Department of Health and Human Services
Maine People Living
Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

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

January 3, 2012

To: Senator Richard Rosen, Senate Chair
Representative Patrick Flood, House Chair,
Members of the Joint Standing Committee on Appropriations and Financial Affairs

Senator Earle McCormick, Chair
Representative Meredith Strang-Burgess, Chair
Members of the Joint Standing Committee on Health and Human Services

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

Re: Information provided by the Department of Health and Human Services in response to questions asked the week of December 12, 2011 and the Work Session on December 20th.

This packet has been separated by the 4 categories listed below:

1. General Questions
2. PNMI
3. MOE
4. Fraud and Abuse

Cc: Governor Paul R. LePage
Dan Billings, Chief Counsel, Governor's Office
Kathleen Newman, Deputy Chief of Staff, Governor's Office
Katrin Teel, Senior Health Policy Advisor, Governor's Office
Sawin Millett, Commissioner, Department of Administrative and Financial Services (DAFS)
Dawna Lopatosky, State Budget Officer, DAFS
Shirrin Blaisdell, Deputy State Budget Officer, DAFS

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General Questions

1. Rep. Martin asked when optional services that are being proposed for cuts were first reimbursed by MaineCare.

Response:

Optional service proposed for elimination	**Date Originated in rule**	
PNMI Appendix A Appendix B Appendix C Appendix D Appendix E Appendix F	 7/1/96 1/1/85 2/26/90 1/1/85 2/24/93 2/24/88	"11/20/24-DHHS announced plans to modify existing PNMI section to incorporate reimbursement policy for PNMI within MBM." This may indicate that the earliest effective date of 1/1/85, identified in the Section 97 rule and in Lucille's documentation, may not be accurate.
Targeted Case Management	4/25/88	
Physical Therapy	6/29/79	
Occupational Therapy	8/3/87	
Podiatry	1/24/79	
Optometry	Ch. II 7/11/79, Ch. III 9/19/86	
Dental	6/29/79	
Dentures	6/29/79	
Eyeglasses	7/11/79	Section 75 states that the date established is 11/1/04
Chiropractic	6/29/79	
Ambulatory Surgical Center	2/1/90	
Adult Family Care	5/6/96	
Consumer Directed Attendant Services	5/8/95	
Smoking Cessation Products (except for pregnant women)		This is included in the PDL which does not list effective dates. Email sent to Jen Palow to request this information.
STD Screening Clinic	10/3/83	

2. Sen. Craven asked for information on family reunification program and on how the populations affected by the optional service cut will get their needs met.

Response: Please refer to the Family Reunification Program fact sheet, initiative number 7483.

3. With regard to all proposed funding cuts from all fund sources, including the MAP account and other program and account cuts, please provide the following information:

   A. What will be the effect on recipients of services and their families and communities and on providers of services?

      Response: The fact sheets provided with each initiative attempted to provide greater background on the impact of these proposals on recipients of services. DHHS cannot respond to the more detailed question of the impact of these proposals on families and communities.

   B. Do the proposed cuts shift costs to other service settings, accounts, programs, payors, communities?

   Response: It is difficult to predict how each of these proposals impact cost shifting to other service settings, accounts, programs, payors, and communities.

4. With regard to repeal of MaineCare Basic under Title 22, section 3174-FF, please provide information about the plans for providing or limiting rehabilitation services for brain injury, psychological services benefits for individual and group counseling, durable medical equipment, prosthetics and orthotics and private duty nursing and personal care.

   Response: The removal of Title 22, Section 3174-FF does not impact these services listed above since any limitations for these services listed in 3174-FF were already promulgated by the APA process into MaineCare rules, as example, the "rehabilitation potential" limits listed for some of these services in 3174-FF. Additionally there are no changes, either in reduction or elimination of benefits, for these proposed listed services in the supplemental budget.

5. With regard to the MAP account 0147:

   A. Please provide information on what percentage of the federal poverty level will qualify a family for eligibility for MaineCare coverage and under what section of the MaineCare statutes.

      Response: Parents would be covered at 100%FPL and children 18 and under up to 200% FPL. MaineCare statutes: 22 MRSA 3174-G.

6. With regard to cuts in the state-funded foster care/adoption assistance account 0139, please provide information on the amounts currently budgeted and services provided under the WrapAroundMe, family reunification and the alternative response programs and the services that will remain under each program.

   Response: Please refer to the fact sheets on these topics, initiative numbers 7482, 7483 and 7484.

7. With regard to targeted case management in the MAP 0147 and Medicaid-Developmental Services 0705, please provide information on the effect on MaineCare members and providers and other MaineCare providers of terminating this service.

   Response: TCM is being eliminated as an optional MaineCare service. Persons with disabilities will be affected if their community case management services are paid through TCM. Consumers can still receive case management services through DHHS but the elimination of the service will directly affect hundreds of consumers. Those consumers on Section 21and 29 Waivers will continue to receive case management services.

8. With regard to the Developmental Services – Community account 0122 and the proposed cut in rental assistance, please provide information on the current reimbursement levels, the HUD reimbursement levels referenced in the budget bill and the effect on persons receiving assistance or waiting for assistance.

   Response: The rental subsidy cut will be $1.2m from the annual figure provided in **Attachment A**. There is no one answer to how each provider will be effected because reimbursement rates differ statewide. The HUD rate will be used and that figure differs by the area of the state. We cannot answer how providers will be forced to react.

9. With regard to children's services in accounts 0731 and 0136 and the MAP account 0147 please provide the following information:

   A. How will residential and nonresidential mental health services for children change? Will this result in a funding shift, increase or decrease?

      Response: We will have a decrease in the amount of funding available for children's residential services. It will either have to come as a rate reduction or a decrease in the number of children we can serve.

   B. With regard to these same accounts in the budget and Part K on dental services, is the proposal to eliminate the MaineCare coverage group of 19 and 20 year-olds? If this coverage group is eliminated, do 19 and 20 year-olds fall into the adult group? Can MaineCare distinguish between different age groups of adults under age 65?

      Response: The 19 & 20 year old coverage group is considered an optional "adult" eligibility group with CMS. Currently, the Maine state plan identifies them as children and will need to be amended to come in line with the federal definition. MaineCare is able to request data that would break down the different age groups under 65 based on claim submission for services rendered.

10. We need a copy of the letter renewing the Childless Adult Waiver and any written documents from CMS stating that DHHS can change or eliminate the waiver without causing an MOE violation?

    Response: See **Attachment B**

11. Does the administration have any pending waiver requests with CMS?

    Response: That would depend on what type of waiver you are referring to.
    - Currently we have a waiver request into CMS for Non-Emergency Transportation service.
    - Regarding an MOE waiver - we do not have a request into CMS to waive the proposed optional eligibility coverage groups from the Maintenance of Effort provision.

12. What is the total loss to the hospitals as a result of these rate reductions?

    A. What is the estimate of the total loss to hospitals as a result of lost MaineCare coverage for individuals?

    Response: *The quantifiable impact to Maine Hospitals by Initiative. Not reflected below are non-quantifiable impacts to the hospitals due to the reduction/elimination of other services or eligibility categories.*

Initiative #	Initiative Name	SFY12 Total	SFY13 Total
7481	Hospital Outpatient Reduction - 5%		(8,537,635)
7467	Hospital Outpatient Limit	(758,306)	(3,973,729)
7488	Hospital Inpatient Rate Reduction	(2,867,137)	(8,395,720)
7468	Hospital Inpatient Limit	(251,066)	(1,315,654)
Total Quantifiable Impact to Hospitals		**(3,876,509)**	**(22,222,738)**

    B. Do you have a breakdown of how those loses will be distributed among hospitals?

    Response: The distribution of these proposals has not been distributed among the hospitals.

C. Can you provide a breakdown paid hospital ER expenses if that is available and can we receive a history of those payments?

Response: We have data from 2010 available as follows (source: Muskie School, *High Cost Members Analysis*)

Outpatient ED					
Distinct Members	Claims	Paid Amount	Avg ER Claims Per Member	Avg Paid Per ER Claim	Avg Paid Per Member
103,178	217,739	$ 76,891,280	2	$ 353	$ 745
Inpatient ED					
Distinct Members	Claims	Paid Amount	Avg ER Claims Per Member	Avg Paid Per ER Claim	Avg Paid Per Member
7,873	10,486	$ 93,043,192	1	$ 8,873	$ 11,818

D. What are your ER costs projected thru FY12 and FY 13?

Response: A detailed ER costs projection for SFY12 and SFY13 has not been completed.

13. In relation to the Suboxone Limit:

A. When will the 2 year clock begin will it be retroactive from first prescribed or 2 years from a specific date (budget enactment)?

Response: It would start with current users and will be retroactive from when the Suboxone was first prescribed.

B. What is the plan for those who hit the two year limit?

Response: Those members that are at the 2 year limit would be able to continue treatment with a prior authorization approval based on medical necessity.

C. Please provide documentation that shows a two year limit is an accepted use standard by the medical community?

Response: This initiative was proposed based on what other states have implemented for limits on this treatment.

- Ohio:

  1. Patient has diagnosis of opioid addiction (NOT approvable for pain)
  2. Prescribing physician has a DATA 2000 waiver ID ("X-DEA" number)
  3. Patient has been referred counseling for addiction treatment (re-authorizations should
     indicate how often the patient is receiving counseling.
  4. Maximum dose 24mg per day (16mg is target, no patient should receive more than 32mg)
  5. Prescriber has reviewed Ohio Automated Rx Reporting System (OARRS) for opioid
     prescription use
  6. Periodic drug screens are addressed in treatment plan (will be performed by prescriber or by
     counseling team)
  7. For reauthorizations – the dose has been reduced in the previous 6 months, or the patient has
     been evaluated for a dose reduction and the prescriber and patient agree that a dose reduction
     would not be beneficial/may be harmful

- **Nebraska limits coverage to 6 months**; for longer therapy prescriber must document medical necessity but this seldom happens. They only cover for treatment of addiction & client must be actively participating in counseling. They block all other opiates & require the client to voluntarily enroll in lock-in which restricts them to 1 pharmacy & 1 prescriber. This has been the process in place for many years.

- Vermont Suboxone criteria can be found here: http://dvha.vermont.gov/for-providers/2011-08-vt-clinical-criteria-august-23-2011-final.pdf. They limit to 14 Doses, limit of 16mg, they are locked in to a pharmacy, and they don't approve it for pain. Medical Director can override dosing, and there's supposed to be a taper schedule, but there often isn't. This is not being followed most of the time but it is there policy.

- Washington just went to a 6 month limit.

- WY's criteria is as follows:
  - Client must have a diagnosis of opioid dependence or abuse. It is not to be used for treatment of chronic pain.
  - Only one narcotic prescription is allowed between fills.
  - The max dose allowed is 24mg/day and they do not allow use beyond two years.

- Arkansas
  - Currently require a manual PA for Suboxone and Subutex. They have quantity limits in place and also do not allow an opioid medication claim to pay until 60 days after a paid claim of Suboxone/Subutex. They also implemented a 24 month limit on therapy in April. Subutex is only allowed for pregnancy and induction.
  - When reviewing the requests, they require:
    - the XDEA number for the physician to be on file,
    - a drug test for baseline new starts and for continuation requests
    - documentation of counseling attendance (it's more difficult when the physician claims to do it, we look at chart notes and make sure they are more detailed)

14. How have you calculated the savings regarding two brand name prescription limit - how do you intend to deal with individuals who use multiple drugs that have no generic and do you know how many of those individuals there are?

    Response: The two brand limit savings were calculated using data to identify members where they are currently filling more than two brand prescriptions per month. This initiative allows members when medically necessary and requested through a prior authorization process to have more than two brand prescriptions filled per month when there is no generic equivalent.

15. Please provide how many individuals are being served by the consumer directed care initiative (A-12)?

    Response: Please refer to the fact sheet Initiative # 7430.

16. Please identify which initiatives would require waivers or other federal action in order to be implemented?

    Response: Those initiatives that change or eliminate eligibility would require a waiver from the Maintenance of Effort requirements. Additionally, all service, eligibility, and payment reform will require state plan amendments that must be approved by CMS. Information also available in the fact sheets.

17. One of the initiatives in the budget limits community mental health services solely to those who experience severe and persistent mental illness.

    A. To what extent does the population with severe and persistent illness comprise the entire population that currently receives services from this program?

       Response: The Crisis Services do not collect data on individuals specifically identifying them as someone with SPMI, the budget initiative description was in error. We are currently working with the Crisis Network to develop efficiencies in the network that have cost savings attached to them.

B. What plan do you have to provide mental health services to persons who do not have persistent and severe mental illness, but still require mental health services?

Response: Behavioral health counseling will continue to exist as a service provision yet will be challenged. It will be challenged capacity wise if individuals with greater mental health needs will be receiving services at lower levels of care, it has the potential to create wait times between an individuals first request for counseling assistance. The system will be challenged with individual's seeking services as their ability to pay will dictate the availability of services. With finite state and federal funds available, it will be difficult to fund all levels of service to match the need..

C. How does the administration plan to continue to comply with the court master and all current consent decrees?

Response: In accordance with the Settlement Agreement, DHHS is submitting a document outlining the impact of the Supplemental Budget on the Consent Decree and suggestions on how to meet its legal obligation..

18. Head Start will lose more than $5 million from cuts to FHM and the general fund. How many children will this impact and what is the plan to ensure they get the services they need?

Response: The general fund cut will impact 242 slots. The FHM cut will impact 125 slots. Head Start works with the families as a part of their program. It is likely they will assist in the family's transition to other services. Also, at the federal level, Head Start is likely to get $424M in additional funding for FY13, as this was voted on recently as a part of the Omnibus Bill.

19. Please provide a list of any federal funds that will be lost from these initiatives which are not recognized in the budget document. For example, the administration is proposing to cut Purchased Social Services by $3.94 million. This is the Child Care Subsidy Program which pays for child care for low income parents who work or are in school. When discussed during the last budget we were told a cut would result in losing a federal block grant if we cut this program is this still the case and are there other examples.

Response: In regards to the Child Care Subsidy Program, as explained in the Fact Sheet, Maine would not meet it's Maintenance of Effort or Matching Requirement. The loss of federal funds would be $6.98M, for a total loss of $10.92M.

20. Please provide a breakdown by MaineCare category of the number of patients with Cancer, Heart Disease, Stroke, Diabetes and other major life threatening conditions that will lose coverage as a result of this proposal.

Response: Requesting data and will provide as soon as available.

21. How many people does the department estimate will no longer be able to work if they lose access to services like Head Start and childcare?

Response: While this is something we can not quantify, we do know that 367 slots will not be available for Head Start and up to 2,426 children receiving subsidy.

22. Please provide more detailed information around Drugs for the elderly programs.

    A. How many individuals will be impacted by the various
    B. Initiatives?
    C. What it the total cost both General fund and FHM?
    D. Is there a current cost analysis of the program available?

    Response: Please refer to the fact sheet for Initiative # 7456.

Shortfall and General Questions

23. Several of the issues raised in the shortfall analysis relate to various parts of the payments we make to hospitals. We need the following information to better understand these payments and their interactions:

    A. Please provide a detailed explanation of how all hospital payments, including DRGs; PIPs; Crossover payments and physician payments billed on the CMS 1500 and the facility payments for hospital based physicians, have been paid since September 2010. For example, was there a period when you or the previous administration were paying both CMS 1500 payments and didn't adjust for those payments in the PIPs?

       Response: Prior to implementation of MIHMS (September 2010), these services were paid through the Hospital Prospective Interim Payment and Settlement process. For a period of time in SFY11, with the implementation of MIHMS, the Department paid both PIPs and claims payments. The Department adjusted this process in the Spring of SFY11 by (1) paying these claim types with a “zero-dollar” payment amount, and (2) adjusting/reducing the payment of the PIPs to the hospitals for the remainder of the fiscal year to account for, and recognize, the “overpayment” to the hospitals.

    B. Please describe the timing and extent of any duplicative payments made during this period, and whether there were any overpayments, if so, the amount of those overpayments, and how much has been recovered?

       Response: The Department did not make duplicative claims payments to the hospitals. However, as noted above, due to the combination of PIP payments and claims payments, the Department did make the appropriate adjustments to the PIPs in the Spring of SFY11 to recognize the excess amounts paid to the hospitals. The PIPs were adequately reduced in the Spring of SFY11 to recognize the combination of PIP payments and claims payments.

24. Are you proposing paying for any items in this budget that in prior budgets have been paid as a settlement or other one time expenditure? If so please provide a detailed list.

    Response: Crossover claims are included in this budget proposal as claims that were previously paid for during the settlement process because these could not b processed by MECMS.

25. Please provide the amount of total annual (state and federal) funds paid to hospitals for in and outpatient services (broken out) for each of the last 5 state fiscal years, including SFY '12 to- date.

Response:

Inpatient Hospital Costs				
SFY	**State**	**Federal**	**ARRA**	**Total**
SFY07	$ 107,514,013	$ 184,673,639	$ -	$ 292,187,652
SFY08	$ 89,842,633	$ 154,969,289	$ -	$ 244,811,922
SFY09	$ 108,184,169	$ 248,600,824	$ 30,118,944	$ 386,903,936
SFY10	$ 54,663,143	$ 140,436,412	$ 21,400,836	$ 216,500,391
SFY11	$ 77,926,599	$ 181,845,482	$ 24,615,438	$ 284,387,519
SFY12	$ 7,365,068	$ 12,980,425	$ -	$ 20,345,493
Outpatient Hospital Costs				
SFY	**State**	**Federal**	**ARRA**	**Total**
SFY07	$ 36,520,538	$ 62,606,315	$ -	$ 99,126,853
SFY08	$ 62,898,302	$ 108,484,591	$ -	$ 171,382,893
SFY09	$ 75,448,441	$ 173,628,306	$ 21,183,349	$ 270,260,096
SFY10	$ 59,371,912	$ 152,499,422	$ 23,241,978	$ 235,113,312
SFY11	$ 53,776,395	$ 126,312,705	$ 17,307,570	$ 197,396,670
SFY12	$ 10,730,927	$ 18,912,518	$ -	$ 29,643,445

26. In the analysis provided by the Office of Fiscal and Policy Analysis, we do not see a significant increase in utilization once carry over claims are factored out. What accounts are showing significant increases in utilization?

Response: We are preparing this detailed report for January 6th.

27. With respect to carry over claims:

    A. If carry over claims were processing in FY2011, why did the Administration miss budgeting these for FY2012?

    Response: The historical amount of claims carried forward from one year to the next is assumed to be in the Department's baseline budget. Due to claims processing issues associated with the implementation of MIHMS, the impact of the claims carried forward has been considerably greater than the amount that would have been "normal" and available in the SFY12/13 baseline budget.

    B. When did you first realize that there would be a larger than usual carry over between 11 and 12?

    Response: In October, after the first quarter of SFY12 was complete.

