while actively scheduling over 250 volunteers. With the transition of the past several months, Community Concepts, Inc. no longer has agency vehicles, has closed or downsized rural locations, lost 100 volunteers and has gone from a staff of almost 30 to a staff of 8.

Region 7 has two transportation providers, Western Maine Transportation Services and Community Concepts, The broker for region 7 has reported transporting 33,836 trips for Sept of 2013. In September 2012, Community Concepts transported 3086 Mainecare members for 32067 trips **alone**. In September of 2013, Community Concepts, Inc. has transported 1288 members for 14246 trips, a reduction of over 50% from the prior year.

Community Concepts, Inc. anticipated a change in ridership and volumes but changes of this magnitude cause great concerns as to how these consumers are reaching their medical appointments or have they decided to no longer seek medical services. Unfortunately, the message we are getting is that they have become frustrated and have decided to not seek medical care. This includes members of the dialysis population who cannot be making such dangerous choices.

Community Concepts, Inc. has worked diligently over the past 90 days to try to be a good partner in the process of transitioning Mainecare members from the existing system to the brokerage system. Community Concepts has participated in all of the broker conference calls and last week we requested another site visit to review the current status of requests. Trying to describe the stress caused by this transition is virtually impossible, Community Concepts, Inc. will incur over \$50k in software upgrades to work with the broker software to allow data and information to flow in a timely manner. The impact of overtime on staff, and their challenges to serve members is exhausting. Community Concepts, Inc. has developed 10 software work arounds to allow the data provided to function within our software, a process which was originally thought to be seamless. The integrity of the data continues to be flawed, we are experiencing a consistent absence of information or inaccurate information, for example on an average day thirty trips without appointment times, missing phone numbers or wrong addresses.

Due to the mileage reimbursement issues along with the high volume of no shows and cancels, Community Concepts has lost 100 volunteer drivers. The volunteer drivers who remain are trying to prevent loss of reimbursements and call the members the night before to remind them of their trip for the next day. These are critical with the various challenges of the population Community Concepts, Inc. transports daily. During the initial promotion of the broker, presenters described how Trapeze software would be auto calling the members the night before and transit providers would no longer be responsible for this phase of the transport. No shows have always been a feature of Mainecare transportation, which transportation providers worked to control. Volunteers are not reimbursed for no shows. No shows occur currently when multiple providers arrive for the same client or pick up addresses are incorrect. Since the broker, the percentage of no shows has been as high as 25%.

Financially in August, Community Concepts, Inc. incurred a loss of \$50k providing services. The ability to schedule several days in advance will continue to be a hurdle as long as data continues to come through the systems in a less than accurate status and trips are received in less than 24 hours prior to the time of the appointment. The day before a trip, approximately 60 to 100 trips appear for the next day, right up to 1:45 in the afternoon. Lack of adequate notification makes the ability to efficiently schedule volunteers and mitigate excessive mileage a challenge. I have one staff person who spends the day cleaning information before we bring the data in for dispatchers to match with volunteer schedules. The data also has had significant spelling issues. There is a clear geographic confusion of the towns in Maine and who serves what areas.

At the end of September when it was time to have the broker build the subscription or ongoing trips for Oct., Community Concepts, Inc. lost approximately 80 members. I worked with the broker trying to explain what had happened, and until the broker's software developer arrived October 10th, for a site visit, were we able to demonstrate, not only were they missing in our system, the clients were deleted from the Trapeze system. The programmer for Community Concepts, Inc. asked the programmer from the broker to recreate these missing clients and trips, and was told by Trapeze, that they could not recreate this information. Community Concepts, Inc. was advised we would have to create the file, provide it to the broker and the broker would reenter the clients. This process which started around September 29th was not fully resolved until after Oct 21st. During this time frame, Community Concepts, Inc. continued to deliver the transportation for the missing clients with the approval of the broker. We turned the file around with 48 hours of the site visit for the broker. It took one staff person at the broker, over two weeks to enter the missing data on their end and as of Monday Oct 20th approx. 7 people were still not appearing but being transported by Community Concepts, Inc. These 7 represented 3 critical care and 4 students going to specialty services. At the time of the visit, I asked the Trapeze programmer why the fields in their system weren't locked, especially

for training; so that all of the required information was captured...the response was Trapeze doesn't do that. As someone who has evolved several software products within our agency, fields were always locked to assure accuracy and prevent missing critical information. This is not an uncommon practice, especially with a training involving many users but it has been found important to maintain field locks as longer term employees tend to skip fields.

There were problems with mileage and data calculations reported to the broker back in September shortly after go live. The errors in calculations continued to appear with October trips. A correction for these trips was done by the broker over the weekend of Oct 19th and we are now testing. To date we are still unable to bill trips with tolls, as Trapeze has no process to reimburse tolls. Community Concepts, Inc. was able to submit some September invoices yesterday, Oct 28th as a result of the fix from the 19th but tolls remain an issue. Community Concepts, Inc. continues to pay the volunteers for all of their expenses including tolls on a weekly basis.