C. What system defects in MIHMS required claims to be carried forward? Were these defects worse than MeCMS?

Response: There were a variety of issues that caused claims to be carried forward. The defects were not worse than with MECMS.

D. Is there a particular type of provider represented in these carry over claims from last year that disproportionately accounts for these payments?

Response: No, providers were affected across the board.

28. With respect to PNMIs (Room and Board):

A. Why are you adding two cost savings initiatives ($8.4 million) from the biennial budget into your shortfall analysis (page 5) if you do not plan to realize them shouldn't they be included on the not realized initiative list (page 5). It appears you may have overstated the shortfall on this page please provide further information.

Response: We have not overstated the shortfall. We have included both sides of the cost savings in the analysis. In the upper portion of the analysis the savings are identified and in the bottom of the analysis the anticipated savings attributable to cost of care are included, effectively reducing the inclusion in the upper section. The primary reason these amounts were included was to not lose the detail associated with a significant “cost-reducer” in the PNMI Room and Board account. As is identified in the analysis, the Department actually anticipates collecting additional cost of care from SFY11. The amount from SFY12 of $2.1 million will not be realized until SFY13 due to timing of the invoices and collections. Therefore, $2.1 million will be realized in SFY12, as is identified in the analysis, and the other $2.1 million is included on the savings not realized in SFY12. No change is necessary.

B. Is it possible that you are double-counting the PNMI "cost of care" initiative shortfall as well? In the summary of analysis on page 11, the $2.1 M shortfall appears to be included in the overall PNMI shortfall at line D. But it is also listed as part of the shortfall from the unrealized savings initiatives at E.

Response: The amount from SFY12 of $2.1 million will not be realized until SFY13 due to timing of the invoices and collections. Therefore, $2.1 million will be realized in SFY12, as is identified in the analysis, and the other $2.1 million is included on the savings not realized in SFY12. No change is necessary.

C. Is the PNMI Room & Board Expenditures [Page 5 of DHHS Analysis] the Z008 account?

Response: No, it is the Z00901 account.

29. With respect to increased enrollment:

    A. What were the enrollment assumptions and the amount finally budgeted for increased enrollment in SFY 12 in the budget enacted in June?

       Response: The State Fiscal Year 2012 and 2013 budget request due-to increased enrollment was based upon the "actual" caseload counts of members through February 2011.

    B. Has enrollment increased beyond that estimate?

       Response: *:* The MaineCare caseload has continued to see an increase in enrollment since February 2011*.*

    C. Are your estimates at this point assuming that enrollment increases will continue at the same rate?

       Response: See Attachment C in the 12/20/11 response for enrollment projections.

    D. When do you anticipate enrollment flattening out as the economy improves?

       Response: See attachment F in the 12/20/11 response for enrollment projections.

30. We understood that the Department was provided with revenue from the cascade to pay for the Targeted Case Management Settlement. How much did you receive and why does this still appear as a cost?

    Response: The TCM payment is included because the budget amount is included.

    A. Why haven't you shown the revenue from either Dirigo or the Fund for a healthy Maine in the structural analysis on page 8? We see that you pulled the DEL account out, but don't understand why when that program receives funding from both the FHM and the General Fund. Where is the contribution from both revenue sources calculated into this analysis?

       Response: *S*ee **Attachment C**

    B. Why is Targeted Case Management owed to the federal government included in the $11.8 million shortfall? Wasn't this addressed in the Biennial Budget? [page 8]

       Response: It is not included as a contributing factor for the shortfall. It was a one-time payment that received adequate funding during the Biennial Budget. It is identified in the analysis because it was a one issue that was not part of the projection for the remainder of SFY12.

31. In the first variance analysis you noted that there was a shortfall related to additional cost of part B premiums. Now, you correctly point out that those will go down and there will actually be a savings.

    A. When did you learn that these savings would be available?

       Response: CMS Notified the State of the changes at the very end of October.

    B. Now you say that you are still short $11.5 M in SFY '12 but attribute that shortfall to increases in Part D.

       Response: That is Correct.

    C. How many people are you paying Part D premiums for?

       Response: As of October, we paid premiums for 55,648 members.

    D. What is the average cost of that premium?

       Response: As of October the premium was $82.38

32. With respect to MeCMS claims not paid during curtailment:

    A. Didn't the department issue a policy establishing a deadline for these claims to be paid? What are the reasons for claims submitted beyond the MeCMS shutdown?

       Response: Yes, the department did establish a policy for providers to submit their claims by 10/31/2011. The providers did adhere to this timeline, and the department has worked these claims manually since the decommissioning of MeCMS.

    B. How many claims exceeded that deadline and how much money did those claims involve?

       Response: See response above.

    C. Which providers did not bill within that deadline? And, which providers were paid following MeCMS shutdown?

       Response: See response above.

33. Please break out the amount of funding from each of the sources listed in the MaineCare review as "other funding sources" with amounts attributable to each identified separately.

Response: The itemized Other Funding Sources are as follows:

Other Funding Sources	
Earned Federal Revenue	1,315,721.00
Dirigo	3,176,836.00
Drugs for Maine's Elderly	10,862,493.00
Fund for a Healthy Maine	5,251,117.00
Total	**20,606,167.00**

34. What type of analysis did DHHS use to project the future costs of these claims? [Page 2 of the DHHS Budget Analysis].

Response: Crossover Claims for SFY 2012 listed on Page 2 of the DHHS Budget Analysis at $36,258,000 are a projection based on $13,248,460 paid through 19 weeks.

35. CMS allowed hospital settlements at a higher match rate for services provided in prior years. The same process was used for adjustments. If this process is acceptable for hospitals, why not for other claims? [Page 3 of DHHS Analysis]

Response: CMS considers the match rate at the time we pay for the service, not the date the service is rendered. Therefore, in regards to hospital settlements, the match rate that is used is the match rate in effect when we pay the settlement, not the rate in which the service is delivered. The same approach would be used for adjustments; we pay the claim based on the processed date, not the service delivery date. We are currently awaiting guidance from the OIG on how we are to process the incremental adjustment.

36. Usually providers collect the cost of care. Have provider rates been reduced as a way to account for cost of care? [Page 5 of DHHS Budget Analysis.]

Response: See response in the 12/20/11 packet question # 12.

37. With respect to the column "Member Months," is that data current member months or increased member months? Is it an increase from 2007? [Page 7 of DHHS Budget Analysis]

Response: See response in the 12/20/11 packet question # 13 and # 14.

38. With respect to Miscellaneous Transactions (Third Party Liability, Audit Recoveries, etc.) why do you show exactly the same amount achieved for the entire year (SFY '12) as achieved in the first five months of the year? Please provide us with a breakdown of all of the items in this overall line of miscellaneous transactions for the past 5 years?

Response: On the MaineCare Review document, the "SFY12 Five Months Ending 11/14/2011" section and the "SFY 12 Projected" section came from two different sources. Not all line items were forecasted exactly the same way. Some amounts shown under Expenditure Transfers and Other Funding Sources contain amounts that make up the Miscellaneous Transactions forecast. The presentation has been revised going forward to properly align the two sections of the analysis. Below is the Miscellaneous Transaction detail at 11/30/2011.

Miscellaneous Transactions At 11/30/2011	**General Fund**	**Special Revenue**	**Federal Funds**
ABSJ - Brain Injury Expenses moved from MAP acct.	78,543.00		-
ABSJ - Correct CR coding from 014701 to Z00901	-		-
ABSJ - Misc Adjustments	(68,013.31)		15,466.32
ABSJ - Cost Settlement	(91,951.49)		(469,245.20)
ABSJ - Medicaid Payments from Child Support	(139,022.71)		(67,753.22)
ABSJ - Recovery of Interim Payments	(3,556.99)		(6,110.95)
ACES - SSI	1,177.61		3,029.34
Audit Charges	-		193,674.05
CR - Premiums for Cubcare, Katie Beckett, Working Disabled, & Special Benefit Waiver	(126,354.91)		(321,732.10)
CR - Cost of Care	(42,728.05)		(62,927.60)
CR - Adjustments	(66,599.94)		(463,710.17)
CR - Deposit by Dept 28A (Treasurer State of Maine)	(286,824.83)		-
CR - Payments from Insurance Co. for TPL (Lockbox Deposit)	(895,393.59)		(1,557,353.84)
CR - MaineCare RA	(725,234.48)		-
CR - Medicaid Enhancement	(740,455.94)		(863,484.51)
CR - Non-Medicaid Supplemental	-		(3,339,456.47)
CR - PCCM Management Claims	(2,563.41)		(187.59)
CR - PCPIP Overpayment	(7,560.57)		-
CR - PHIPP	(677.11)		(662.22)
CR - PIP Overpayment	(96.34)		(165.99)
CR - PNMI Cost of Care	(897,162.25)		-
CR - Program Integrity	(55,825.14)		(51,639.18)
CR - Repayment of QMB Part B	(106.33)		(183.17)
CR - Returned Interims	(838.39)		(1,421.41)
CR - Returned PHIP	(2,202.61)		(4,332.24)
CR - TPL, HMS, HIPO, Drgmrk, Co-pays, CLNTRL, Fees	(1,819,849.25)		(3,191,437.43)
CR - Misc (M. Clifford-Bauer deposits)	(3,787.81)		-
CR - Waiver Cost of Care	(142,822.71)		(79,725.29)
CR - Premium Payments	(30,668.74)		(82,160.80)
CR - Refund	(1,673.17)		-
Gax	974,665.33	680.46	1,434,910.25
IET	143,429.04	172.38	30,788.33
JVC/JV - Miscellaneous Adjustment	(5,251.19)	-	692.46
PRC	677,313.91	184,339.67	-
Sta-cap	-	3,426.81	2,273.15
Total Miscellaneous Transactions	(4,282,092.37)	188,619.32	(8,882,855.48)

39. With respect to Drug rebates, explain why total FY '12 projected drug rebate revenue is the same amount as for the first 5 months of FY '12?

    Response: On the MaineCare Review document, the "SFY12 Five Months Ending 11/14/2011" section and the "SFY 12 Projected" section came from two different sources. Not all line items were forecasted exactly the same way. Some amounts that should have been listed under Drug Rebates were shown under Expenditure Transfers. The presentation has been revised going forward to properly align the two sections of the analysis.

40. Have you considered the impact of these cuts on the eligibility of hospitals for 340b prescription drug programs that lower the cost of drugs for hospitals and their patients? Do you have an estimate of the increase in prescription drug costs related to any loss of this eligibility?

    Response: It is the departments understanding that hospitals can participate in the 340b program with MaineCare and private payers. The eligibility and service cuts would not affect a hospitals ability to participate in this program.

41. The administration proposes to limit outpatient hospital visits to fifteen in a year. Obviously this will disproportionately affect people with disabilities and older Mainers. Please provide an analysis of who will be affected by this cut, including age, disability status and type of condition for those currently using more than 15 outpatient visits annually.

    Response: This proposal excludes Emergency Department services – which includes diagnostic services performed at the time of the ED visit. Also, certain recurring services such as chemotherapy, radiation therapy, and hemodialysis are excluded from this limit.

42. You propose a 50% reduction in the Family Reunification Program in this budget. How many children do you estimate would not be able to be reunified with their families as a result of this cut?

    Response: As explained in the Fact Sheets, the Department is going to be absorbing these cases. Caseworkers already do some of this, and with reworking caseloads, we can provide all of the services necessary to work through reunification. We do not believe any child who is going to be reunified with their families will be impacted by this cut.

43. We note in materials provided to the Committee that there are federal maintenance of effort implications is maintenance of effort cut associated with this cut that could result in the loss of child care for 1,740 children.

    A. Please provide us the information necessary to determine if we will not meet the maintenance of effort requirement.

       Response: The loss of MOE will impact up to 1,688 children receiving child care subsidy.

    B. Please provide the total number of families that will lose access to care as a result of the cut alone, without loss related to maintenance of effort.

Response: Access to care is not quantifiable. As stated in #52-B, the proposal would impact up to 2,426 children receiving care.

44. Again we note from materials that the Administration provided that Crisis Services-Initiative 7470-cuts funds that are needed for the SAMSHA Community mental health block grant. Please tell us the amount of federal funds that we are at risk of losing as a result of this cut and how many additional people will lose services if we lose these federal funds.

    Response: Currently Community Block Grant funds are allocated for Crisis Services (approximately $221,000 across five agencies). Prior to the Supplemental Budget being proposed, OAMHS was already in a deficit for not meeting the Maintenance of Effort agreement of the CBG. We are in the process of applying for a waiver with a good probability of approval.

45. You note that there is also Maintenance of effort issue related to the cuts you propose in home visiting. Please explain how much in federal dollars we are at risk of losing as a result of this cut and how many families with newborns will lose service as a result of this loss.

    Response: There is a MOE for the federal home visiting funds as outlined in federal statute, however, they are applicable only to general fund investments, not to special revenue (such as FHM) as of March 2010. At that time, Maine had no general funds in home visiting, so therefore, Maine would not be in violation of MOE. However, the reduction in state investment in home visiting may put the state in the position of defending what will essentially be supplantation with federal funds, which is not an allowable use of federal formula or expansion home visiting grant funds. This has a value of $6.6M this year (both direct service and infrastructure) for a total of $30.1M over four years.

    We estimate that the FHM loss would mean 750 families would not get services. The federal funding estimate of families TO BE SERVED was: Yr 1=350, Yr 2=900, Yr 3=1300, Yr 4=1700.

46. Podiatric services are already very limited and currently cover about 12,000 people who, without this care would be at risk of losing a limb or significant function. If this service is eliminated where would people receive this needed care and what would be the additional cost? Have you budgeted for that cost?

    Response: Requesting data and will provide as soon as available.

47. Dental coverage for adults is limited already to emergencies like elimination of pain or the prevention of imminent tooth loss. Last year about 15,000 adult got this emergency dental service. Have you offset from the savings from this initiative any cost for adults who will now get this service from the hospital ED? If so, what is that amount? What would the cost be if 90% of these individuals got this care at the ED?

    Response: Requesting data and will provide as soon as available.

48. MaineCare vision services are very limited for adults now and are only provided for medically necessary care. Only one pair of glasses is provided in a lifetime for those with very poor vision. This cut does not eliminate reimbursement for physicians for providing these services as this is federally mandated. Have you calculated the increased cost from these individuals receiving this service through their physician instead of other eye care providers?

    Response: Requesting data and will provide as soon as available.

49. What evidence does the administration have to show individuals are moving to Maine in order to receive benefits?

    Response: OFI tracks the number of people who move to Maine and subsequently apply for benefits.

50. Has the Department applied (or does it plan to) for the 90% enhanced federal match for Medicaid medical homes for enrollees with chronic conditions?

    Response: Yes, the Department is currently working on a State Plan Amendment to provide Health Home services for members with chronic conditions, under Section 2703 of the Affordable Care Act.

51. Has the Department applied for any recent Medicaid waivers or state plan amendments relating to chronic disease initiatives?

    Response: The Department is currently working on a State Plan Amendment to provide Health Home services for members with chronic conditions, under Section 2703 of the Affordable Care Act. MaineCare filed a SPA to meet ACA guidelines for children's hospice care (to allow both treatment and palliative care simultaneously)) and a HCBS waiver to allow treatment for individuals with Other Related Conditions (such as Cerebral Palsy) in the community instead of a NF.

52. Does DHHS have a chronic disease/care management initiative in place currently? If so, please provide details.

    Response: **Care Management –**
    The state is currently approaching care management in three different ways:

    - We have asked the hospitals for the top 20 MaineCare members that they have noted are repeaters of the ED for avoidable conditions. The hospitals often identify over time patterns with MaineCare members who with care management services could better use clinical resources such as primary care provider services and other services in the community such as behavioral health or certain specialty services. MaineCare care managers will work closely with care management capacity in the community to maximize state resources and use them for tracking and filling in the gaps where no care management capacity exists.
    - In addition, each day we receive a daily census from the hospitals to tell us who has been to the ED the previous day and who is an inpatient in the hospital. This information is used to identify trends in members who are in the hospital or ED for

conditions that may have been prevented with better self management of their conditions including medications compliance or through better supports set up in the home to prevent inpatient hospital needs.

- As a third tool, the state also now has predictive modeling software as part of our new MIHMS system enabling the state to predict who may be a high cost member if the pattern of services is not altered. This allows us to outreach members who can be prevented from becoming high cost based on service and medication use.

53. Has the Department done a breakdown of its Medicaid beneficiaries by type and by cost?

Response: See attachment F in the 12/20/11 packet response that shows the PMPM since 2007 for each caseload caragory.

54. The Department's Value Based Purchasing Initiative includes the "health homes"/medical home model. The federal government has provided funding for 15 federally qualified health centers across Maine that will facilitate these practices attaining the top certification available for medical homes. Does the Department intend to-- or has it considered-- taking advantage of those efforts so as to provide Maine's high-cost beneficiaries with medical home support (particularly in an opt-out scenario), and potentially qualify for the enhanced 90% federal match, as well?

Response: Yes, the Department intends to leverage Maine's 14 federally qualified health centers that will be participating in CMS' Advanced Primary Care Practice demonstration, along with other practices in a position to attain medical home certification and provide Health Home services, in order to best serve MaineCare's highest need members and also benefit from the enhanced 90/10 match.

55. Rep. Webster asked what MIHMS defects caused claim rejections and carry forwards from FY12 will cause carry forwards to FY13. Rep. Webster asked for the types of providers whose claims are not being paid on a timely basis. He also asked for information on carry forward balances and reasons from the last 5 years and what information was provided to this administration by the prior administration.

Response: See **Attachment D**

56. Sen. Craven: What are the consent decree requirements for housing of persons with mental illness?

Response: The Settlement Agreement Paragraphs 93, 94, 95, 97, and 98 require that DHHS/the defendants fund, develop, recruit, and support a variety of housing options that accommodate varying level of assistance to clients, depending upon need. Paragraph 93 and 97 refers to the need for providing supervision.

Below are the actual paragraphs of the Settlement Agreement. (Supervision references are highlighted in yellow). We gave you the standards as well.

<u>Housing</u>

93. Defendants shall fund, develop, recruit and support a variety of housing options which can accommodate varying levels of supportive assistance to clients, depending upon

client need. Some class members will live independently in their own homes, some will require community support worker assistance in their homes, others will require increased levels of supervision in their own homes, and yet others will need to live out of home in more restrictive environments which are fully staff supported.

94. As of the date of this Agreement there are patients at AMHI whose treatment or discharge plans state that they could live in community settings, but for the lack of available appropriate housing. Additional AMHI or other hospitalized class members may later be identified as needing community housing in order to be safely discharged.

95. To comply with this sub-section of the Agreement, defendants shall develop, fund, recruit, or support sufficient housing to meet the ISP identified housing needs of the class members referred to above and of class members who are at imminent risk of hospitalization due to lack of available appropriate housing. Defendants shall develop, fund, recruit and support housing which is designed to address other individual class members' needs in accordance with applicable terms and timetables in their plans required by Section V of this Agreement.