As I mentioned we have downsized staff, aside from one staff person cleaning data, we have one supervisor dedicated to be the contact with the broker. This staff person handles daily cancels, requests for phone numbers, address issues, and urgent trips. A manager is responsible for oversight of volunteers. This leaves the remaining staff to schedule trips, assure volunteers are paid, prepare information for when billing is ready and deal with incoming calls. We are still receiving over 400 calls per day from members unsure about their trips, unaware of the broker or totally discouraged. The broker has reported that call wait times are improving but members contacting us are still reporting frustrations with getting through to the call center. Many of our members with limited minute phones report an inability to continue calling the broker as their minutes have been used earlier in the month.

Many are not seeking medical care any longer due to the frustration. Other medical and social services providers in our catchment area have experienced an increase in no shows for services resulting in loss of agency revenues. Many of the clients are now seeking services through the emergency room as they deal with the results of loss of medications or providers due to no show appointments.

I believe these issues are not exclusive but are distributed thorough out the network. Those transit providers with agency or buses, I know are struggling with these issues compounded by the variance in modes. I would request that this committee look into the data around number of clients served, trips and miles for MaineCare Transportation services offered from August 1 2012 through Oct 31 2012 vs. the services offered under the broker from August 1 2013 through Oct 31 2013. Community Concepts, Inc. wants to assure members are receiving their necessary transportation for medical care.

Thank you for inviting us here today and listening to how brokerage has impacted transit providers and Mainecare members.

Submitted by

Koriene K Low

Community Concepts, Inc. 240 Bates Street, Lewiston Me 04240



Maine Transit Association
c/o General Manager
Downeast Transportation, Inc.
P.O. Box 914
Ellsworth, Maine 04605

October 29, 2013

Senate Chair Margaret Craven
House Chair Richard Farnsworth
Health and Human Services Committee
100 Statehouse Station
Augusta, ME 04333

Re: Non Emergency Transportation Brokerage

Dear Committee Members:

The purpose of this letter is to update you on the continuing challenges posed by the new transportation brokerage system, which went into effect on August 1, 2013. We also offer our recommendation for a way forward that will better serve the needs of MaineCare recipients.

I serve as the General Manager of Downeast Transportation in Ellsworth and as the President of the Maine Transit Association (MTA). The Maine Transit Association is a professional association providing leadership, resources, support, and technical assistance to transit agencies throughout Maine. Our members provide a variety of services including regularly scheduled local and inter-city bus service, demand-response services statewide, inter-city commuter programs, and ferry service. When we speak of "transit," we are referring to transportation services available to the general public. Each year our members provide more than 7 million trips totaling over 60 million miles.

Our members include the state's 10 regional transportation providers (RTPs). Until the shift to the MaineCare transportation brokerage system on August 1, 2013, the RTPs managed transportation in their service areas. Maine had an integrated, efficient transportation system that had been in place for 30 years.

The new brokerage system divides Maine into 8 regions. In the region served by Penquis, Region 3 - Penobscot and Piscataquis counties, the new brokerage is working well. Penquis was previously the transportation provider in that region and, building on those resources and knowledge, has been able to provide high quality service as a broker.

Unfortunately, that is not true for the other 7 regions in the state. The new system is consistently failing to meet the needs of MaineCare recipients.

At your last meeting on September 11th, representatives of MTA appeared and discussed the problems that riders and transportation providers have experienced with the new brokerage system. There was hope at that time that there would be significant improvement in the system moving forward. Unfortunately, that improvement has not materialized. MaineCare clients continue to have problems, including:

1. Spending hours on hold and being unable to book a ride
2. Booking a ride that never shows up
3. Having a ride show up much earlier or later than scheduled.
4. Drivers having difficulty finding a destination or the client's home.

The regional transportation providers exist to serve those without access to transportation, including MaineCare patients. CTS and Logisticare continue to make it extremely difficult for us to fulfill our mission. Problems we continue to encounter include:

1. Ride requests delivered with little or no advance warning. We have even received requests for rides that should have happened in the past.
2. We accept a ride from the broker, but when our driver shows up, someone else is already there to provide the same ride.
3. We accept a ride from the broker, but when our driver shows up, we learn the client has called the broker and canceled, but we were never informed.
4. We decline a ride request from the broker, inform them pursuant to their policies, but the broker does not process the decline. When the client calls to ask about their ride, we receive an angry call from the broker wondering why we haven't made the pick-up.
5. Broker and provider computer systems are not communicating effectively, requiring a significant investment of time to manually check each and every ride.

We have spoken with representatives of groups who work with MaineCare patients, such as the Maine Association of Community Service Providers and the Maine Area Agencies on Aging, and they are all experiencing these problems with the clients they serve.

Recommendations for the MaineCare Transportation System

Because the situation is not improving and to provide MaineCare recipients with the quality service they deserve, the Maine Transit Association recommends this Committee urge the Department of Health and Human Services to do the following:

1. Closely review the brokers performance in each and every region. As discussed above, we think Region 3 is in good shape. The other regions all are experiencing significant problems, but some are worse than others. We understand this review may be underway.
2. In those regions where the broker is not performing anywhere near the RFP standards, DHHS should pull the contract pursuant to the terms of the RFP.
3. For those regions, DHHS should seek CMS' permission to operate in that region under the administrative model, at least for a few months.
 - a. The administrative model, which is in use in Vermont, allows DHHS to contract with a provider to offer and manage MaineCare transportation services. This is similar to the situation in Maine before August 1.

- b. This change will allow MaineCare recipients to receive the trips they need.
 - c. It will mean a reduction in federal reimbursement for services from the Medicaid rate of 62.57% to the administrative rate of 50%.
 - d. The administrative model is a CMS approved alternative to the brokerage.
4. DHHS should then re-assess how best to manage MaineCare transportation on an ongoing basis. Options will include:
- a. Utilizing the Vermont administrative model permanently in those regions where the brokerage model is not working.
 - b. Rebidding the brokerage under a revised RFP that will prevent the current service problems and that reflects the significant changes made since the RFP was written. Those changes include:
 - i. Greater flexibility in payment to volunteer drivers;
 - ii. Greater flexibility in the use of and rates charged for rides on agency vehicles; and
 - iii. A reduction in the penalties to be assessed for failure to meet performance targets.

All of these changes make it more likely that transportation providers will bid on the RFP.

After pulling a contract, DHHS should not simply turn to the other entities that responded to the RFP for a specific region. This would be a very poor decision for at least two reasons: the RFP itself was flawed as demonstrated by the failure of the broker to perform in most regions and the terms of the RFP have changed significantly given the policy changes made with regard to volunteer drivers, agency vehicles, and penalties. DHHS needs to step back and evaluate what has gone wrong and why before entering into any new brokerage agreements.

It is worth noting that several transportation providers do intend to bid if the state re-issues the RFP. Given the positive performance of Penquis, that may be the best option for the state and MaineCare recipients.

Impact of the Brokerage on Other Transportation Services

This Committee has also requested MTA's thoughts on how the implementation of the brokerage system has impacted other transportation services. The short answer is that it has made the delivery of other transportation services significantly more difficult and that both riders and agency bottom lines are suffering as a result.

Riders are Confused

The clients we serve, both MaineCare and those paid for through other sources, are confused by the change to the brokerage system. They don't know whether they should call us or the broker. Those paid for through direct HHS contracts, such as low-income children, are especially confused and often incorrectly assume they are in the MaineCare system.

Agency Vehicle Trips

One of the benefits of the old system, where providers received funding from several different sources and operated agency vehicles, was that we could combine rides from several different

funding sources in one trip. This meant riders who are private pay, MaineCare, child welfare and other funding sources could ride on one vehicle. It also meant a particular rider could easily combine a trip to the doctor with a stop at the grocery store. The new brokerage system severely limits that flexibility. An individual now separately calls the broker for the MaineCare trip and the transportation provider for that necessary trip to the store. The coordination is gone.

The RFP expressly said that if a MaineCare paid rider is on a vehicle, no one else on the vehicle could be charged a rate less than the MaineCare rate. We understand the desire to give MaineCare the best deal, but that is logistically a major headache. It eliminates the benefits Maine had enjoyed from our coordinated transportation system.

To make it more confusing, there are reports that brokers are being told the rule that MaineCare must be given the lowest rate will not be applied. The argument, as we understand it, is that because MaineCare pays a capitated (per person per month) rate to the broker, it does not matter from CMS's perspective what rate the broker pays the provider for any individual ride. Clarity around this issue would be extremely helpful for everyone involved in transportation.

Lack of Access to the System

Many providers are delivering fewer rides than they did a year ago. We do not have access to the brokers data, but we suspect fewer rides overall are being delivered. We would recommend that the Committee ask DHHS for comparative information on the number of rides delivered under the brokerage compared to the same months in 2012.

It's only anecdotal evidence, but we are seeing an increase in ER visits and in the incidence of mental health patients crashing due to lack of regular treatment.

Financial Impact on Providers

The brokerage system is having a negative impact on the finances of most providers. Several are seeing a reduction in MaineCare revenues. Some are also seeing delays in receiving payment for services. For example, a software glitch around allocation of toll costs means several agencies have still not been paid for some August trips.

The members of MTA are disappointed that the MaineCare Transportation Brokerage is in such poor condition. We are distressed that our clients, Maine residents we served well for many years, are now suffering with an unreliable, needlessly complex system. We are asking for the Committee's help in persuading DHHS to address these problems as outlined above.

Sincerely,



Paul Murphy, President
Maine Transit Association



Maine Association of
Area Agencies on Aging

Maine Association of
Area Agencies on Aging

P.O. Box 5415
Augusta, ME 04332

WRITTEN INFORMATION PROVIDED BY
JESSICA L. MAURER, EXECUTIVE DIRECTOR OF
THE MAINE ASSOCIATION OF AREA AGENCIES ON AGING
Submitted October 29, 2013

Senator Craven, Representative Farnsworth and members of the Joint Standing Committee on Health and Human Services:

My name is Jessica Maurer. I am the Executive Director of the Maine Association of Area Agencies on Aging, also known as M4A.