Residential Support Services:

97. Defendants shall fund, develop, recruit and support residential support services for delivery in a variety of home settings, including the client's private home or an agency owned or operated apartment or home. The services shall be designed to provide the client with the support and supervision appropriate to his level of independence. The services shall be flexible so that the support and supervision may be initiated or discontinued, increased or decreased as the class member's needs change and so that the class member is not required to move to another setting as his or her needs change.

98. To comply with this sub-section, defendants shall develop, fund, recruit and support residential support services to meet the ISP identified residential support service needs of all class members who are hospitalized and who require residential support services in order to be safely discharged and of all class members who have been identified as being at imminent risk of hospitalization due to lack of available appropriate residential support services. Defendants shall develop, fund, recruit or support residential support services for other class members in accordance with the terms and timetables of their plans required by Section V of this Agreement.

The Standards for Defining Substantial Compliance are:

97, 98 (Performance Standard #12) of the AMHI: Demonstrate that the array of residential support services is flexible and is adequate to meet ISP-identified residential support needs of class members and the needs of hospitalized class members ready for discharge.

Substantial compliance means:

- Quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 5% or fewer class members have ISP-identified unmet needs for residential support services; **[IV.22]** and

- EITHER quarterly unmet needs data about residential support services for one year shows that the percentage of qualified non-class members with unmet needs does not exceed by 15 percentage points or more the percentage of class members with unmet needs; **[IV.23]**

- OR, if the quarterly data for one or more quarters in that year shows that the percentage of qualified non-class members with unmet needs for residential support services exceeds by 15 percentage points or more the percentage of class members with unmet needs for residential support services, the Department produces information sufficient to explain the cause of that disparity and to show that the cause of the disparity is something other than the defendants having deprived non-class members of services because they are not members of the class; **[IV.23]** and:

  Note: the term "qualified" modifying "non-class member" in this context means qualified for state financial support.

  Note: for purposes of this standard, residential support services includes support services provided not only in independent living situations, but also in settings such as nursing homes or residential treatment facilities.

- meeting the Riverview discharge standards (see Part V below, Goal 2 Objective 2), or, if not met, the Department documents the reasons for not meeting the standards, and the documentation demonstrates that the failure to meet those standards is not attributable to a lack of residential support services in the community. **[IV.24]**

94, 95 (Performance Standard #14)**:** Demonstrate that an array of housing alternatives is available and sufficient to meet the ISP-identified needs of class members and the needs of hospitalized class members ready for discharge.

Substantial compliance means:

- quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 10% or fewer class members have ISP-identified unmet needs for housing resources; **[IV.25]** and

- meeting the Riverview discharge standards (see Part V below, Goal 2 Objective 2), or, if not met, the Department documents the reasons for not meeting the standards, and the documentation demonstrates that the failure to meet those standards is not attributable to a lack of housing alternatives in the community. **[IV.26]**

96 (Performance Standard #15): Demonstrate that clients in homes with more than 8 beds have given informed consent to reside there.

Substantial compliance means:

- the Department has certified that class members residing in homes with more than 8 beds (see list of facilities, dated July 2007) have given informed consent to reside there, in accordance with the approved protocol (updated July 2007). **[IV.27]**

57. Sen. Craven : Is there any shortage in transportation services for the homeless?

Response: There have been problems in the past for homeless members to access transportation services due to the definition of a members "own home" in the MaineCare policy. Previously, the department had defined a members home as the following:

Own Home means the recipient's residence, foster home, group home, or boarding home; not an institution such as a skilled nursing facility or intermediate care facility, except as noted in Section 113.06-3(A)(4).

58. Rep. Webster: Was there a shift in use of disproportionate share money when Maine implemented the non cat waiver?

Response: The Department was not making disproportionate share payments to Maine Hospitals when the Childless Adult waiver was implemented. When the Childless Adult Waiver was implemented, the Legislature appropriated General Fund dollars to fund the Waiver.

59. Rep. Rotundo: Can we provide information on the loss in services through loss of FHM-FP money and GF FP funds?

Response: The Fund for a Healthy Maine funds supplement the clinical family planning services that are purchased through Maine CDC and OCFS's blended funding. The supplemental work that the FHM supports focuses upon adolescent pregnancy prevention by providing training and professional development opportunities to teachers, school nurses, guidance counselors, school health coordinators and community-based organizations regarding puberty, adolescent development, and the delivery of age appropriate health and sexuality education to Maine youth. To supplement clinical services, teen pregnancy/STI prevention activities are targeted toward high teen pregnancy rate areas of the State that have hard-to-reach and vulnerable populations. Training on how to engage their communities in addressing the multiple factors that can play a role in teen pregnancy and sexually transmitted infections (STIs) is provided along with how to identify and implement evidence-based programs that have been proven effective. Print and web-based materials are made available to family and community members.

60. Rep Webster: What is the cost to the State of unintended pregnancies?

Response: Based on 2010 data, the cost to the state for unintended births equaled $403,640 state and federal funds.

61. Sen. Craven: What is the unemployment rate among Maine Care recipients?

Response: There are 105,879 MaineCare adults under 65 who do not have a documented disability. There are 60,193 of these adults who are not working. Reasons for their lack of employment are not collected. This population does include adults who are caretakers of young children, adults who are receiving unemployment, and adults who have medical conditions that do not meet the criteria of Social Security Disability.

62. Rep. Flood: What is the number of MaineCare members who are being treated for cancer?

Response:

	Nov 2011			Oct 2011			Sep 2011		
Clinical Condition	Patients	Visits Patient	Net Payment	Patients	Visits Patient	Net Payment	Patients	Visits Patient	Net Payment
Cancer - Breast	111	166	$105,516.08	388	606	$382,997.33	435	702	$506,234.41
Cancer - Cervical	139	145	$51,945.03	292	339	$114,584.85	326	364	$193,567.97
Cancer - Colon	30	46	$69,810.67	157	288	$204,972.54	211	458	$250,118.80
Cancer - ENT	15	24	$5,453.29	49	97	$42,464.96	66	122	$152,066.41
Cancer - Endocrine, NEC	26	31	$19,167.73	55	77	$29,445.54	58	92	$23,969.86
Cancer - Eye	0	0	$0.00	1	1	$13.24	4	4	$3,275.89
Cancer - Gastroint Ex Colon	8	15	$6,902.59	55	103	$53,066.49	60	131	$46,478.11
Cancer - Gynecological, NEC	9	9	$3,710.20	29	31	$2,268.28	38	49	$27,366.46
Cancer - Hepatobil Ex Pancreas	8	8	$824.21	32	49	$58,097.37	29	55	$34,021.20
Cancer - Leukemia	39	51	$25,512.34	148	247	$105,431.34	167	324	$190,515.77
Cancer - Lung	58	88	$56,957.22	238	480	$372,204.90	326	653	$371,809.34
Cancer - Lymphoma	44	96	$73,955.84	134	311	$190,414.20	163	363	$167,566.08
Cancer - Male Genital Ex Prost	3	3	$2,477.66	15	30	$19,893.10	12	15	$8,039.23
Cancer - Nonspecified	41	60	$51,246.99	182	291	$221,973.62	233	366	$250,009.09
Cancer - Oral Cavity/Mandible	17	29	$20,221.96	73	131	$114,104.25	91	188	$134,164.69
Cancer - Ovarian	10	12	$4,201.66	36	68	$38,045.18	45	81	$93,485.63
Cancer - Pancreas	6	10	$13,880.70	23	50	$62,933.36	35	94	$88,424.01
Cancer - Primary Bone	4	10	$8,400.60	10	16	$9,150.20	16	28	$11,453.99
Cancer - Prostate	17	24	$8,965.67	179	251	$100,171.66	237	338	$161,819.86
Cancer - Renal/Urinary	18	24	$19,024.08	119	196	$110,027.77	163	252	$102,531.97
Cancer - Respiratory Ex Lung	0	0	$0.00	2	2	$86.97	1	1	$102.64
Cancer - Skin	29	32	$14,820.12	276	311	$97,224.45	342	411	$133,852.79
Cancer - Uterine	7	8	$1,025.98	44	57	$19,295.29	54	79	$32,941.56

The decrease in the number of patients with a clinical diagnosis of cancer is low due to the expected claim lag that happens each month.

63. Rep. Rotundo: How many students receive school based health services who do not have access to services elsewhere?

Response: The data reported by the funded School Based Health Centers (SBHC) indicate that 80% of students enrolled in the SBHCs do have a primary care provider. 90% of students enrolled in the SBHCs have insurance (either MaineCare or private, third party). The majority of student SBHC visits are for acute issues such as headache, sore

throat, rash, etc. The SBHC enables these students to be seen earlier than if they waited until they could get an appointment with their primary care provider. This means that the students remain in school and their parent(s) do not have to take time off from work to take them to their primary care provider.

64. Sen. Rosen: What is the history on DEL program and use and how does it compare to the present usage?

Response: **See Attachment E**

ATTACHMENT – A

FY12 Encumbered Rental Subsidy Amount 12-22-11

Agreement Number	Vendor Name	Appropriation	Line Amount
DS2-12-241	ALTERNATIVE SERVICES, INC.	012260	$115,606.34
DS2-12-215	BFLI AGENCY	012260	$70,440.00
DS3-12-144	BRANCHES, LLC (PENOBSCOT COUNTY)	012260	$80,490.00
DS1-12-120	CAFÉ INC / CHOICES ARE FOR EVERYONE INC	012260	$24,028.00
DS1-12-157	CASA INC	012260	$75,229.00
DS3-12-217	CENTRAL AROOSTOOK ARC	012260	$40,730.36
DS3-12-104	CHARLOTTE WHITE CENTER	012260	$95,083.00
DS2-12-104	COASTAL OPPORTUNITIES (PREVIOUSLY COASTAL WORKSHOP)	012260	$39,432.00
DS3-12-105	COMMONSENSE HOUSING, INC.	012260	$1,940.00
DS1-12-151	COMMUNITY HOUSING OF MAINE (CHOM)	012260	$6,400.00
DS3-12-203	COMMUNITY LIVING ASSOCIATION	012260	$13,975.00
DS1-12-101	COMMUNITY PARTNERS, INC.	012260	$145,520.00
DS3-12-106	DEH (DOWNEAST HORIZONS) OPERATING CO	012260	$33,032.00
DS2-12-206	ELMHURST INC	012260	$11,675.00
DS2-12-106	EMPLOYMENT SPECIALISTS OF MAINE	012260	$23,436.00
DS3-12-214	GETCHELL AGENCY, INC.	012260	$133,077.00
DS1-12-112	GOOD NEIGHBORS, INC	012260	$20,386.00
DS1-12-145	GOODWILL INDUSTRIES OF NORTHERN NEW ENGLAND	012260	$32,758.68
DS1-12-156	GRANITE BAY CARE INC	012260	$312,528.00
DS2-12-108	GROUP HOME FOUNDATION, INC.	012260	$36,229.00
DS1-12-116	GROUP MAIN STREAM	012260	$25,241.00
DS1-12-104	INDEPENDENCE ASSOCIATION	012260	$157,015.00
DS2-12-208	JOHN F MURPHY HOMES, INC	012260	$231,653.00
DS3-12-136	KAREN M LEE, DBA LEE RESIDENTIAL CARE	012260	$34,850.00
DS3-12-108	KFI	012260	$4,123.90
DS2-12-212	LEAP, INC (LIFE ENRICHMENT ADVANCING PEOPLE)	012260	$2,764.00

FY12 Encumbered Rental Subsidy Amount 12-22-11

Agreement Number	Vendor Name	Appropriation	Line Amount
DS1-12-155	LUTHERAN COMMUNITY SERVICES, INC.	012260	$159,022.00
DS2-12-238	MEDICAL CARE DEVELOPMENT, INC.	012260	$77,369.18
DS2-12-204	MOBIUS, INC	012260	$56,507.00
DS2-12-932	NEW BEGINNINGS	012260	$23,592.00
DS3-12-210	NORTHERN MAINE GENERAL	012260	$66,084.00
DS3-12-112	OHI (OPPORTUNITY HOUSING, INC.)	012260	$133,484.67
DS2-12-125	OPPORTUNITY ENTERPRISES	012260	$11,749.00
DS3-12-146	PENOBSCOT AREA HOUSING DEVELOPMENT CORP (PENOBSCOT COUNTY)	012260	$6,275.00
DS1-12-130	PEREGRINE CORPORATION	012260	$2,195.00
DS1-12-105	PORT RESOURCES INC	012260	$191,201.00
DS2-12-201	PROGRESSIVE HOUSING (ROBIN BOGGS)	012260	$31,929.00
DS1-12-154	RESIDENTIAL RESOURCES OF MAINE INC	012260	$186,501.00
DS2-12-113	SKILLS INC	012260	$15,613.00
DS1-12-153	SPURWINK SERVICES INC	012260	$173,662.00
DS1-12-152	SUPPORT SOLUTIONS INC	012260	$193,804.00
DS3-12-115	UNITED CEREBRAL PALSY OF NORTHEASTERN MAINE	012260	$34,680.00
DS2-12-114	UPLIFT INC	012260	$5,554.00
DS1-12-102	WABAN PROJECTS, INC	012260	$2,796.00
DS1-12-127	WOODFORDS FAMILY SERVICES	012260	$39,697.00
DS3-12-117	YESTERDAY'S CHILDREN, INC.	012260	$11,136.00
DS1-12-103	YORK CUMBERLAND ASSOC FOR HANDICAPPED PERSONS D/B/A CREATIVE WORK SYSTEMS	012260	$54,046.00
			$3,244,539.13

ATTACHMENT – B

Mayhew, Mary

From: Nadeau, Stefanie
Sent: Friday, May 06, 2011 2:31 PM
To: Mayhew, Mary; Dushuttle, Patricia; VanBurgel, Barbara; Hamm, Bethany
Subject: Fw: Question Regarding MOE

Stefanie Nadeau
Acting MaineCare Director
Office of MaineCare Services
207-287-2093

From: McGreal, Richard R. (CMS/NC) [mailto:richard.mcgreal@cms.hhs.gov]
Sent: Friday, May 06, 2011 02:30 PM
To: Nadeau, Stefanie
Cc: Lasowski, William S. (CMS/CMCS) <William.Lasowski@cms.hhs.gov>; Strauss, Richard (CMS/CMCS) <richard.strauss@cms.hhs.gov>; Wachino, Victoria A. (CMS/CMCS) <Victoria.Wachino@CMS.hhs.gov>
Subject: Question Regarding MOE

Stefanie

Since the Maine Childless Adult waiver was renewed by CMS after March 23, 2010, it is no longer subject to the MOE provisions in Section 1902(a)(74) and 1902(gg) as added by Section 2001(b) of the Affordable Care and the State would have the flexibility to modify or terminate the waiver without any MOE violation. If the State would like to modify the waiver we would be willing to work with you on an amendment to address options for the continued eligibility of the individuals in the waiver as we mentioned in our February 25th guidance. However, if the State chooses to end the waiver it must comply with all the phase-out terms and conditions in the approved waiver. In addition, the State must also follow all existing rules regarding the termination of coverage, including determining whether an individual's eligibility should continue under another unaffected eligibility category and providing all applicable notice and appeal rights. We ask that you work closely with CMS in the phase-out process.

Rich

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

cc Russ Begin
Tony Maple
Brenda McCormick

SEP 2 3 2010

Ms. Brenda M. Harvey
Commissioner
Maine Department of Health and Human Services
442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011

Health & Human Services
SEP 27 2010
Commissioner's Office

Dear Ms. Harvey:

We are pleased to inform you that the extension request of the MaineCare Childless Adults section 1115 demonstration has been approved in accordance with section 1115(a) of the Social Security Act. Under this Demonstration, the State will continue to provide health care coverage to childless adults and non-custodial parents with incomes at or below 100 percent of the Federal poverty level (FPL). Your section 1115(a) demonstration is authorized through December 31, 2013, upon which date, unless reauthorized, all waiver and expenditure authorities granted to operate this demonstration will expire.

Our approval of this demonstration project is subject to the limitations specified in the enclosed waiver and expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as inapplicable to expenditures for demonstration expansion populations and other services not covered under the State plan. As part of this renewal, the waiver and expenditure authorities were revised to more accurately reflect the renewed demonstration program.

The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs), defining the nature, character, and extent of anticipated Federal involvement in the project. All previously granted waiver and expenditure authorities are superseded by this approval, the enclosed STCs, and waiver and expenditure authority lists.

The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver and expenditure authorities within 30 days of the date of this letter.

Russ!

Your project officer is Mr. Thomas Hennessy. Mr. Hennessy is available to answer any questions concerning implementation of your section 1115 demonstration. His contact information is as follows:

Centers for Medicare & Medicaid Services
The Center for Medicaid, CHIP and Survey & Certification Mail Stop S2-01-16

7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-8143
Facsimile: (410) 786-5882
E-mail: Thomas.Hennessy@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Hennessy and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's address is:

Centers for Medicare & Medicaid Services
JFK Federal Building
Rm 2275
Boston, MA 02203-0003

If you have additional questions, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid, CHIP and Survey & Certification at (410) 786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

Cindy Mann
Director

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00158/1**

TITLE: **MaineCare for Childless Adults Section 1115 Demonstration**

AWARDEE: **Office of MaineCare Services (OMS)**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning October 1, 2010, through December 31, 2013.

The following waiver shall enable Maine to operate the MaineCare for Childless Adults Section 1115 Demonstration.

1. Disproportionate Share Hospital (DSH) Payments	**Section 1902(a)(13)(A) Insofar as it incorporates 1923(c)(1)**

To the extent necessary to allow the State to reduce the amount of payments to disproportionate share hospitals beneath the levels specified in the approved State plan, to the extent necessary to fund expenditures under this demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00158/1**

TITLE: **MaineCare for Childless Adults Section 1115 Demonstration**

AWARDEE: **MaineCare Services (OMS)**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maine for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable Maine to operate the Maine section 1115 Health Insurance Flexibility and Accountability Demonstration.

1. **Demonstration Population ("Childless adults"):** Childless adults and non-custodial parents, subject to an enrollment cap, who do not meet the eligibility requirements of MaineCare and have family income at or below 100 percent of the FPL.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration population beginning October 1, 2010, through December 31, 2013.

1. Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable Maine to vary the amount, duration, and scope of services offered under the State Plan to the childless adult population at or below 100 percent of the FPL who are eligible for Medicaid services under the Demonstration.

2. Retroactive Eligibility **Section 1902(a)(34)**

To enable Maine to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for expansion groups.