In preparation for this meeting of the Health and Human Services Committee, I solicited information from staff at Maine's five Area Agencies on Aging, case managers at EIM and in the Community Care Teams, and health care and mental health providers. I asked them if they've seen appreciable changes in MaineCare transportation services in the last three weeks.

The responses I received suggested that some progress has been made at addressing some of the problems in some areas. However, the stories from just the past two weeks suggest that real and significant problems persist and that these problems continue to take a serious toll on the physical and mental health of MaineCare consumers, on the employment status of their caregivers and on the ability of health care and mental health providers to care for patients, many of whom say they continue to spend far too much time arranging rides. Finally, a new issue has emerged that needs attention.

There is some limited good news. There is consensus among transportation providers and community based organizations that there is some progress being made to resolve problems. They report hearing fewer complaints generally about transportation problems. CTS has added and trained new staff and has resolved some of the communication and software compatibility issues. Some consumers have reported progress with shorter waiting times for scheduling rides. However, significant concerns persist that people were so discouraged by the failure of previous months that they have given up trying to use the broker to get their transportation needs met. There are concerns that they are relying on friends and family who are not being reimbursed as they should be. We encourage the State to do some comparative analysis of people served and rides provided in prior years to determine if the current level of rides is comparable to previous usage at similar times.

With that said, the rest of the news is bleak. Some consumers complain that customer service is still poor. Some consumers who have complained and gotten satisfaction have experienced

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repeated problems. In essence, the problem gets fixed on a one-time basis, but the system problem that created it isn't addressed, so the problems repeat.

When I asked the health care and case management community if the problems are better, I heard a very consistent story – things are still bad and not getting better for many of their consumers. In fact, one health care provider said that frustration within the health care provider, and particularly mental health provider, community is at an all-time high. I am going to share direct stories from health care providers and case managers from situations that have all occurred within the last three weeks, one from as recently as yesterday morning.

“My adult son with disabilities uses MaineCare transportation services. The problems remain. Not only are rides to therapy appointments and to work sometimes forgotten but it is close to impossible to reach CTS to find out why a ride is late or to make changes to the schedule. I never had any trouble reaching RTP when they had the contract.”

“One of my patients secured a ride for 10/24 for an 11:40am doctor appointment with Dr. X. She arrived for her appointment and met briefly with me afterwards. Ms. C rushed from my meeting with her to get outside and wait for her CTS ride home. At approximately 3:30 that day, I was informed by one of our clerical staff at the practice that CTS had just called stating that they now had a ride for Ms. C. In other words, Ms. C waited approximately three hours for her ride to pick her up on 10/24. Ms. C has significant mental health issues and I believe that due to those, she did not come back to the practice to ask for a taxi home and instead waited for CTS to pick her up. So, this patient waited three hours for a ride to pick her up that day.”

“The problem has only stayed the same. I have set up appointments directly myself (last week) and was given a confirmation number. My patient was not picked up. My other patient on Friday (who is 82) was also not picked up and she had to pay for her own taxi. I provided a voucher for her for one back so she could get home without worry. It is NOT a reliable service in any way.”

“I did a home visit with a consumer on Friday who had multiple complaints/concerns regarding transportation. The broker she uses is CTS. She was concerned with long hold times when calling, she was brought to an appointment but not picked up, she also said that she has an appointment coming up November that she needs out of state transportation for and she has been waiting for weeks for a confirmation on whether it was approved or not. She keeps checking back and can't get a confirmation number.”

“A couple of weeks ago a transportation agency brought an elderly patient to our office for an appointment. Her provider had some difficult appointments that morning and unfortunately

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got behind. When it was time for the agency to take her home, they had left because she took too long. When our staff called to inquire when she could be picked up it was going to be four hours later. Our staff felt so bad that they chipped in and got her a taxi to take her home.”

“I had a consumer that I had to cancel her medical appointment because they sent the wrong van to pick her up, it should have been a bus with the wheel chair lift, the consumer was very upset and has me call to confirm with WMTS that they received the right information from the broker.”

“I have two patients that still have difficulty. I have one that has a PCP out of town, she lives in Lewiston and PCP is in Topsham-CTS cannot find rides for her because the drivers refuse to go out of town. According to City Cab it is because CTS does not reimburse them. The second patient is disabled and requires a vehicle with a lift, CTS repeatedly sends the bus which does not have a lift, last incident was 10/25/13. Patient has missed several specialist and PCP appointments because of this.”

“I would like to state that the hospital is now paying for these people to get to these appointments. There is a HUGE cost shift here.”

“I got a complaint on Friday from a caregiver who states that CTS has only provided correct transportation for his wife once out of 8 scheduled appointments. They call to schedule, are told everything is all set, but they don’t show up. Due to CTS not showing up, the caregiver has been calling to verify and finds that his wife (the consumer) is not in the system or that all the information is wrong. They have failed to show up, have shown up with the wrong type van and have come on the wrong day. The caregiver has repeatedly had to cancel work to take his spouse to rehab therapy appointments.”

From yesterday, “I just had a patient that had an appt here at 9:00 am; he saw the provider, then he saw me and he said he had to be outside waiting for his ride at 10. He was outside at 10 because I walked him out. CTS never came he had to call and he waited 2 and ½ hours before his pick up.”

“Transportation continues to be a nightmare. I have 2 recent examples both happening on Fridays between 3-5. I had a person waiting for pick up for 1 and ½ hours before the practice involved me. I called CTS and they told me they had no record of any pickup or drop off at the practice. I spoke with the patient and he said KVCAP brought him here. When I shared this with CTS they then said had no record of a scheduled pickup. I was on hold for at least 20 minutes while they checked it out and did send a cab. Last week this same person missed appt because transportation didn’t show. The previous Friday CTS picked a patient up at home who

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was recently in the hospital, uses a walker, and is VERY unsteady on his feet. They sent a driver not the van. They dropped him off at the wound clinic. He had a PCP visit across the street afterwards. When they were dropping him off and helping him out of the "car" he almost fell and if it had not been for 2 EMTs walking by he would have. They were very worried how he was going to get home and almost admitted him because of the transportation issue. He came to the PCP visit and CTS was called for pick up they said they had already sent someone to pick him up but he wasn't there. They sent driver to wound clinic not PCP office even though they knew he had back to back appointments. I called them and was on hold for close to 40 minutes and they said they would send a cab. I told them this was not safe and they stated that was all they could do. I explained that we would have to admit him if they could not send the wheelchair KVCAP van they did finally. This was at 4:45 on a Friday. The MA from the practice had to sit with the patient outside in a wheelchair until van the came which took at least 45 minutes. It took me and the driver to get this guy in the van. We have since set up home health."

"What I am finding is if they do home pick up, they schedule the PCP pick up time, drive up and if patient is not there, they leave. As you can imagine doctors are not always running on time. When KVCAP provided the transportation we would call them for a pickup. I don't see this as the case anymore."

The stories actually keep coming in, but I must stop here. I will say that there have been stories of consumers using 911 for transportation, essentially making an unnecessary ED visit because they cannot secure timely transportation to a provider during regular hours. One mental health provider said their consumers, who are suppose to be learning independent living skills, have become dependent on case managers to arrange transportation and that they're now billing the state huge amounts for arranging transportation. These are unnecessary costs.

Finally, the new issue that has emerged as a problem is timely reimbursement to friends and family. We're hearing consistent complaints that it is taking a long time for people to receive their reimbursement checks. For instance, many have not received reimbursement for August or September.

This situation remains unacceptable for MaineCare consumers, their caregivers and health care providers.

Thank you.

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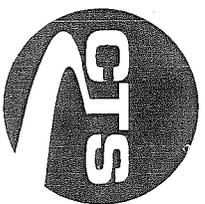
Performance Indicators and Statistics
Penquis Transportation Brokerage

	August	September	October MTD	TOTAL / AVG CTD
Trips Scheduled (excludes reimbursement)	23,785	23,262	22,920	69,967 TOTAL
Trips Missed (no transporter available)	969	283	308	1,560 TOTAL
% Trips Missed (no transporter available)	4.07%	1.22%	1.34%	2.23%
Complaints	3	1	0	4 TOTAL
Calls to Complaint Line (Total)	57	37	N/A	94 TOTAL
Number of MaineCare Eligible Members	39,171	38,892	38,808	38,957 Average
Call Center - Abandon %	4.80%	3.20%	2.00%	3.33% Average
Call Center - Service Level (Ans within 1 min)	87.30%	90.80%	96.40%	91.50% Average
Call Center - Avg Speed to Answer	0:00:43	0:00:33	0:00:19	0:00:32 Average
Call Center - Call Offered	9,414	8,509	8,199	26,122 TOTAL



Charles Newton
 President-Chief Executive Officer
 Corporate Services Department

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Coordinated Transportation Solutions