3. Reasonable Promptness **Section 1902(a)(3) and 1902(a)(8)**

To enable Maine to cap enrollment and maintain a waiting list for Demonstration service expenditures.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00158/1

TITLE: MaineCare for Childless Adults Section 1115 Demonstration

AWARDEE: MaineCare Services (OMS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Maine's Section 1115 Health Care Reform Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Maine Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective October 1, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration renewal is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Transitional Activities Under The Affordable Care Act (ACA); Monitoring Budget Neutrality; Evaluation of the Demonstration; and, Schedule of State Deliverables for the Demonstration Extension Period.

Additionally, Attachment A has been included to provide supplemental information and guidance for the Quarterly Report.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Maine Childless Adults Demonstration provides a specified benefits package to childless adults and non-custodial parents who are at or below 100 percent of the federal poverty level (FPL). The Demonstration expands access to those without health insurance and who are otherwise ineligible for MaineCare. This Demonstration is funded by disproportionate share hospital (DSH) payments and is capped at $80.3 million total computable federal and state share. Enrollment is capped at 20,000 individuals.

The Childless Adults Demonstration will evaluate the outcomes of providing a targeted benefits package to a previously uninsured population on:

- reducing the uninsured rate;
- overall health care costs;

- improved health outcomes; and
- routine access to quality primary care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement[s] will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as

amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 12, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) An up-to-date CHIP allotment neutrality worksheet, if necessary;

   d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

9. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and

afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this Demonstration.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Maine Childless Adults Demonstration provides a specified benefits package to childless adults and non-custodial parents with family income at or below 100 percent of the FPL. The Demonstration expands access to those without health insurance and who are otherwise ineligible for MaineCare. Individuals with other insurance may receive this benefit. MaineCare may pay premiums/cost-sharing for this insurance according to current MaineCare rules.

13. **Eligibility.**

Those non-Medicaid eligible groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

The eligibility criteria for the Childless Adults Demonstration are as follows:

- Childless adult or non-custodial parent;
- U.S. Citizens;
- Financially eligible;
- Completed information form related to other insurance, i.e., third party liability (TPL); and
- Applicable cost-sharing.

Eligible individuals with access to employer sponsored insurance may be eligible to receive premium assistance and MaineCare may pay premiums/cost-sharing for this insurance according to current MaineCare rules.

Demonstration Eligibility Group	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Eligible Benefit
"Childless Adults"	Childless adults or non-custodial parents at or below 100 percent of FPL	Comprehensive benefits package as defined in paragraph 15

14. **MaineCare Childless Adults Demonstration Benefits.** The targeted benefits package is designed to serve as many eligible individuals as possible with a comprehensive set of health care services, as described below.

    The following MaineCare categories of services and respective policies of the MaineCare Benefits Manual (MCBM) ***are included*** in the limited benefit for "Childless adults":

General Category of Service	Specific Services Included
Hospital	MCBM Chapter II, Section 45, Hospital Services
Psychiatric Facility	MCBM Chapter II, Section 46, Psychiatric Facilities
Physician Services	MCBM Chapter II and III, Section 90 Physician
Medications	MCBM Chapter II, Section 80, Pharmacy Services
Ambulatory Surgical Center Services	MCBM Chapter II, Section IV, Ambulatory Surgical Center Services
Rural Health Care	MCBM Chapter II and III, Section 103, Rural Health Care Services
Federally Qualified Health Clinic Services	MCBM Chapter II and III, Section 31, FQHCs
Private Non-Medical Institutional Services, substance abuse facilities only.	MCBM Chapter II, Section 97 and Chapter III, Appendix B
Substance Abuse Treatment Services	MCBM Chapter II and III, Section 111, Substance Abuse Treatment Services
Family Planning	MCBM Chapter II and III, Section 30, Family Planning Agency Services
Advance Practice Registered Nursing	MCBM Chapter II, Section 14, Advance Practice Registered Nursing Services
Ambulatory Care Clinic Services	MCBM Chapter II and III, Section 3, Ambulatory Care Clinic Services

General Category of Service	Specific Services Included
Vision Services	MCBM Chapter II, Section 75, Vision Services (ophthalmologist and optometrist only)
Outpatient Psychiatric Care*	MCBM Chapter II, Section 46, Psychiatric Facility Services (outpatient)
Licensed Clinical Social Worker and Licensed Clinical Professional Counselor*	MCBM Chapter II and III, Section 58
Mental Health Services*	MCBM Chapter II and III, Section 65, Mental Health Services
Psychological Services*	MCBM Chapter II and III, Section 100
Dental	MCBM Chapter II and III, Section 25, Dental Services
Chiropractor	MCBM Chapter II and III, Section 15, Chiropractic Services
Transportation	MCMB Chapter II and III, Section 113, Transportation Services
Medical Supplies and Durable Medical Equipment, oxygen and insulin pumps/supplies only	MCBM Chapter II and III, Section 60,
Podiatric Services	MCBM Chapter II, Section 05, Podiatric Services
Ambulance Services	MCBM Chapter II and III, Section 5
Medical Imaging Services	MCBM Chapter II, Section 101
Laboratory Services	MCBM Chapter II, Section 55
Licensed Clinical Social Worker and Licensed Clinical Professional Counselor	MCBM Chapter II and III, Section 58

* For all services received under Sections 46, 65, and 100 of the MCBM, MaineCare will cover only face to face visits with a licensed practitioner up to a total of 24 outpatient mental health visits in aggregate annually except for the following services that will not be counted against the 24 visit limit: (1) Section 46 outpatient methadone services being billed by hospitals as of the date the waiver is approved; and (2) Section 65 emergency, crisis, and medication management services.

15. **Expenditure Cap**. The expenditure cap is set at $80.3 million total computable per year as per the Maine State legislature. Should the State exceed $80.3 million annually in redirected DSH, the State will be subject to return FFP in excess of the annual cap.

16. **Enrollment Cap.** The enrollment cap is set at 20,000. The State employs a rolling enrollment methodology outlined below:

Major Action Steps	Procedural Actions	Responsible Party	Due Date	Completion Date
Monitor size and cost of childless adult group to keep population under 20,000	Monthly query WELFRE for childless adult population size.	OIAS/OIT*	1st of each month	Ongoing
	Monthly query MECMS for childless adult expenditures.	OMS	1st of each month	Ongoing
	Query ACES to determine monthly closure rate	OIAS/OIT	1st of each month	Ongoing
Add applicants from waiting list up to 20,000 cap	Determine number to get to 20,000.	OIAS	15th of month	Ongoing
	Determine date up to which wait list added	OIAS	15th of month	Ongoing
	Mass data fix to add identified wait list.	OIT	25th of month	Ongoing
	Letters/MaineCare cards to those added.	OIT	25th of month	Ongoing

* OIAS: Office of Integrated Access and Support
OIT: Office of Information Technology
OMS: Office of MaineCare Services

V. COST SHARING

Allowable premiums and cost-sharing are charged to "childless adults" as defined below:

Population	Premiums	Deductibles	Co-Payments	
"Childless Adults" at or below 100% FPL	None	Same as Medicaid (see MaineCare State Plan), nominal	Same as Medicaid, nominal	
			Type	Amt
			Rx	$3
			Services	$1-$3

VI. DELIVERY SYSTEMS

17. **Service Delivery.** Services for the demonstration are provided using the same mechanism as MaineCare members (Medicaid-eligible individuals), including services that require prior authorization and are ordered and prescribed by a physician.

Participants will be permitted to choose among MaineCare participating providers (agencies).

Individuals with other insurance may be participants of this demonstration. The Office of MaineCare Services may pay premiums/cost-sharing for this insurance according to current Medicaid (MaineCare) State Plan rules.

18. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

    Payments under contracts with public agencies, not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

VII. GENERAL REPORTING REQUIREMENTS

19. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section VIII.

20. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section X.

21. **Quarterly Calls.** CMS will schedule quarterly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or relevant State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

22. **Quarterly Operational Reports:** The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a) An updated budget neutrality monitoring spreadsheet;

    b) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to:

a. Systems and Reporting Issues;
b. Approval and contracting with new health plans;
c. Benefits;
d. Enrollment;
e. Grievances;
f. Quality of care;
g. Access;
h. Health plan financial performance that is relevant to the Demonstration, including progress towards corrective action related to expenditure reporting;
i. Pertinent legislative activity; and
j. Other operational issues.

c) Action plans for addressing any policy and administrative issues identified;

d) Evaluation activities and interim findings.

Quarterly report for the quarter ending December 31 is due **February 28**
Quarterly report for the quarter ending March 31 is due **May 31**
Quarterly report for the quarter ending June 30 is due **August 31**
Quarterly report for the quarter ending September 30 is due **November 30**

VIII. Transition Activities under the Patient Protection Affordable Care Act (ACA)

23. **Transition Plan.** The state is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

24. **Annual Report.** The State must submit a draft annual report documenting accomplishments project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives (if relevant), policy and administrative difficulties in the operation of the Demonstration, and systems and reporting issues. The State must submit the draft annual report no later than 120 days after the end of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted, and posted to the CMS Web site with prior permission.

IX. GENERAL FINANCIAL REQUIREMENTS

25. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered

expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X, Monitoring Budget Neutrality.

26. **Reporting Expenditures Subject to the Budget Neutrality Cap.** The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Maine must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the SMM.

b) For each demonstration year, a CMS-64.9 Waiver and/or 64.9P Waiver form will be submitted reporting expenditures for individuals enrolled in the demonstration and subject to the budget neutrality cap. The State must complete these forms for the following enrollment category:

- **"Childless adults"** who do not meet the eligibility requirements of MaineCare, but who are childless adults or non-custodial parents and are at or below 100 percent of the FPL.

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 26 and who are receiving the services subject to the budget neutrality cap, provided by DSH funds). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and shall be reported on forms CMS-64.9 waiver and/or 64.9P waiver.

d) Cost sharing contributions from "Childless Adults" that are collected by the State from "Childless Adults" under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

e) Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs will be identified on the

Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any costsettlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

27. **Reporting Member Months.** The following describes the reporting of member months subject to the budget neutrality cap:

a) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

b) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Population described below:

- **"Childless Adults"** who do not meet the eligibility requirements of MaineCare, but who are childless adults or non-custodial parents and are at or below 100 percent of the FPL.

c) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly operational report required under paragraph 22, the actual number of eligible member months for the Demonstration Population defined in paragraph 27 (b). The State must submit a statement accompanying the quarterly operational report, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

28. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the demonstration. Maine must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS.

Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

29. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section X:

    a) Administrative costs, including those associated with the administration of the Demonstration; and

    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

    c) Net medical assistance expenditures made under section 1115 Demonstration authority under the Childless Adults Demonstration.

30. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

31. **State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements. The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the State utilizes certified public expenditures (CPEs) as the funding

mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

32. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

X. Monitoring Budget Neutrality for the MaineCare Childless Adults Demonstration

33. **Limit on Federal Title XIX funding.** Maine will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the Childless Adults Demonstration. For the purposes of this demonstration, Maine has imposed a cap of $80.3 million total computable per year in the use of available DSH funds. Maine is capping enrollment at 20,000.

34. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the Budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual

budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

35. **How the Limit will be Applied.** The limit calculated above will apply to actual expenditures for the Demonstration on an annual basis, as reported by the State under section VIII. If at the end of any demonstration year, including the approval period ending demonstration year 5, the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 3-year period, the budget neutrality test will be based on the time period through the termination date.

The population under this budget neutrality agreement is childless adults and non-custodial parents up to or equal to 100 percent of the FPL:

a) For each year of the budget neutrality agreement an annual limit is calculated for the "Childless Adults"

b) The "Childless Adults" estimate will be based on available DSH funds.

c) Budget neutrality limit for "Childless Adults" will be assessed on an annual basis and is limited to an amount that, when added to total DSH payments under the plan, does not exceed the allowable aggregate DSH allotment for the State under the Federal statute (calculated with the Federal and State shares) for *each* of the years of the demonstration. The State must continue to comply with the hospital specific limits as provided in OBRA 1993 for DSH payments under the plan; for purposes of these hospital specific limits, individuals eligible only under the demonstration shall be considered "eligible for medical assistance under the State plan."

d) For the purpose of monitoring budget neutrality, within 60 days of the end of each quarter and within 90 days of the end of each waiver year, the State will provide a report to CMS, in the format provided by CMS, identifying the State's actual enrollment and corresponding actual expenditures for "Childless Adults".

36. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. If Maine exceeds the budget neutrality limit of $80.3 million total computable on any given demonstration year, Maine must submit a corrective action plan to CMS for approval and will be subject to the return of FFP for expenditures over the annual cap.

XI. EVALUATION OF THE DEMONSTRATION

37. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS's approval of the Demonstration extension. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of

these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

38. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

39. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annually (by February 1st)	Draft Annual Report	Section VIII, paragraph 24
Quarterly	Quarterly Operational Reports	Section VII, paragraph 22
	CMS-64 Reports	Section VIII, paragraph 25
7/1/2012	Initial Transition Plan	Section VIII, paragraph 23

ATTACHMENT A
QUARTERLY REPORT CONTENT AND FORMAT

Under Section VII, paragraph 23, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – MaineCare for Childless Adults Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2008 (10/1/10 - 12/31/10)

Introduction
Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Enrollment Counts
Note: Enrollment counts should be person counts, not member months

	Demonstration Populations (as hard coded in the CMS 64)	Current "childless adults" (to date)	Disenrolled in Current Quarter
"Childless adults":	Demonstration "Childless adults"		

Outreach/Innovative Activities
Summarize outreach activities and/or promising practices for the current quarter

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues
A summary of the types of complaints or problems consumers possibly identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, telephone, facsimile, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT – C

Below is a listing of all of the MaineCare-related Other Special Revenue accounts (Tax, Drug Rebates, Dirigo and Fund for a Healthy Maine). The Department took a General Fund deappropriation for the Tax increases, the Dirigo transfer, etc. The General Fund did receive an increase due to the reduction in FMAP to recognize the reduction in matching rates in the applicable Other Special Revenue accounts.

Appropriation	Appropriation Name	Type of Account	SFY11 OSR Expenditures	SFY OSR Budget	Variance
014 10A 014701	Medical Care Services	Tax	12,274,679	14,425,672	2,150,993
014 10A 014703	Medical Care Services - Dirigo Health	Dirigo	5,389,004	6,031,821	642,817
014 10A 014704	Medical Care Services - Hospital Tax	Tax	80,663,199	81,607,236	944,037
014 10A 014705	Medical Care - Drug Rebate Non-match	Drug	32,550,528	34,460,962	1,910,434
014 10A 014708	Durable Medical Equipment (DME) Rebates	DME	612,739	676,210	63,471
014 10A 014715	Earned Federal Revenue	Earned Revenue	9,691,542	1,754,295	(7,937,247)
014 10A 014801	Nursing Facilities			5,693	5,693
014 10A 014802	Nursing Facilities - NF Tax	Tax	33,549,736	37,160,906	3,611,170
014 10A 020201	Drugs for Maine's Elderly	Prior-year Carryover		838,912	838,912
014 14A 070542	Medicaid Services - MR - Service Provider Tax	Tax	569,809	572,364	2,555
014 14A 070552	Medicaid Match - DS - Service Provider Tax	Tax	15,521,789	17,055,884	1,534,095
014 14A 070557	Medical Match - Developmental Services - RTFA	Tax		46,400	46,400
014 14A 073244	MH Services Community Medicaid - PNMI Tax	Tax	2,256,301	2,343,836	87,535
014 14A 073246	MH - Community Support Tax	Tax	3,075,302	3,351,977	276,675
014 14G 084401	Medicaid Seed - PNMI Tax	Tax	576,231	614,320	38,089
014 14G 094802	FHM - OSA - Medicaid Match	FHM - Cycle Payments	269,156	1,257,666	988,510
014 10A 096001	FHM - Medical Care	FHM - Prescription Costs	5,588,774	7,876,677	2,287,903
014 14A 097801	Res. Treatment Fac. Assessment	Tax	1,954,135	2,028,726	74,591
014 14A Z00601	Developmental Svs Supports Waiver	Cycle Payments		80,376	80,376
014 10A Z01501	FHM - Drugs for the Elderly & Disabled	FHM - DEL	12,352,334	12,061,914	(290,420)
Total of Other Special Revenue Accounts (Tax Revenue, FHM, Drug Rebates, etc.)			216,895,257	224,251,847	7,356,590