An Official MaineCare NET Service Provider

October 29, 2013

**The State of Maine, Legislative Testimony
Department of Health and Human Services Committee**

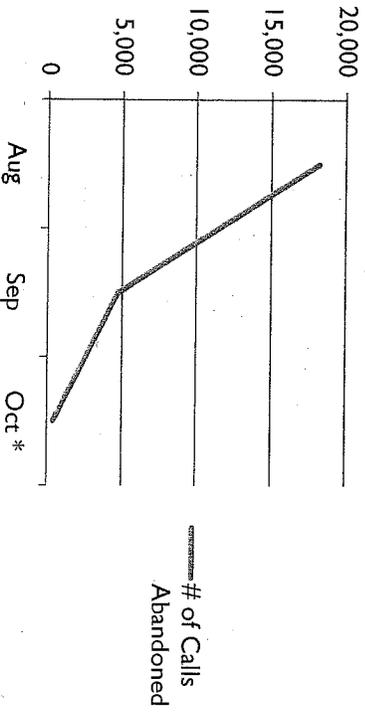
Call Center Metrics



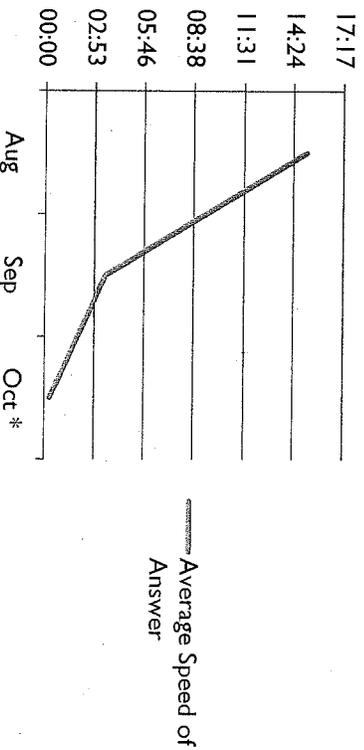
	August	September	October*
• Calls into Call Center	36,552	26,692	21,007
• # of Calls Abandoned	18,233	4,753	412
• Abandon Percentage	50	18	2
• Average Talk Time	08:43	06:53	05:46
• Average Speed of Answer	15:10	03:32	00:17

91% of calls were answered within 60 seconds during the month of October

of Calls Abandoned

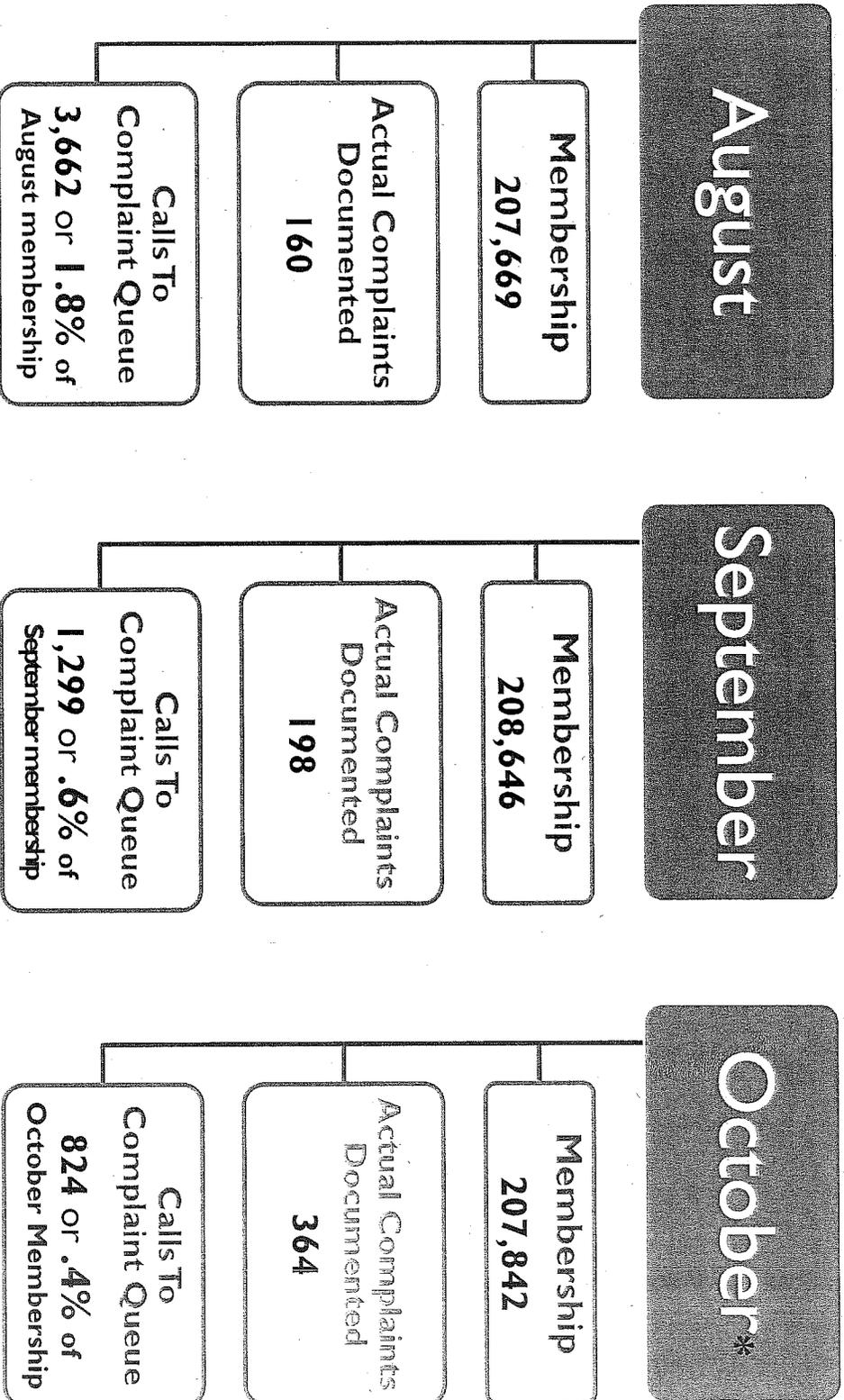
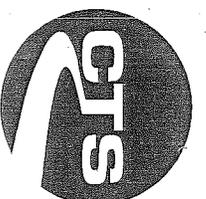