ATTACHMENT – D

Defect ID	Headline	Legislative Description					
TR-1005026	PRD -- correction to 11 Pharmacy claims to correct 835 generation	Eleven Pharmacy claims were incorrectly run through processing in MIHMS. They had to be corrected to their original format from MEPOPS in order to be processed for payment.	A - Severe	Closed	1/3/2011	Y	Pharmacy
TR-1005005	PROD-Adding Patient Status Codes to CAH type of bill.	Valid Patient Status Codes were added to MIHMS to prevent inappropriate denials.	A - Severe	Closed	1/4/2011	Y	CAH Hospitals
TR-1004887	Update 6016 stored proc for Hospital PT 35	An edit to suspend hospital claims for manual review was changed so that these claims no longer suspend resulting in faster claims turn around time for hospitals.	C - Minor	Closed	1/4/2011	Y	Hospitals
TR-1004914	COBVA Alert Concerning Future Reporting of Fractional Mileage For 837 Institutional Claim Ambulance Services	Hospitals that own ambulance services now bill fractional mileage to Medicare and thus MIHMS had to be updated to allow this.	C - Minor	Closed	1/5/2011	Y	AMBULANCE
TR-1005044	PROD-G0430 and G0431 need to be added to Physicians contracts.	Codes were add to Physician contracts to allow them to bill for anesthesia services.	A - Severe	Closed	1/6/2011	Y	PHYSICIANS
TR-1005045	PROD-Modifier 26 restriction is configured in error for the "Lab Services" term of "Professional MBCHP Contract"	Maine Breast and Cervical Health Contracts were configured incorrectly with a modifier that was not needed. The modifier was removed so these claims could process appropriately.	A - Severe	Closed	1/6/2011	Y	PHYSICIANS
TR-1004894	Custom Code for Claim Edits 611/612 - Auth Decrement	A new process was implemented to calculate the number of units used on prior authorizations.	A - Severe	Closed	1/7/2011	Y	ALL
TR-1004915	Operational Improvement - Auto Override 252 When 216 is OKAY,	A change was implemented to prevent MIHMS from posting an erroneous edit which in turn improved claims turn around time.	C - Minor	Closed	1/7/2011	Y	All
TR-1005011	Crossover Claims Repricing Denied Claim Lines	MIHMS was inappropriately pricing denied claim lines. This was fixed such that denied claims do not have paid amounts.	A - Severe	Closed	1/7/2011	Y	ALL
TR-1004936	Manual pricing of auth via the interface partners not consistant.	This was a problem with training of the OACPD staff entering pricing information in their prior authorizations. There was no system defect.	B - Major	Closed	1/12/2011	Y	WAIVER
TR-1005050	Adding the OCFS program id for all EIS auth matching	The logic which identifies Prior Authorization numbers was updated in order to recognize OCFS Authorizations.	A - Severe	Closed	1/14/2011	Y	Behavioral Health
TR-1005062	Crossover - TPL Modified Pricing Paying Denied Line	MIHMS was inappropriately pricing denied claim lines on crossover claims. This was fixed such that denied claims do not have paid amounts.	A - Severe	Closed	1/21/2011	Y	ALL
TR-1005095	PROD-Change pricing of T1502 frol Flat rate to Per unit.	MIHMS was originally configured to only allow medication administration by Private Duty Nurses once per day. This change allows that service to be paid per unit rather than per day.	A - Severe	Closed	1/23/2011	Y	Private Duty Nursing
TR-1005096	PROD-Edit 402 set to PEND.	A change was made to an edit to manually pend professional services related to once in a lifetime surgical procedures so that they would not deny automatically.	A - Severe	Closed	1/23/2011	Y	All
TR-1005103	PROD-Procedure codes need to be added to Podiatrist and Podiatrist CSHN contracts.	Podiatry contracts were updated to remove inappropriate codes (JCODES). They were further updated to restrict services to certain places of service.	A - Severe	Closed	1/25/2011	Y	PODIATRISTS
TR-1005109	PROD-Edit 176 needs to be changed from IGNORE to PEND.	MIHMS was altered to pend Out of State Emergency services claims.	A - Severe	Closed	1/27/2011	Y	OOS Emergency
TR-1004872	Pend COBA	The system was altered to identify the appropriate Service Location when Medicare has paid primary.	C - Minor	Closed	1/28/2011	Y	All
TR-1005112	PROD-Edit status changes.	Four edits in MIHMS were set to auto deny when they should have been recycling the claims for 7 days before denying.	A - Severe	Closed	1/28/2011	Y	All
TR-1004841	Edit 245 changes	MIHMS was updated to create separate edits for professional vs. hospital claims for multiple procedures on the same day.	C - Minor	Closed	1/28/2011	Y	All
TR-1004946	Certified Seed Solution needs to be Updated	Funding of Certified SEED claims was updated to look at the provider type on the service location. This allowed proper handling of SEED claims.	B - Major	Closed	1/28/2011	Y	Schools
TR-1004971	Claim Line Gap populating Funding provider type and specialty incorrectly	Claims were not determining the appropriate provider type and specialty for accurate funding.	A - Severe	Closed	1/28/2011	Y	All
TR-1004491	EIS Authorizations not matching Provider input	Prior authorizations for OACPD were coming in with a hyphen in them and the system was not accepting them. MIHMS was altered to allow this.	B - Major	Closed	1/29/2011	Y	Waiver
TR-1005113	PROD-TPL edit 378	MIHMS was updated to prevent inappropriate denial of claims for Third Party and Medicare billing. Procedures are not covered by other insurances and thus these should not be denied.	A - Severe	Closed	1/30/2011	Y	All
TR-1005115	PROD- OOS Dialysis Contracts - Emergency Terms	Out of State Dyalysis contract terms were updated to allow emergency services. The non emergency terms were also updated to require prior authorizations.	A - Severe	Closed	1/31/2011	Y	OOS DIALYSIS
TR-1005116	PROD-Need to add procedures 92506 and V5014 to Audiologist contracts.	Audiology contracts were updated to allow 2 procedures that were previously missing from those contracts.	A - Severe	Closed	1/31/2011	Y	AUDIOLOGY

Defect ID	Headline	Legislative Description					
TR-1004639	Custom Edit 6016_Claim-Review	An edit was created to pend hospital claims for manual review per direction of DHHS-OMS.	B - Major	Closed	1/31/2011	Y	All
TR-1005117	PROD-Procedure codes need to be added to Ophthalmology contract	Opthamology contracts were updated to include procedures that should have been configured originally. These codes were missed and thus inappropriate denials were occurring.	A - Severe	Closed	1/31/2011	Y	OPTHALMOLOGY
TR-1004889	Updates to External Enrollment Hierarchy	MIHMS was not selecting the appropriate insurance coverage information when processing claims.	B - Major	Closed	2/1/2011	Y	all
TR-1004861	XTPL_TPL_Reprice_Dental _Not Setting Clearyby -ClearDate on Edit Line	MIHMS was inappropriately reprocessing claims where posted edits had been overriden previously.	A - Severe	Closed	2/2/2011	Y	Dental
TR-1005120	PROD - Attachments submitted for claims not storing in FileNET	Attachments coming into MIHMS were not being stored appropriately in the system.	B - Major	Closed	2/2/2011	Y	All
TR-1005144	PROD-Procedure codes need to be added to Physician, Physician Assistant and APRN contracts.	Procedure codes were added to Physician contracts to allow appropriate processing of claims for certain services. Claims were previously denying.	A - Severe	Closed	2/8/2011	Y	PHYSICIANS
TR-1004560	CR 14319 - Pend Claims when Wrong Service Location Selected	An edit was added to deny provider claims when billing with an inappropriate service location.	A - Severe	Closed	2/9/2011	Y	All
TR-1005146	Removal of the temporary Stored procedure that ensured claims were pended for 6021.	This change was to begin processing hospital claims after a change in pricing logic had been made.	A - Severe	Closed	2/9/2011	Y	Hospitals
TR-1003852	CR-14319 APC: ApcMedicare	Medicare crossover claims were not paying correctly. This was due to the incorrect selection of payment methodology.	B - Major	Closed	2/9/2011	Y	All
TR-1005152	PROD-TPL Edit 378	MIHMS was updated to prevent inappropriate denial of claims for Third Party and Medicare billing. Procedures are not covered by other insurances and thus these should not be denied.	A - Severe	Closed	2/10/2011	Y	All
TR-1005100	0155: Member missing enrollrestriction for State Custody	A member was identified that should have been indicated as copay exempt in the system and that indicator was not set.	B - Major	Closed	2/14/2011	Y	All
TR-1004817	Medical segment was not readded by the classification sweep	Medical eligibility was not being processed appropriately in the system.	B - Major	Closed	2/14/2011	Y	All
TR-1004470	Financial Coverage Code Missing from Member Record	Member records were identified which showed medical eligibility but no financial eligibility and they should have had both. Thus causing claims to deny inappropriately.	B - Major	Closed	2/14/2011	Y	All
TR-1004698	0155 Prod: Ratecode Not Displaying For An Enrollment And Enrollment Closed Based On Classification	Members financial eligibility was being ended inappropriately in the system based on a change in their medical eligibility.	B - Major	Closed	2/14/2011	Y	All
TR-1004327	0155 - Void w/o readd	Members were inappropriately being dropped from the system.	B - Major	Closed	2/14/2011	Y	All
TR-1004420	0155 - Missing enrollcoverage/enrollstatus	Members eligibility was inappropriately being dropped from the system.	B - Major	Closed	2/14/2011	Y	All
TR-1004600	0155 Prod: Valid Member Eligibility Did Not Load In MIHMS	Members financial eligibility was being ended inappropriately in the system based on a change in their medical eligibility.	B - Major	Closed	2/14/2011	Y	All
TR-1004768	PROD - Member - Eligibility Problems	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/14/2011	Y	all
TR-1004800	Overlapping category 6 RACs for '4Y' and '57-PCCM'	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/14/2011	Y	all
TR-1004824	0155 UATX: Multiple Erroneous Overlapping Ratecodes For A Member	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/14/2011	Y	All
TR-1004786	Update 6016 adjudication pre-financial script	An edit to pend hospital claims for manual review per direction of DHHS-OMS was updated to select the claims based on specific contract terms.	C - Minor	Closed	2/14/2011	Y	All
TR-1005167	PROD-Edit 210 Member not enrolled on DOS and Edit 218 Member lost coverage during date span.	Edits were updated to deny rather than pend when a provider was billing for a span of dates and a member's eligibility changed during that span. These claims must be billed on separate claim lines in this instance. Claims now autodeny for this situation.	A - Severe	Closed	2/15/2011	Y	All
TR-1005101	Correction to CR #16948 remediation/UTC336	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/16/2011	Y	All
TR-1004524	MIHMS Product Defect - Overlapping RATE code eligibility (reopen of TR-1004428)	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/16/2011	Y	All
TR-1005129	Blank THEVALUE on Crossover Indicator Attribute	Medicare crossover claims were not having the Part A or Part B indicator set appropriately in the system.	B - Major	Closed	2/16/2011	Y	All
TR-1004724	Claims should allocate the account string from the allocation Matrix.	Claims were not being funded appropriately.	B - Major	Closed	2/21/2011	Y	Schools
TR-1004773	Missing ratecodes in enrollments	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	2/23/2011	Y	All
TR-1005178	stored procedure to add medically unlikely edits (MUE) functionality.	CMS correct coding initiative edits were implemented for medically unlikely combination editing.	B - Major	Closed	2/24/2011	Y	All

Defect ID	Headline	Legislative Description					
TR-1005165	Reject EDI Claims with an Alpha Frequency Code	Claims were coming into MIHMS with an inappropriate value in the frequency. This change prevents them from entering MIHMS and denies them at the HIPAA validation level.	B - Major	Closed	2/25/2011	Y	all
TR-1005142	PRD -- 837 Validation -- Extended code set -- Local codes	An edit was added to ensure providers cannot bill using previously allowed local procedure codes.	C - Minor	Closed	3/2/2011	Y	All
TR-1005190	Incorrect formtype on 4 pharmacy claims	Four pharmacy claims were tagged inappropriately as being billed on an incorrect claim form. This was corrected.	B - Major	Closed	3/2/2011	Y	PHARMACY
TR-1005160	Update edit 524 stored procedure	MIHMS was inappropriately paying claims that should have been denied. The processing logic was updated to correct this issue.	B - Major	Closed	3/3/2011	y	All
TR-1005153	Deny claims with TOB frequency = zero	MIHSM was updated to deny claims being received with a type of bill frequency of zero as this is not allowed by MaineCare.	C - Minor	Closed	3/3/2011	Y	All
TR-1004878	Update Edit_502_Stored_Procedure	An edit in MIHMS which identifies duplicates was set to pend and it was altered to auto deny.	B - Major	Closed	3/8/2011	Y	All
TR-1005025	PREMASS_clear532_edit / pre_mass_n_fin_clear532_edit	Duplicate processing in MIHMS was updated to consider all modifiers submitted on the claim. Thus claims were previously pending inappropriately.	B - Major	Closed	3/8/2011	Y	All
TR-1005148	Hospital Crossovers Paying Denied Lines	MIHMS was inappropriately paying claims that should have been denied. The processing logic was updated to correct this issue.	A - Severe	Closed	3/8/2011	Y	HOSPITAL
TR-1005060	Previously Pended Pharmacy Claims, Incorrect Current Status	Pharmacy claims received from MEPOPS were not able to be processed. This change fixed those claims.	B - Major	Closed	3/10/2011	Y	PHARMACY
TR-1005141	Transformation Issues NPI#1376528398 York Hospital	A hospital enrollment did not fully tranfer into the MIHMS system and thus they could not be paid for certain services.	B - Major	Closed	3/11/2011	Y	HOSPITAL
TR-1005182	Modifiy the Mass Copay Adjustment service	MIHMS was not applying member copayments correctly to claims payments.	C - Minor	Closed	3/12/2011	Y	All
TR-1005189	PRE_MASS & PRE_FIN - comment out edit 6020 for xover FQHC	Federally Qualified Health Center Medicare crossover claims were inappropriately suspending.	C - Minor	Closed	3/15/2011	Y	FQHC
TR-1005123	copay process to override edit 217 for crossovers	MIHMS was inappropriately applying copayment exemptions to Medicare crossover claims.	C - Minor	Closed	3/15/2011	Y	All
TR-1005155	Esclated Pharmacy External Enrollments added via QNXT UI	This change allows users to add Pharmacy Insurance information directly into MIHMS.	B - Major	Closed	3/15/2011	Y	PHARMACY
TR-1005175	Deny claims for specified edits after required days	An edit was altered to recycle pended claims for a given number of days before denying them. This allows time for eligibility to be entered into the system.	C - Minor	Closed	3/15/2011	Y	all
TR-1005183	Remediation to correct active secondary with inactive primary enrollstatus	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	3/16/2011	Y	all
TR-1005196	Correct RX Claims in Wait Status for One Provider.	Pharmacy claims were inappropriately set to a wait status. This change fixed these claims so they could be paid.	B - Major	Closed	3/18/2011	Y	PHARMACY
TR-1005271	PROD-ADD H2033 to TPL Exclusion list	This change prevented editing for third party insurance for mental health clinic services for multisystemic therapy.	A - Severe	Closed	3/18/2011	Y	MENTAL HEALTH CLINICS
TR-1005179	OCFS denied services or payments	Claims authorized by the Office of Child and Family Services were being denied inappropriately.	B - Major	Closed	3/21/2011	Y	All
TR-1005135	Copay Spanning Months	MIHMS was inappropriately deducting copayments when the dates of service spanned across two months.	B - Major	Closed	3/22/2011	Y	All
TR-1005211	TCM claims are denying â€œMember does not have coverage code required on benefitâ€	Targeted Case Management claims were denying inappropriately.	A - Severe	Closed	3/22/2011	Y	Case Management
TR-1005200	Fix Crossover Memo Parser	Crossover claims were not being processed correctly when there is a Medicare action code on the claim.	B - Major	Closed	3/23/2011	Y	All
TR-1005180	Pharmacy Provider Not Enrolled in MIHMS	MEPOPS was sending claims to MIHMS for providers who were not enrolled. The provider enrollments were updated and claims paid.	B - Major	Closed	3/23/2011	Y	PHARMACY
TR-1005110	Omit COB Paid Date Default by Sungard Application	Paper claims with other insurance were inappropriately loading into MIHMS with an erroneous date and thus causing them to deny.	B - Major	Closed	3/29/2011	Y	All
TR-1005133	PRD -- EDI X12 Validation -- Nursing Home Type of Bill	The HIPAA validator was inappropriately denying claims for outpatient reasons when the claim was actually for inpatient services.	B - Major	Closed	3/29/2011	Y	Nursing Home
TR-1005136	New Duplicate Rule - Find Duplicate claims by Member ID	Duplicate processing in MIHMS was updated to consider member ID. Thus claims were previously pending inappropriately.	A - Severe	Closed	3/29/2011	Y	All
TR-1005004	PRD -- Institutional Service Lines -- 837I agent loading process	HIPAA loading processes were not populating the assessment dates.	B - Major	Closed	3/30/2011	Y	All

Defect ID	Headline	Legislative Description				
TR-1005063	CR9905 & 15185 Deny FQHC\RHC\INP\IHC when line delnes & DOS >=4/1/2011	An edit was implemented to prevent payment of ancillary services when the inpatient stay is denied. This edit also applies to FQHC, RHC and Indian Health Centers when the clinic service is denied then other ancillary services on the claim should also deny.	B - Major	Closed	3/30/2011 Y	FQHC, RHC, IHC
TR-1005162	Populate admit date with start date	MIHMS was altered to populate the admit date with the starting date of service on an inpatient claim when the admit date is left blank by the provider.	B - Major	Closed	4/1/2011 Y	HOSPITAL
TR-1004966	Outlier payments applying to Outpatient claims in error	MIHMS was inappropriately assigning outlier payments to outpatient claims when these should only apply to inpatient claims.	B - Major	Closed	4/5/2011 Y	HOSPITAL
TR-1005131	Claimline_Gap update needed to populate specialty 040 and 164	Claims were not appropriately funding for pharmacy providers who also provide Durable Medical Equipment services. Additionally school claims were not funding appropriately for provision of therapy services.	B - Major	Closed	4/8/2011 Y	DME and Schools
TR-1005170	Update Claimline_Gap process for COBA and Edit 6010	MIHMS was not paying Medicare crossover claims appropriately.	A - Severe	Closed	4/8/2011 Y	All
TR-1005316	PROD - The â€˜Pay by APC/OPPS Systemâ€™ flag was deselected in a number of Hospital PIP terms causing Edit 172 to fire.	Hospital contracts were updated to pay appropriately as directed by DHHS-OMS.	A - Severe	Closed	4/11/2011 Y	HOSPITAL
TR-1005147	Update claim line gap so edit 6007 posts in deny status	MIHMS was updated to autodeny claims where the providers specialty has end dated for the type of service being billed.	C - Minor	Closed	4/13/2011 Y	All
TR-1005298	Edit_532 Not being overriden when History Claims in PAY Status	Claims were denying inappropriately against another claim in history which was also denied. Logic was updated to only look at history claims in a paid status.	B - Major	Closed	4/15/2011 Y	All
TR-1005294	COC - Replenish COC taken on denied claims and claim lines	MIHMS was not correctly replenishing the cost of care amounts when a claim was denied.	C - Minor	Closed	4/15/2011 Y	All
TR-1004920	Rolling Days on Benefits in QNXT	MIHMS editing for limitations of services does not function as the state understood it. Thus limit editing had to be reconfigured and in some cases removed to allow proper payment of claims.	B - Major	Closed	4/19/2011 Y	All
TR-1005282	Change eligibleorgid for MED_D from Medicare to COB Eligible	Medicare Part D coverage was inappropriately set up in MIHMS and thus causing claims to deny when they shouldn't.	C - Minor	Closed	4/27/2011 Y	All
TR-1005353	PROD-Update to the limit for Liner/Shields.	Limits in the system for supplies were configured to calculate by the case rather than per unit and thus were causing claims to deny inappropriately.	A - Severe	Closed	4/27/2011 Y	DME
TR-1004064	TPL Dental Claim: Edit 378 is not overridden if member has comprehensive TPL coverage but is not appropriate for Dental claim	Dental claims were denying inappropriately for other insurance when the members' other insurance was not an appropriate dental coverage.	C - Minor	Closed	4/27/2011 Y	DENTAL
TR-1005274	MHP mistakenly allow a claim to move from WAITREV to OPEN	The online portal was allowing providers to reprocess claims that were not available for reprocessing because they were being reversed.	B - Major	Closed	4/27/2011 Y	All
TR-1004378	Adjustments: Incorrect Pay (net Withhold) Amount on the Reversed Claim	Reversal claims were not setting amounts correctly.	B - Major	Closed	4/29/2011 Y	All
TR-1005318	PROD - Add edit 202 to the Crossover disregard edit list.	Medicare Crossover claims were inappropriately suspending for benefits edits that did not need to be posted. Thus this change improved turn around times on claims payment.	A - Severe	Closed	4/29/2011 Y	All
TR-1005321	NDC JCode Gap code must treat blank JCodes as if they were null	Claims were inappropriately editing for JCODE edits when the procedure code was blank. This correction updated MIHMS to not process for JCODE rules when this is the case.	C - Minor	Closed	5/3/2011 Y	PHYSICIANS
TR-1005229	PRD -- EDI X12 validation -- SL validation using claim DOS	HIPAA loading processes were not considering the dates of service when assessing a service location on a claim.	C - Minor	Closed	5/5/2011 y	All
TR-1005378	The emergency benefit for Oxygen (E1390-RR) should only be selected when the emergency indicator is selected.	Claims were inappropriately selecting an emergency benefit when emergency was not indicated on the claim.	A - Severe	Closed	5/9/2011 Y	DME
TR-1005380	For CSHN, the benefit â€œHospital Services â€“ Nurseryâ€ should require PA	Hospital claims for Children with Special Health Needs were not requiring prior authorization for nursery services.	A - Severe	Closed	5/9/2011 Y	HOSPITAL
TR-1005381	The benefit â€œPhysicians - Ob Care - Endocrinologist - Referral Exemptâ€ should not be selected except when the Dx and Specialt	Certain claims were unable to be processed in MIHMS due to improper configuration of benefits.	A - Severe	Closed	5/9/2011 Y	PHYSICIANS
TR-1005225	Update Pre_Fin_6016 SP	Medicare crossover pricing correction.	A - Severe	Closed	5/9/2011 y	All
TR-1005253	Crossover Indicator Atrribute - Missing from Claims	Medicare crossover claims were not being identified appropriately as crossover claims.	A - Severe	Closed	5/9/2011 y	All

Defect ID	Headline	Legislative Description				
TR-1005325	Add PA to Pre_Mass_n_Fin_clear532_edit (CR14093)	Duplicate processing logic was updated to include assessing the prior authorization number.	A - Severe	Closed	5/10/2011 y	All
TR-1005040	Brain injury edit 524 historical claims - CR15082	MIHMS was updated to override an edit when certain historical claims are paid for brain injury services.	C - Minor	Closed	5/10/2011 y	All
TR-1005385	PIP Payment terms entered incorrectly into some OOS Hospitals	Some out of state hospital contracts were inappropriately configured to pay Prospective Interim Payments.	A - Severe	Closed	5/10/2011 Y	OOS Hospitals
TR-1005260	PRD -- HIPAA validation updates (Inbound X12)	The HIPAA validator was inappropriately denying claims for service location.	B - Major	Closed	5/11/2011 y	All
TR-1005231	PRD -- PREMASS Auth Auto Match updates	This change separated logic into two different edits. One for provider mismatch on the prior authorization and one for the benefit requiring prior authorization allowing for more appropriate denials to be displayed to the provider.	B - Major	Closed	5/12/2011 y	All
TR-1005305	Defect in TPL-Post-SQL_Edit378	MIHMS was not setting a needed flag when MaineCare was paying as primary.	B - Major	Closed	5/12/2011 y	All
TR-1005206	Claim COB Calculations	Medicare crossover claims were not calculating payment correctly.	C - Minor	Closed	5/13/2011 Y	All
TR-1005397	A limit of 1 every 5 rolling years is on the benefit â€œDME â€" No PA <21 Mod â€" UEâ€ in error.	Limits were removed from MIHMS in regards to Durable Medical Equipment. These limits were configured in error.	A - Severe	Closed	5/13/2011 y	dme
TR-1005398	Code D7960 is missing from the under 21 dental benefit in OCFS.	Benefits for children being served by the Office of Child and Family Services did not include a covered dental procedure. This was updated.	A - Severe	Closed	5/13/2011 Y	DENTAL
TR-1005369	Copay: Calc for previosly paid copay needs to account for "REV" status	Copay calculations in MIHMS were not looking at reversed claims. There is a monthly cap on copayments and these claims were not being considered.	B - Major	Closed	5/20/2011 Y	All
TR-1005395	Correct Claimsteps in Copay processing to name the restriction	This change records information about copayment exemptions in the audit log of MIHMS so that it can be easily traced as to why a copayment was not assessed.	D - Cosmetic	Closed	5/20/2011 Y	All
TR-1001515	CostofShareDeductionForAProfessionalClaim - No Service with Cost of Share	Claims were not paying correctly when a member had cost of care to be applied to the claim.	C - Minor	Closed	5/24/2011 Y	All
TR-1005377	COC - Unusual scenario not calculating correct COC	Claims were not paying correctly when a member had cost of care to be applied to the claim.	C - Minor	Closed	5/25/2011 y	All
TR-1005312	Correct claimline_gap Process	Claims were not properly being funded because MIHMS was not populating needed data in a table.	B - Major	Closed	5/27/2011 Y	All
TR-1004130	Missing EIM Specialty Changes	Elder Independence of Maine and Alpha One were not able to bill for certain services under Section 96 Private Duty Nursing and Consumer Directed Attendant Services respectively.	C - Minor	Closed	6/1/2011 y	Waiver
TR-1003750	TEST with TR-5275 - Post Go-Live (Report needed by 10/1) OM: ApcDupeEdit (Overlapping Dates)	Claims were not editing appropriately for duplicates when the dates of service were overlapping.	B - Major	Closed	6/1/2011 Y	HOSPITAL
TR-1005275	Update to Duplicate Rule 6026 SP - Test 3750 with this TR	Duplicate editing was updated to look for overlapping dates of service on outpatient claims.	B - Major	Closed	6/1/2011 y	All
TR-1003699	CR 11109 (Post Go-Live) DRG: Claim is pending for edit 0150 while using rev code 0180 for inpatient claims.	Hospital contracts were updated to allow billing of leave of absence.	C - Minor	Closed	6/1/2011 y	HOSPITAL
TR-1005337	Flexi Void issue	Twelve providers payments were held in the financial system due to budget issues and a fix had to be put in place in order to void these finalized payments.	C - Minor	Closed	6/1/2011 y	All
TR-1005181	Use Service Location PT/Specialty for Xover Processing	Medicare crossover claims were not processing correctly because they were considering the provider type of the rendering provider rather than the service location.	A - Severe	Closed	6/6/2011 y	ALL
TR-1005391	Adding TOB to existing logic for Rule 532	Duplicate processing logic was updated to include assessing the type of bill code.	B - Major	Closed	6/8/2011 Y	All
TR-1005354	PROD - Edit a claim with more than 10 claim lines casuing claim line data mismatch	Claims with 10 or more claim lines were being loaded inappropriately such that the claims line numbering did not match from the portal to the MIHMS system.	C - Minor	Closed	6/8/2011 Y	All
TR-1005361	Missing Lines on Allocation Matrix for PT14	Targeted Case Management claims were not being funded appropriately.	B - Major	Closed	6/8/2011 Y	Case Management
TR-1005366	Missing COB details for External Enrollment	A correction to member eligibility erroneously removed insurance information from the members records.	C - Minor	Closed	6/8/2011 y	all
TR-1005311	Pharmacy Claims with PEND claimdetail	Certain pharmacy claims were not being processed in MIHMS for payment. The data was corrected so the claims could be paid.	B - Major	Closed	6/9/2011 y	PHARMACY
TR-1003233	PA: Claim with Modifier UB got Paid for a PA that does not match and units are utilized incorrectly	Claim was paid inappropriately as it did not match the prior authorization that was issued.	C - Minor	Closed	6/20/2011 Y	all

Defect ID	Headline	Legislative Description					
TR-1005458	Automatically exempt TPL By Provider Type and Specialty	This was deemed a change and not a defect and the change is not yet implemented.	C - Minor	Closed	6/20/2011	Y	All
TR-1005472	PROD-Scoring issue between Sections 19 and 40 when code G0154 is billed.	MIHMS was not properly identifying when skilled nursing services were provided by a home health agency vs. a private duty nursing provider.	A - Severe	Closed	6/21/2011	Y	HOME HEALTH
TR-1005198	Classification Coverage Code Conflict	Medical eligibility was being entered into MIHMS inappropriately as it was not allowed in certain combinations. This was being done manually and was not really a system defect.	B - Major	Closed	6/22/2011	y	All
TR-1005427	0071 - COBA deletes record classification	Members medicare eligibility was not being properly reported to Medicare potentially causing claims to not cross over.	A - Severe	Closed	6/24/2011	Y	All
TR-1005246	UTC#358/(UTC#367 TR-1005453) - Enrollkey having only classification and no financial eligibility	MIHMS was not appropriately loading eligibility for certain members.	B - Major	Closed	6/29/2011	y	All
TR-1005276	Correct provider data on RX claims for prov PMP000002292877	Pharmacy claims for Miller Drug were processed prior to the provider being reenrolled appropriately in MIHMS. Once provider was enrolled properly the claims were updated and paid.	B - Major	Closed	7/7/2011	Y	PHARMACY
TR-1005288	Update PRE FIN COST OF CARE	MIHMS was not paying claims where cost of care must be applied accurately.	C - Minor	Closed	7/20/2011	Y	All
TR-1005364	Add Lines to Allocation Matrix for 2011 DME Terms	Durable Medical Equipment Claims were not being paid due to fund allocation issues.	B - Major	Closed	7/26/2011	Y	DME
TR-1005375	RAC code 28 not working correctly w/ buy-in	Certain members eligibility was being incorrectly tied to the Medicare Buy-In program.	C - Minor	Closed	7/26/2011	Y	All
TR-1005091	Duplicate NABP Numbers on NABP table	NABP Pharmacy numbers sent to MIHMS by GHS were inappropriately assigned to multiple providers. Therefore certain pharmacy claims could not be paid.	B - Major	Closed	7/27/2011	Y	PHARMACY
TR-1005527	Addressing scoring between Sections 19 and 40.	MIHMS was not properly identifying when certain services were provided by a home health agency vs. a private duty nursing provider.	A - Severe	Closed	7/28/2011	Y	HOME HEALTH
TR-1005357	UTC#363 : MS SQL Server(SSIS) bug causing eligibility issue in production	MIHMS was not appropriately loading eligibility for certain members.	A - Severe	Closed	8/17/2011	Y	All
TR-1005191	UTC#351- overlapping eligibilty because of 3ab rule failing to create final void for a remainder	MIHMS was not appropriately loading eligibility for certain members.	C - Minor	Closed	8/17/2011	Y	All
TR-1005401	0155 UTC#267 PEM0027 - Invalid Citizenship Type	Member citizenship information was not being loaded appropriately in MIHMS.	B - Major	Closed	8/17/2011	Y	All
TR-1005576	PROD-"Applies to specific place of service code(s) only" flag on the benefit has been set incorrectly.	Benefits were being restricted to certain places of service inappropriately.	A - Severe	Closed	8/24/2011	Y	PHYSICIANS
TR-1004341	In Claim Header the Allowed Amount is Displaying some value but in the Service Detail the allowed amount is displaying $0	The claim header allowed amount was not adding up to the sum of the line level allowed amounts.	C - Minor	Closed	8/31/2011	Y	ALL
TR-1005450	Error while Reversing Claims	The portal was not allowing providers to reverse claims.	C - Minor	Closed	8/31/2011	Y	ALL
TR-1005514	Missing Carriers from QNXT	Certain insurance companies were not originally loaded into MIHMS at go live. Thus claims could not be edited for these insurances.	B - Major	Closed	9/7/2011	y	DENTAL
TR-1005484	Good Cause not processed for COB Dental	Claims were denying inappropriately for dental insurance when the member record indicated they should not.	B - Major	Closed	9/13/2011	Y	DENTAL
TR-1005554	Carrier EG parm sync stored procedure needs updating	MIHMS was updated to include more information about various insurance plans for proper editing.	C - Minor	Closed	9/13/2011	Y	All
TR-1005556	Updates Need to OOS Service Groups	Configuration changes were made to MIHMS for appropriate payment of Out of State inpatient services.	C - Minor	Closed	9/13/2011	Y	OOS
TR-1005000	Claims in RevSynch without Adjustments	Reversal claims were getting stuck in MIHMS waiting for a corresponding adjustment to be processed.	B - Major	Closed	9/15/2011	Y	ALL
TR-1005368	Change allocation logic to handle R&B charges for rate code members 3O and 3P	MIHMS was not properly funding claims for room and board services for certain members.	B - Major	Closed	9/16/2011	Y	Nursing Home
TR-1005410	Add lines to Exception Matrix for Rate Code 53 for Part A and B	Medicare crossover Part A and B claims were not funding appropriately for certain members	B - Major	Closed	9/16/2011	Y	ALL
TR-1005447	Missing Lines on Allocation Matrix for rev code 0189 under PT13/Spec023	Boarding Home claims were not being funded appropriately for room and board services.	B - Major	Closed	9/16/2011	Y	Boarding Homes
TR-1005389	Data Clean up - Certified Seed Claims held in Flexi due to no budget	Certain school providers did not supply the needed information to process their claims as Certified SEED. Once the budget information was received these claims were paid.	C - Minor	Closed	9/23/2011	Y	SCHOOLS
TR-1004751	PROD- Change PEND code for spenddown claims	Claims were processing inappropriately because of the standard edit that was originally used for spend down editing. The edit was changed to a custom edit so the claims would pay appropriately.	A - Severe	Closed	9/29/2011	Y	ALL
TR-1005356	Claims held in Wait Status	Certain claims were stuck in the financial system due to inappropriate processing of reversals.	B - Major	Closed	10/6/2011	Y	ALL

Defect ID	Headline	Legislative Description					
TR-1005623	Duplicate Contracts for PNMI NH, rates were not updated in the one Contract that the Provider was utilizing	A certain provider had invalid rates in their contract. This providers contract was updated.	A - Severe	Closed	10/7/2011	Y	PNMI & NH
TR-1005577	Correct Stored Procedure Fix_RX_EXT_Enrollments_Added_Via_UI	Pharmacy Insurance information was not being stored appropriately in MIHMS thus causing the MEPOPS system to not consider this insurance information when processing pharmacy claims.	B - Major	Closed	10/11/2011	Y	PHARMACY
TR-1004999	$0 Reversal claims not processing through to Financials from QNXT	Claims were not reversing appropriately when a hospital was being paid via the PIP methodology.	B - Major	Closed	10/13/2011	Y	ALL
TR-1005549	UTC#374. There are CB (DEL) with the incorrect coveragecodeid and date ranges.	Coverage information for members who have coverage under the Drugs for the Elderly program.	B - Major	Closed	10/16/2011	Y	PHARMACY
TR-1005521	Claims/Claim Reversals not being finalized in QNXT	Claims were not reversing appropriately when a hospital was being paid via the PIP methodology.	B - Major	Closed	10/16/2011	Y	ALL
TR-1005646	Edit 532_Add Check for Dental Duplicates	Duplicate procesing was not assessing quadrants when identifying dupes in dental claims.	C - Minor	Closed	10/24/2011	Y	DENTAL
TR-1005663	Add codes 99386 and 99387 to benefits 'Z-Physicians Preventive Services >21' and 'Physicians â€" Preventive Services >21 (11)'	Benefits for physician's services for members over 21 years old were updated to add certain office visit codes.	A - Severe	Closed	11/7/2011	Y	PHYSICIANS
TR-1005667	Remove the limit present on code G9007 in OCFS under the benefit 'Behavioral Health Services â€" Collateral contacts <21'	Claims for members involved with The Office of Child and Family Services were being denied for limits exceeded when OCFS does not wish to limit this service. The service is collateral contact.	A - Severe	Closed	11/9/2011	Y	MENTAL HEALTH CLINICS
TR-1005681	Rev codes 0305, 0459 and Benefit restriction group â€œDiagnosis Exclude Abortion/PCCM Referral Exemptâ€ issue	Benefits were updated to allow billing of certain emergency surgeries by hospitals.	A - Severe	Closed	11/17/2011	Y	HOSPITAL

ATTACHMENT – E

DEL Only Members:

Group A: These members are people who are between the ages of 19 and 62 and are disabled and are at 185% of FPL. These members come in two categories:

1. Not yet eligible for Part A, B and D so we pay no premium, we only share the cost of meds. We pay 80% less $2.00 the member pays the rest.
2. SSI Disabled for 24 months are eligible for Part A, B and D. We pay the Part D premium, copay, ½ of the deductible and Gap. In the Gap we pay 80% less $2.00 of the drug cost.

Group B: Members are 65 and older, 185% of FPL (they are over the income level for MSP) they have Part A, B and D. These members receive assistance with Part D premium, copay, ½ of the deductible and Gap. In the Gap we pay 80% less $2.00 of the drug cost.

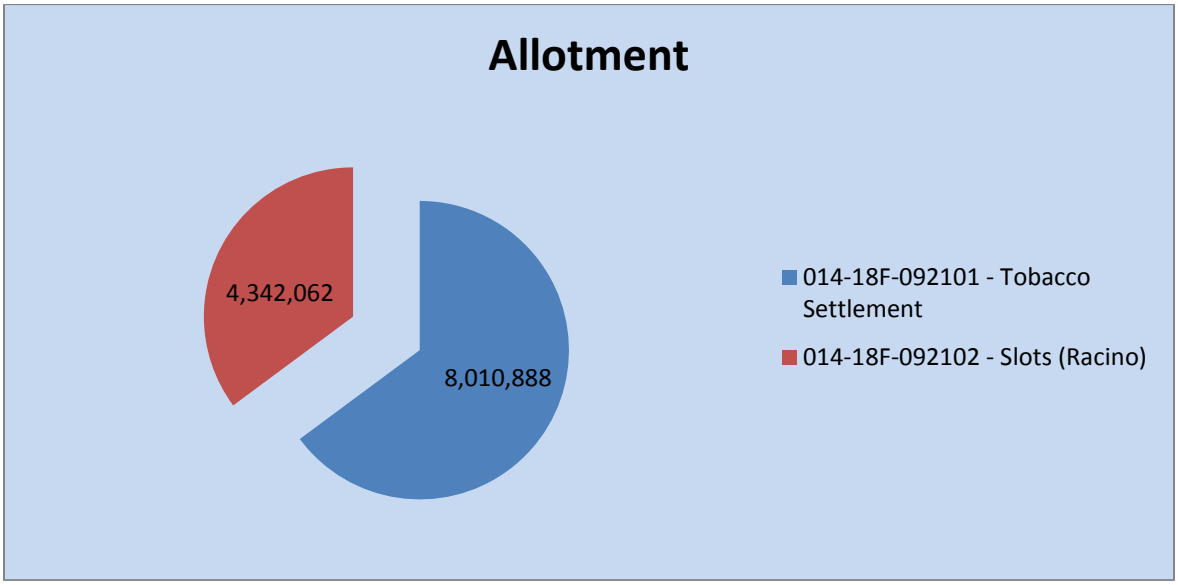
MSP/Buy-In Members:

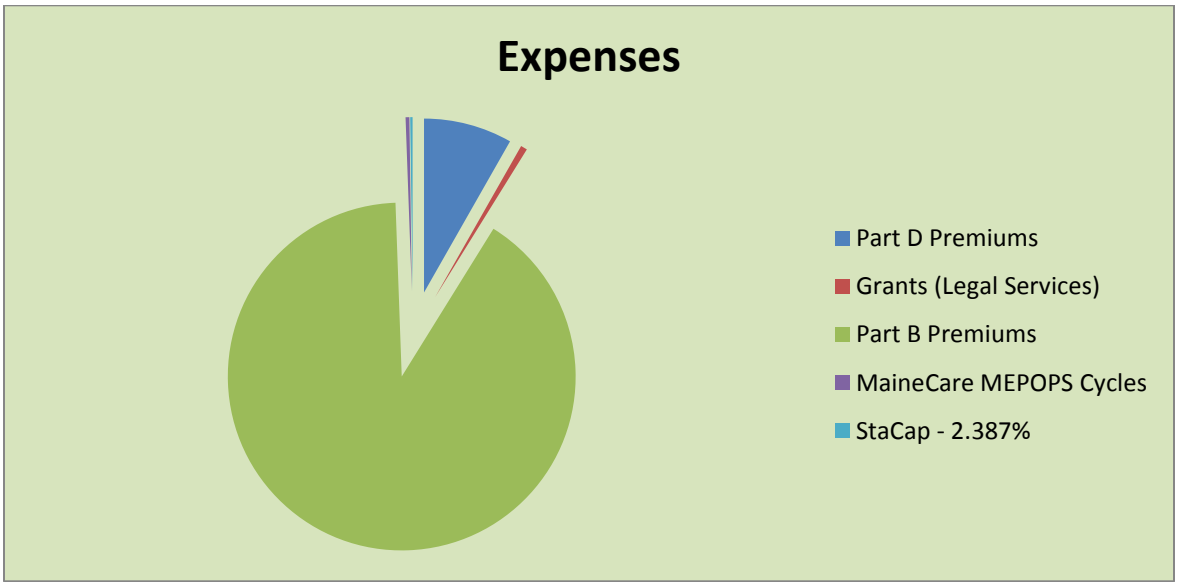
- Based on income only, no asset test
- SLMB (Specified Low-Income Medicare) receives SS, monthly income is less than $2,084.
- QMB (Qualified Medicare Beneficiary) receives SS, monthly income is less than $1,922
- QI (qualified individual) receives SS, monthly income is less than $2,347
    - Maine will pay the Part B premium
    - Feds pay the Part D Premium
    - No GAP (Donut hole) for drugs
    - $0 copay for generic drugs and $3.15 for brand name members
    - No Deductable
- Income level varies from single to couple but there is no asset test in either scenario.