Average Speed of Answer



*October MTD (10/1-10/25)

Complaints Logged



All Calls to Complaint Queue are not true complaints, but someone hitting an incorrect prompt, looking to book a trip, or deciding not to log a formal complaint after speaking to a representative

*October MTD (10/1-10/25)

Trips Booked

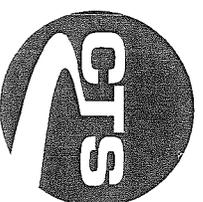
August September October*

	August	September	October*
Taxi/Livery	67,791	82,746	79,760
Volunteer Network	53,264	55,164	55,427
Wheelchair	8,744	9,647	8,704
Public Transit	9,734	10,289	13,253
Friends/Family	34,308	38,703	34,845
Total Trips Booked	173,841	196,549	191,989
Unduplicated Members	11,379	11,682	11,259



*October MTD (10/1-10/25)

Testimony



Coordinated Transportation Solutions has made significant progress since August, eliminating most of the issues that regrettably caused so much difficulty to our constituents at the time of implementation.

Approximately 200,000 trips for MaineCare members will be scheduled by the end of this month. This is a 25% increase from the projection provided by The Department within the original RFP. The number of trips scheduled today has also increased by 13% since August.

The call volume at our Lewiston branch has stabilized, and all call center metrics are within contractual requirements. This includes:

- rate of complaints at less than 1%
- average wait time of 17 seconds before a telephone is answered
- abandoned calls at just 2%

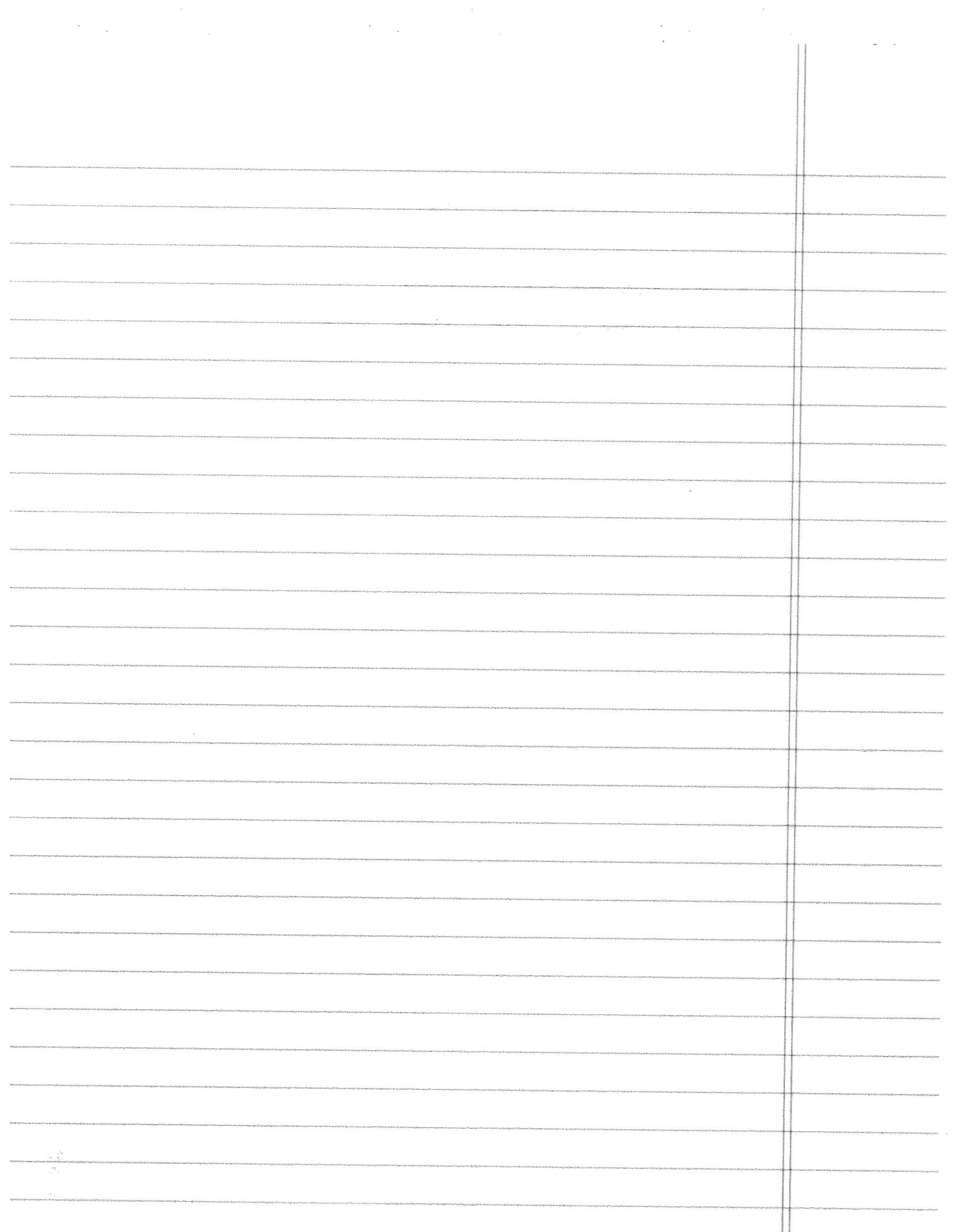
CTS is dedicated to providing the best NET services possible to the citizens of Maine. We are confident that all standards set forth by OMS will continue to be met.