Paid for under the DEL budget:

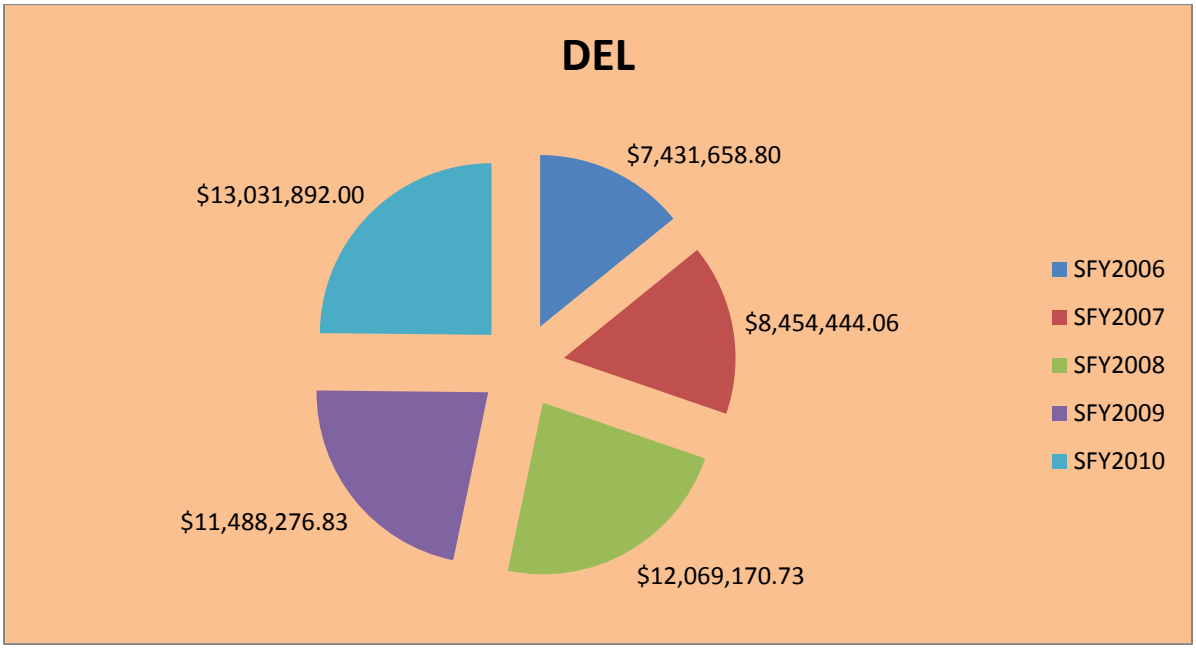
1. Goold Health Systems Contract:
    a. Process Part D Claims
    b. Enroll members into Part D plan using the IRA process
        i. IRA – Intelligent Random assignment, looks at formulary, pharmacy network, members drug history and select a plan that fits their needs of at least 80%.
    c. Create enrollment files and sends to plan
    d. Reviews invoice from plan so that we can pay by member
    e. Clinical review of formularies
2. Assist the low-income elderly in obtaining prescription drugs through leveraging participation in the Medicare Part D program by contracting with Part D plans and helping members find a plan that fits them best.
3. Pays a portion of the Part B premiums for the low-income elderly.
4. Part D Premiums

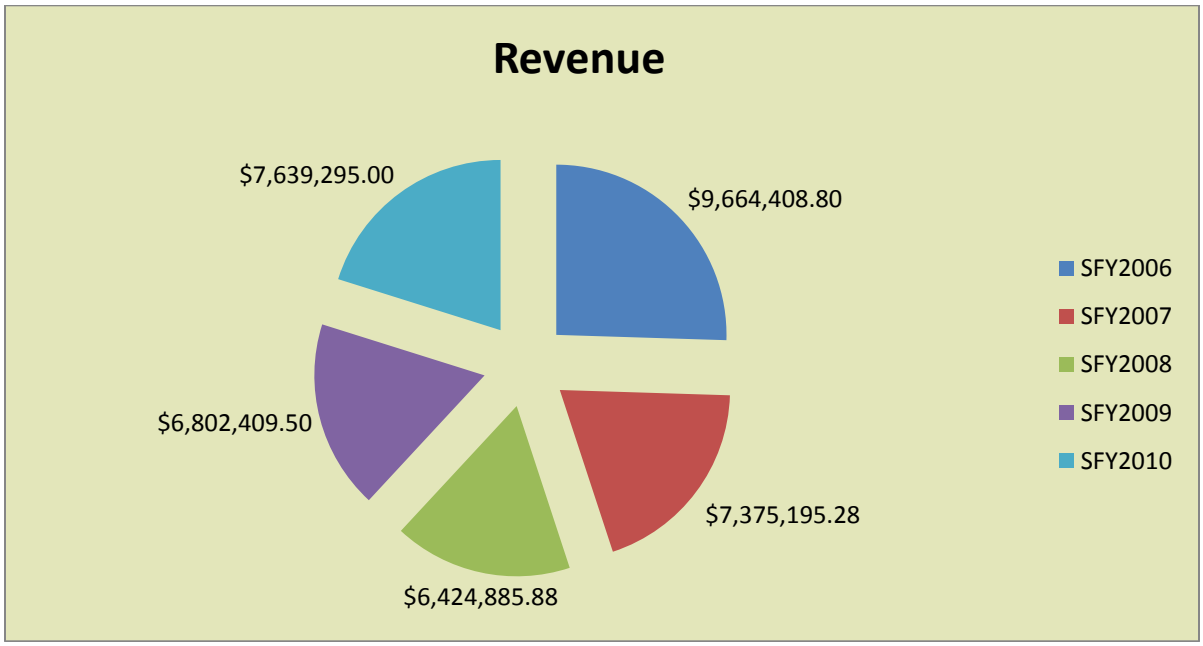
FY11 Allotment and Expenses

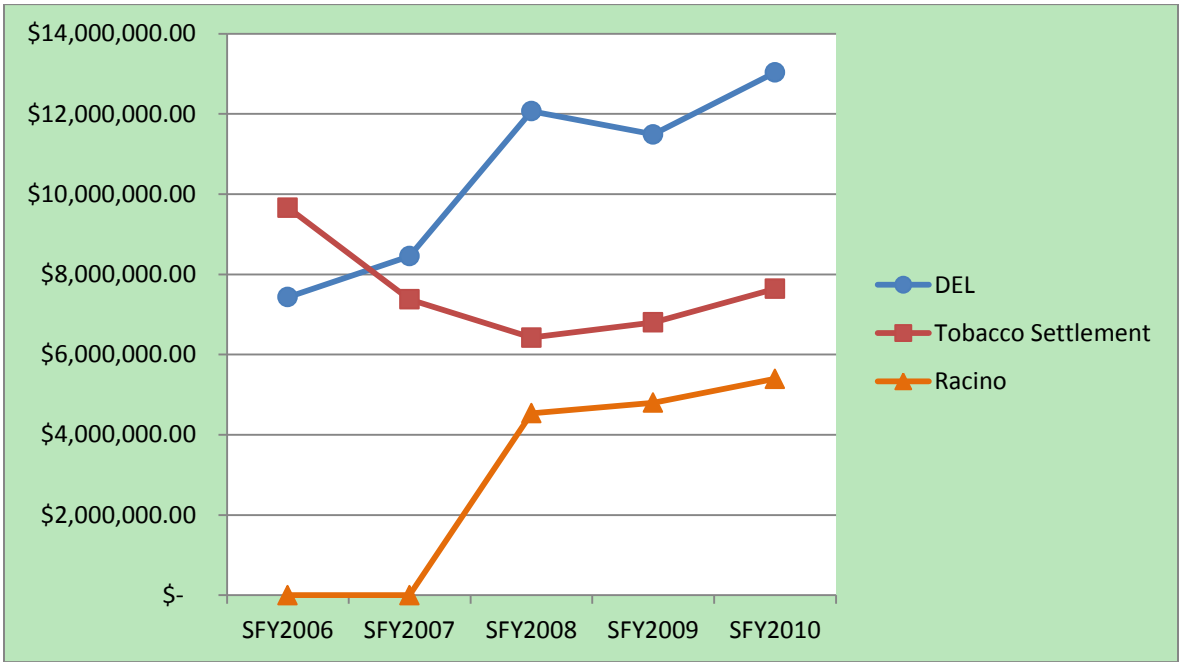




Five Year Review



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Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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

PNMI

1. Have any other states applied for and received a waiver for their PNMI structure?

   Response: Other states do not fund "PNMI" services as does Maine, since federal regulations now require that model to be through a non-risk contract that can only be reimbursed under the authority of a managed care waiver. Some states that operate their Medicaid programs differently, such as under an 1115 demonstration waiver like Vermont, may indeed cover these services differently than does Maine. Since Maine has sought to cover the majority of these services under its State Plan, it has less flexibility and must conform to the state plan requirements. The Maine model is more similar to North Carolina, which has also recently eliminated PNMI reimbursement (at the request of CMS) and is also closing facilities (to respond to a Department of Justice suit around the facility like settings that these community based services are being delivered in).

2. Provide comparison of our PNMI structure to other similar states that receive federal funding.

   Response: AARP has published a report (September 2011) that suggests that in some measures, Maine has the highest threshold of nursing facility eligibility of all states in the nation. Accordingly, in most other states, many of the services and facilities that Maine covers as "PNMI" are covered as nursing facility (NF) services. Additionally, since NF eligibility is required for other options that many states reimburse under, such as Home and Community based waivers and PACE programs, so Maine's options under the state plan are more limited. Two models used by other states that might work in Maine are nursing facility and "personal care homes."

3. Can we model our PNMI after those structures with minimal changes?

   Response: Many facilities that are currently PNMI would need substantial physical structural changes to meet NF licensing standards.

4. Discuss the impact and interconnected nature of PNMIs on veterans and veterans homes in Maine.

   Response: There are 5 veteran's homes of 30 beds each that are PNMI's. These homes are treated no differently than other PNMI's.

5. Sen. Craven – how many qualify for nursing care?

   Response: Based on the September 15, 2011 roster of Appendix C facilities, it appears that 812 of the 3132 MaineCare residents in PNMI's meet NF eligibility.

   Of the 786 PNMI residents who are non-MaineCare, 290 appear to meet the medical eligibility - these individuals are potentially NF eligible but it depends on whether they meet

financial eligibility. OES does not have access to that information. A person must beet both medical and financial criteria for NF.

6. With regard to each account under which a PNMI funding cut is proposed, does the administration have any pending waiver requests with CMS and what is the budget breakdown of each PNMI budget initiative.

   Response: There are no pending waivers with CMS regarding PNMI funding. There are several options we are investigating for all PNMI services, however given the financial challenges we face, we are looking to the legislature to establish priorities for services. Once those have been established, we will go forward with our necessary work with CMS.

7. What are the plans for providing services in the community or institutional-based to MaineCare members who are entitled to those services?

   Response: We will continue to provide MaineCare services to those who are entitled to them.

8. Does the cut impact state GF funds now used for room and board payments?

   Response: Yes, Account Z00901 MR/Elderly PNMI room and Board was taken into account under initiative # 7462 Non Medicaid Elderly in a residential setting it was not considered as part of the PNMI initiative.

9. Will additional funding be required to provide community or institutional-based services? Will this result in a funding increase or decrease?

   Response: The funding will increase in the short term. In the longer term, it's possible that models can be developed that will be less expensive.

10. With respect to the elimination of PNMIs [private non-medical institutions]. How many clients will be impacted?

    Response: 5,397 clients would be affected.

11. How many will be eligible for nursing home care?

    Response: 812 of the current clients are eligible for nursing home care. .

12. What will happen to those who are not eligible for nursing home care?

    Response: Depending on the available funding, there are several options the department is considering. We could lower the NF eligibility, apply for a waiver, changeover to personal care homes, or apply for an ISPA to cover these services.

13. Does the Administration have a plan for the relocation of clients who do not qualify for nursing home care?

    Response: The first priority will be to keep clients where they are if that is their choice. If that is not possible, we will partner with the facilities to work with the clients and their families to provide the best option.

14. Are you aware of how many facilities (both stand alone and combination) will no longer be able to operate if they lose payment for these MaineCare clients?

    Response: The Department does not have business or financial plans for each agency and therefore we are not aware of the affect losing MaineCare payment will have on each agency.

15. Has CMS given the department a date certain for which they will no longer pay for PNMI reimbursement or guidance on what they would like the department to transition to?

    Response: Our communications with CMS have been mutually cooperative and CMS has thus far not given the department a date for which they will no longer pay for PNMI reimbursement. CMS has sent consultants to educate the Department on ISPA's and waivers.

16. Please provide details and any correspondence with CMS regarding PNMI's funding and any proposed transition to other funding model?

    Response: CMS has provided documentation regarding IMD's. The communication around PNMI funding has occurred only with phone calls between CMS and the Department. The Department has not yet proposed a transition plan to other funding models. Once we have the priority of services from the Legislature we will prepare and propose a transition plan to CMS.

17. We have heard in testimony that eliminating PNMI funding for the veteran's home will result in a federal clawback - is this the case?

    Response: We do not have the answer at this time, however we are working with the Maine Veteran's Home to resolve this question.

18. We have heard that MSHA has underwritten loans of Maine PNMI's what effect will this proposal have on those loans and MSHA?

    Response: There are 350 PNMI units financed by Maine State Housing. Depending on the details, all 350 could become empty and the subsidy funding and public purpose will be lost. The exposure on the bank side is 3.38 million, and the carrying costs if all properties were to become empty could be between $500,000 and $1,000,000.

19. When the administration figured the savings from closing PNMIs did they account for the loss of the PNMI provider taxes? If so, how was that calculated? If not, why not?

    Response: The PNMI Tax reduction was included in the Initiative for PNMI's. We lowered the PNMI Tax based on the percent drop in the program from the expected drop in expenditures.

20. How many available nursing facility beds are there at the present time to accommodate the anticipated numbers?

    Response: There are 480 beds current available. However the occupancy rate is approximately 93% and as we approach 95-98% the system is stressed. There are 1,425

beds that possibly could be converted to NF beds. Most will require Fire Marshalls and DLRS site visit. This may trigger CON based upon conversion cost and interpretation on whether these beds are being added to the system. An RFP may be required.

21. We understood the Governor to say that the federal government has informed Maine DHHS that the services provided in PNMIs are no longer reimbursable. What are those services and please share that correspondence?

    Response: The communication from CMS regarding PNMI has been through phone calls only. CMS has requested that Maine move to a different reimbursement model for the delivery of these services. Services impacted are substance abuse, assisted living, children's services, adult mental health services, and services for developmental disabilities and services for brain injured clients.

22. Veterans are among the population of non-categorical and individual's receiving support from the private non-medical institutions. Do you know how many veterans will be affected and what is the administration's plan for them?

    Response: The Department does not have the number of veterans in the non-categorical population. There are 150 beds in veteran's homes that are PNMI's.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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

MOE

1. When would we need to file the MOE waiver for the 19/20 year olds, rollback of eligibility levels in savings plan and poverty levels? What is our timeline for needing the waiver to be approved so we can implement?

   Response: The submission of the waiver to the Maintenance of Effort would need to be filed immediately after the Legislature takes positive action on our budget proposals. The waiver would need to be approved by 4/1/12 in order for the Department to realize savings in SFY12.

2. The Commissioner indicated she would get them a copy of the letter that was sent to Secretary Sebelius. What correspondence has been received from Secretary Sebelius in regard to MOE waiver potential?

   Response: **Attachment F** is the letter sent by Governor LePage to Secretary Sebelius.

   There has been no direct correspondence from Secretary Sebelius in regard to receiving an MOE waiver.

3. When was the data on number of 19/20 years olds compiled in the 12/13/11 presentation? The 12/13/11 presentation showed 7,014 and Beth Hamm just indicated there are currently 8,700. This is a big difference for just a few days?

   Response: The data for the 19 & 20 year olds that was presented to the Committee on 12/13/11 was compiled the first week in December. The document Beth referred to on Tuesday 12/20/11 had incorrect data for the number of 19 & 20 year olds. OFI has completed an additional query and confirmed that the number of 19 & 20 year olds as presented to the Committee on 12/13/11 is accurate."

4. Would it be possible to have a small presentation of the ACA requirements effective 1/1/2014?

   Response: See **Attachment G.**

5. How do we fund DHHS services while waiting for a response from Secretary Sebelius?

   Response: The budget assumptions for those provisions are based on an implementation of April, 1, 2012. Should the Secretary reject the waiver request or not act by April 1, 2012, the Legislature will need to authorize the Governor to implement curtailment of spending in order to fund DHHS services.