We are encouraged by our latest set of reports and the prospect of future enhancements to the NET Program.

Regional Transport Program -

Jack DeBerardinis

jackd@rtprides.org



Orbeton, Jane

From: Jessica Maurer <jmaurer@spectrumgenerations.org>
Sent: Thursday, September 12, 2013 9:53 AM
To: Green, Mark; Peter Stuckey; Orbeton, Jane
Cc: jessica maurer; rmccarthy@eatonpeabodyconsulting.com; Belfiore, Linda
Subject: RE: hhs committee meeting

I echo Mark's sentiments – it is hopeful that the Committee remains fully engaged in this discussion.

Jessica "Jess" L. Maurer, Esq.
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Maine Association of Area Agencies on Aging
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Like us on Facebook



From: Green, Mark [<mailto:MGreen@whcacap.org>]
Sent: Thursday, September 12, 2013 9:48 AM
To: Peter Stuckey; jane.orbeton@legislature.maine.gov
Cc: jessica maurer; 'Rick McCarthy' (rmccarthy@eatonpeabodyconsulting.com); Belfiore, Linda
Subject: RE: hhs committee meeting

Thank you for hearing us yesterday. I wish you and your fellow committee members the best with all the challenging issues you have before you. When you get ready to delve more deeply into the "unintended consequences" of the brokerage system I would be happy to help in any way I can. Thanks.

From: Peter Stuckey [<mailto:pstuckey114@yahoo.com>]
Sent: Wednesday, September 11, 2013 5:29 PM
To: jane.orbeton@legislature.maine.gov
Cc: Green, Mark; jessica maurer
Subject: hhs committee meeting

hi jane,
for our discussion about transportation at our 10/29 hhs committee meeting, I hope we'll expand our discussion to include the other components of the 40+ year old integrated regional transportation system in maine. after removing non-emergency mainecare transportation resources from the integrated system, what are the consequences for riders and for the costs of these changes?

initially, I was told this change came about because the federal cms told maine dhhs that they would need to change their reimbursement from the direct service rate to the administrative rate (50%/50%). that would mean a loss of \$6.5 million. so my question has been what is the cost - in dollars and in the consequences of loss of services - to the balance of the transportation system when the medicaid resource is removed? it seems like the old system was fairly collaborative and did pretty well integrating resources. pulling out mainecare seems to be a move toward recreating silos.

i think we need to know the total costs and consequences of this bifurcation...and whether or not, when we consider the needs and alternative resources of all the stakeholders and consumers, it's possible or desirable to restore the old system, or something similar.

i think people who could help us understand this larger picture include jessica maurer from m4a, mark green from whcacap, someone from the departments of education and transportation, and folks from non-mainecare bureaus within dhhs.

thanks,
peter

Orbeton, Jane

From: Orbeton, Jane
Sent: Wednesday, September 18, 2013 11:04 AM
To: Nadeau, Stefanie; Adolphsen, Nick
Cc: 'Margaret Craven'; Farnsworth, RepRichard; Broome, Anna
Subject: Information on MaineCare non-emergency transportation services

Hi, Stefanie and Nick,

I am looking for information with which to put together a brief summary of MaineCare non-emergency transportation services. Do you have any materials already prepared?

In particular I think it would be helpful for the HHS Committee members to have the information listed below. If there is other information that you think would be of assistance, by all means please let me know and include it. It would be most helpful if I could have the information by October 1. Thank you. Jane

Old System

- Brief summary of the old system, including eligibility for transportation services, the roles of the contractors (with organizational names), methods of providing transportation, and payment rates.
- Information on challenges and successes and performance standards.
- Data on missed ride rates, error rates and call line performance.
- Overall costs in GF and FF; costs for the four largest contractors (state and federal). Please use State FY13 for costs.

New System:

- Brief summary of the new system, including eligibility for transportation services, the roles of brokers and contractors (with organizational names), methods of providing transportation, and payment rates.
- Information on challenges and successes and performance standards.
- Data on missed ride rates, error rates and call line performance.
- Overall costs in GF and FF; contract costs with the three brokers (state and federal) and locations served. Please use State FY14 for costs.