6. What is going to happen if waiver is not approved, and does this pose a risk for all MaineCare recipients?

Response: The budget provisions would be conditional on approval of a waiver request by the Secretary of the U.S. DHHS. We believe the financial situation for the State of Maine warrants action by the Secretary. If we proceed with proposals in which Maintenance of Effort is violated there is a risk of the loss of all federal Medicaid funds.

7. Is it possible to restrict coverage for clients who do not follow what their doctor has prescribed? How do we keep our healthy outcomes as high as possible?

   Response: We do not have the flexibility to restrict coverage based on a member not following doctors prescribed treatments, however, we have implemented an ED project which is targeted at frequent users of the ED and trying to divert them to primary care versus the emergency room for treatment.

8. We note from the material you provided that a number of the issues in the supplemental budget violate a federal Maintenance of Effort provision.

   Response: The following initiatives, as noted in the fact sheets, would be MOE violations without a signed waiver from Secretary Sebilius:

   - Elimination of the coverage of 19 & 20 year olds
   - Rolling back the MSP population to the federal minimums
   - Rolling back parents to 100% FPL (we have received guidance from CMS that states it is not a vaiolation to roll back this population to 133% FPL)

9. You acknowledge that the MaineCare 19 and 20 year olds are "children" under the Affordable Care Act, meaning that their eligibility cannot be reduced until 2019. How do you propose to take these budget savings when you are not allowed cut them under federal law and no waivers have been granted allowing such a cut?

   Response: Federal regulations consider the 19 & 20 year old eligibility group as an optional coverage group. We are required from the federal perspective to cover children through age 18 if they are full time students. Our state plan currently identifies 19 & 20 years olds as children, which we intend to amend.

10. Similarly with approximately 15,000 parents with incomes below 133% FPL, the Affordable Care Act does not allow you to cut them off. Again, how do you propose to take these budget savings?*:*

    Response: We believe that with positive action from the Legislature we will be in a position to request a waiver from the Maintenance of Effort requirements of Secretary Sebilius.

11. In June you were told by CMS that you could not cut eligibility as you proposed at that time for seniors and people with disabilities getting help with prescription drugs and Medicare cost sharing through the Medicare Savings Program. Yet, you propose the very same cut again 6 months later. What makes you think you can achieve these savings?

    Response: We believe that with positive action from the Legislature we will be in a position to request a waiver from the Maintenance of Effort requirements of Secretary Sebilius. We believe there is a strong case with this population as they are not a Medicaid group, but that we are purchasing Medicare coverage.

ATTACHMENT – F

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

April 15, 2011

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Waiver of Maintenance of Effort Requirements In Section 2001(b) of PPACA

Dear Secretary Sebelius:

I am writing to ask that you grant Maine a waiver from the maintenance of effort (MOE) requirements of the Patent Protection and Affordable Care Act (ACA). Maine is a state that has been disproportionately affected by the nation's fiscal crisis in large part because of its generosity over the past several years in expanding Medicaid coverage to optional populations. Maine is dealing with declining revenues, increases in Medicaid eligibility, while preparing for healthcare reform in 2014. Our state has no option but to request a waiver from the maintenance of effort requirements for the reasons set forth below.

Maine's Medicaid program is extremely generous and in several instances has exceeded the minimum guidelines for eligibility set by federal law:

Childless adult waiver program ("Non-cat waiver"). Maine is one of just six states that covers childless adults through a waiver. Our waiver program insures approximately 17,500 adults with an annual budget (state and federal) of $80.3 million.

Medicare buy-in program. Maine, Connecticut and the District of Columbia are the only states/districts that exceed the federal minimums requirements for eligibility in the MSP (Buy-in plans) for this program. Where the federal requirement for qualified Medicare Beneficiary (QMB) is 100% of federal poverty level ("FPL"), Maine's eligibility is 150%. Where the federal requirement for specified low income Medicare beneficiary (SLMB) is 120%, Maine's eligibility is 170%. For the qualified individual (QI), the federal requirement is 135%; Maine's eligibility requirement is 185%.

Katie Beckett program. Maine covers 1,000 children in this program, at an annual cost of $ 20 million (state and federal). Maine now charges a 2% premium to parents and needs to increase the premium in order to keep this program viable.

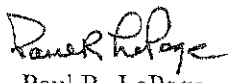
Unfortunately, Maine is unable to sustain such a generous Medicaid program, and seeks to be allowed to back down to the federal minimums for eligibility.

Maine faces a $800 million dollar deficit for fiscal years 2012 and 2013. Today, one in five Maine residents (approximately 300,000 individuals) are covered under MaineCare, Maine's Medicaid program. The proposed 2011/2012 budget includes more than $460 million in state funding just to support the loss of the significant – but temporary – American Recovery and Reinvestment Act (ARRA) enhanced federal matching funds.

Maine has taken steps to address this critical deficit issue: (1) Pursuant to Section 2001(b)(3) of ACA, it has submitted a certification that the state faces a budget deficit, which will allow Maine to reduce eligibility for non-disabled, non-pregnant adults with incomes above 133 percent of the federal poverty line; (2) Maine has attempted to manage care for high-cost enrollees; (3) Maine will be submitting a request to amend its state plan to reduce eligibility for the Medicare buy-in program because it believes this will not violate the MOE, and (4) Maine has worked to assure Program Integrity. The only viable solution to preserve the Maine Medicaid program is for approval of a waiver that exempts Maine from the MOE requirements.

The Patient Protection and Affordable Care Act maintenance of effort requirement severely restricts the manner in which states can control the costs of their Medicaid programs, and I respectfully request that you waive this requirement for the State of Maine. Thank you for your consideration and I look forward to working with you on this important effort.

Sincerely,



Paul R. LePage
Governor

cc: Rich McGreal, Richard R. McGreal, Associate Regional Administrator, CMS
Mary C. Mayhew, Commissioner, DHHS
William J. Schneider, Attorney General
Stefanie Nadeau, Acting Director, Office of MaineCare Services, DHHS

ATTACHMENT – G

CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Proposed Rule (CMS-2349-P)

Section-By-Section Summary -- September 27, 2011

MEDICAID		
Regulatory Section	**Provision**	**Summary**
§431.10, §431.11	Single State Agency. Organization for Administration.	Modifies existing regulations to allow government operated Exchanges to make Medicaid eligibility determinations. Sets forth single State agency responsibilities and written agreement requirements between State and Federal agencies when eligibility is delegated to another agency. Retains the requirement that agencies performing services for the Medicaid agency must not have the authority to change or disapprove any administration of that of the Medicaid agency. Solicits comments on potential changes regarding public agency role, particularly in the context of an Exchange operated by a nonprofit or contracting out eligibility determinations.
§433.10	Rates of FFP for program services.	Lays out the statutory Federal medical assistance percentages (FMAP) that will be available to States for coverage of low-income adults with incomes below 133% of the FPL ("newly eligibles") beginning on January 1, 2014 and the conditions under which these matching funds will be available. Defines "expansion States" and discusses the FMAPs available for such states.
§433.202, §433.204	Scope and Definitions Related to FFP for "Newly Eligibles"	Defines "newly eligible" for purposes of the increased FMAP available for coverage of newly eligible individuals beginning in 2014.
§433.206	Choice of Methodology. (FMAP)	Provides three potential approaches States may select in order to ensure that the appropriate FMAP is claimed for newly eligible individuals beginning in 2014:"threshold" methodology, "statistically valid sampling" methodology, and "CMS established FMAP proportion" methodology.
§433.208	Threshold methodology. (FMAP)	Provides the parameters for the threshold FMAP approach.

CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Proposed Rule (CMS-2349-P)

Section-By-Section Summary -- September 27, 2011

Regulatory Section	Provision	Summary
§433.210	Statistically valid sampling methodology. (FMAP)	Provides the parameters for the statistically valid sampling FMAP approach.
§433.212	CMS established FMAP proportion.	Provides the parameters for the data-based FMAP approach.
§435.4	Definition and use of terms.	Revises the definition of "families and children" and adds definitions of "advance payments of the premium tax credit," "Affordable Insurance Exchange," "agency," "caretaker relative," "dependent child," "effective income level," "electronic account," "household income," "insurance affordability program," "MAGI-based income," "minimum essential coverage," "modified adjusted gross income," "pregnant woman," "secure electronic interface," and "tax dependent."
§435.110	Parents and other caretaker relatives.	Revises the existing section 1931 eligibility category for low-income families to create a simplified parent/caretaker relative eligibility category that uses MAGI-based income standards. Provides for a simplified income standard for this group.
§435.116	Pregnant women.	Combines six existing eligibility groups for which pregnancy status and income are the only factors of eligibility to create a simplified pregnant women eligibility category that uses MAGI-based income standards. States may provide pregnancy-related services to women whose income is above the State-established standard for full coverage of pregnant women.
§435.118	Infants and children under age 19.	Combines seven existing eligibility groups for which age as a child and income are the only factors of eligibility to create a simplified children's eligibility category that uses MAGI-based income standards. Provides a simplified income standard for infants, children ages 1-5, and children ages 6-18 under this group.

CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Proposed Rule (CMS-2349-P)

Section-By-Section Summary -- September 27, 2011

Regulatory Section	Provision	Summary
§435.119	Coverage for Individuals ages 19-64 with income at or below 133 percent FPL.	Creates the new eligibility group for individuals over age 18 and under age 65, who are not pregnant, not eligible for any other mandatory eligibility group, and not enrolled in or entitled to Medicare, whose household income does not exceed 133% FPL using a MAGI-based income standard. Provides that coverage for a parent or caretaker relative may only be provided if all dependent children are enrolled in Medicaid, CHIP or other minimum essential coverage.
§435.218	Individuals above 133 percent FPL.	Creates a new optional eligibility group for individuals under age 65 who have income above 133% of the FPL using MAGI-based income standards and are not eligible for any other eligibility group based on the information provided on the application. Provides that States establish the upper income limit for eligibility and may choose to phase-in coverage over time.
§435.403	State Residence.	Revises and aligns the definition of residency for most adults and children to be consistent with the definition being proposed in the Exchange rule.
§435.603	Application of Modified Adjusted Gross Income (MAGI).	Implements the use of MAGI-based methods in determining Medicaid eligibility beginning in 2014. In nearly all cases, provides that States adopt tax MAGI rules to determine income in order to align with the proposed rule for premium tax credits available through the Exchanges; identifies the few areas in which MAGI-based income calculations for purposes of Medicaid eligibility diverge from tax rules. Defines which individuals in a household are included in the calculation of household income. Specifies that assets tests and disregards (except for the across-the-board disregard of 5% FPL) will no longer be permitted in determining eligibility for individuals for whom MAGI rules apply. Identifies populations exempt from application of MAGI and for whom current Medicaid financial methodologies would continue to be applied.

Regulatory Section	Provision	Summary
§435.905	Availability of program information.	Adds "electronic" as a format in which program information should be made available to the public (in addition to the paper and oral formats currently provided for).
§435.907	Application.	Establishes a key element of the streamlined, coordinated eligibility determination system with options for individuals to apply via the internet, by phone, mail, fax, and in person. Provides for the use of either the single streamlined application for all insurance affordability programs developed by the Secretary or an alternative streamlined application developed by the State and approved by the Secretary. Provides for the use of supplemental forms or an alternative application for use by individuals whose eligibility is not MAGI-based. Proposes that Social Security Numbers (SSNs) may not be required for non-applicants, but permits that SSNs be requested on a voluntary basis. (Current rules that require SSNs for applicants are retained.)
§435.908	Assistance with application and redetermination.	Codifies that States will assist individuals with completing the application and redetermination process through a variety of means, including by phone, by mail, on line and in person. Provides that the assistance be accessible to individuals living with disabilities and those who are limited English proficient.
§435.911	Determination of eligibility.	Provides that individuals under 65 applying for coverage be first evaluated for Medicaid eligibility using simplified, MAGI-based income standards. Individuals not eligible based on MAGI must be evaluated for Medicaid eligibility through other pathways (e.g. disability, assistance with Medicare cost-sharing) and enrolled in a qualified health plan through the Exchange with advance payment of a premium tax credit as appropriate.

Regulatory Section	Provision	Summary
§435.916	Periodic redeterminations of Medicaid eligibility.	Provides that eligibility be redetermined once every 12 months, unless information becomes available to suggest an earlier review. Provides for a data-driven review using information already available to the agency in the electronic account or from other reliable data sources. For individuals whose eligibility cannot be renewed based on available information, a streamlined, pre-populated form must be provided and individuals would have the opportunity to respond online, by phone, mail, or in person. Provides that individuals determined ineligible for Medicaid will be assessed for eligibility for other insurance affordability programs and for electronic transfer of account information. Provides for timely reporting of and action on changes in an individual's circumstances.
§435.940, §435.945	Basis and scope. General requirements. (Verification)	Proposes rules for verifying eligibility to achieve a data-driven, coordinated eligibility and enrollment process consistent across insurance affordability programs, and also meet statutory requirements in place prior to the Affordable Care Act. Codifies existing policy regarding attestation of information.
§435.948	Verifying financial information.	Provides that when verification is needed, States access data through electronic sources. If such data is not available, States may request additional information, including paper documentation, from individuals. Retains current rules regarding electronic data sources required under §1137 of the Act to access when useful to verifying income.
§435.949	Verification of information through an electronic service.	Directs the Secretary to establish an electronic service through which States will obtain information from other federal agencies to verify eligibility for Medicaid or other insurance affordability programs. Provides that States obtain relevant information through the electronic service if available and that States may propose alternative mechanisms for collecting and verifying information.

Regulatory Section	Provision	Summary
§435.952	Use of information and requests of additional information from individuals.	Lays out the process for States to promptly evaluate the information received through the data sources and from the applicant as necessary. Provides that additional verification (including paper documentation) will only be sought if information obtained via electronic data sources is not reasonably compatible with information provided by the applicant or is not otherwise available.
§435.956	Verification of other non-financial information.	Provides that States are permitted to accept self-attestation to verify residency and other non-financial eligibility criteria, except for citizenship and immigration status; immigration documents may not be used as the only source for verification of residency; and States shall accept self-attestation of pregnancy, age, and birth date unless the State has information that is not reasonably compatible with the information provided by the applicant.
§435.1200	Medicaid agency responsibilities.	To ensure coordination of coverage across insurance affordability programs, provides that States enter into agreements with other agencies providing health coverage. Provides that individuals have access to coordinated information on their coverage options and the ability to conduct business with the State through an Internet website that is accessible to individuals with disabilities and who are limited English proficient. Provides for electronic transfer and prompt eligibility determination for individuals identified as eligible for Medicaid by any of the other insurance affordability programs, and vice versa. For individuals who are being determined eligibility on a basis other than MAGI, such as disability, provides for coordinated a coordinated eligibility determination for other insurance affordability programs while a Medicaid determination is pending. Provides that the Medicaid agency will certify for the Exchange all criteria necessary for it to determine Medicaid eligibility.

CHIP		
Regulatory Section	**Provision**	**Summary**
§457.10	Definitions and use of terms.	Replaces the term "family income" with "household income," adds definitions for "Affordable Insurance Exchange," "household income," "insurance affordability program," "modified adjusted gross income," "secure electronic interface," and "single, streamlined application."
§457.80	Current State child health insurance coverage and coordination.	Provides that CHIP programs will ensure coordination with other insurance affordability programs, both in determining eligibility for those programs and in ensuring that individuals do not experience gaps in coverage.
§457.300, §457.301, §457.305	Basis, scope and applicability. Definitions and use of terms. State plan provisions.	For consistency and coordination, applies the Medicaid eligibility and enrollment provisions in the NPRM to separate CHIP programs. Provides for coordination with the Exchanges and adds new definitions of "family size," and "Medicaid applicable income level." Provides that the CHIP state plan include a description of the State's methodology for determining MAGI for CHIP children as well as the policies regarding enrollment and disenrollment.
§457.310	Targeted low-income child.	Modifies the definition to provide that a child determined ineligible for Medicaid as a result of the elimination of income disregards be considered a targeted low-income child eligible for CHIP.
§457.315	Application of modified adjusted gross income and household definition.	Provides that CHIP programs will use the new MAGI-based financial methodologies, consistent with the MAGI-based methods to be used in Medicaid, in determining eligibility for CHIP.
§457.320	Other eligibility standards.	Provides that CHIP programs use a modified residency definition consistent with Medicaid and the Exchange.

Regulatory Section	Provision	Summary
§457.330	Application.	Provides that CHIP programs will use the same single, streamlined application that is being developed for purposes of enrolling in health coverage through the Exchange and Medicaid. Provides that the application may only request a Social Security Number for non-applicants on a voluntary basis and in a manner that makes clear how the SSN will be used and that it is not required as a condition of eligibility for the child.
§457.335	Availability of program information and Internet Web site.	Provides that States furnish, in electronic and paper formats and orally as appropriate, information about CHIP eligibility requirements, covered benefits, and other program rules available to all applicants. Provides that all materials will be accessible to individuals with disabilities and those who are limited English proficient and that the State will maintain a website presence designed to assist CHIP enrollees and applicants in applying for the program and renewing their coverage, as well as selecting a health plan.
§457.340	Application for and enrollment in CHIP.	Provides that States afford families an opportunity to apply for CHIP coverage without delay using a single, streamlined application and enrollment assistance must be offered. Assistance will be provided through a variety of means including by phone, by mail, online and in person. Provides that SSNs would be required for all CHIP applicants (but not required for non-applicants), in order to align with Medicaid rules. Provides that States determine the effective date for CHIP eligibility to ensure coordination and transition between programs and to avoid gaps or overlaps in coverage.

Regulatory Section	Provision	Summary
§457.343	Periodic redetermination of CHIP Eligibility.	Provides that eligibility be redetermined once every 12 months unless information becomes available to suggest an earlier review. Provides for a data-driven review using information already available to the agency in the electronic account or from other reliable data sources. Provides that individuals determined ineligible for CHIP will be assessed for eligibility for other insurance affordability programs and provides for electronic transfer of account information and the timely reporting of and action on changes in an individual's circumstances.
§457.348	Determination of Children's Health Insurance Program eligibility from other applicable health coverage programs.	Provides that for individuals identified as eligible for CHIP by any of the other insurance affordability programs, the agency will receive account information electronically and complete an eligibility determination without delay. Gives States the option to accept eligibility determinations for CHIP from all insurance affordability programs. Provides that the CHIP agency will certify for the exchange all the criteria necessary to determine CHIP eligibility.
§457.350	Eligibility screening and enrollment in other insurance affordability programs.	Provides that the CHIP State plan include a description of the coordinated enrollment system to ensure effective screening for all other insurance affordability programs. Provides that for individuals identified as eligible for Medicaid or other insurance affordability programs, account information will be promptly transferred electronically to the appropriate program. For individuals potentially eligible for Medicaid on a basis other than MAGI, provides that the CHIP agency will complete a CHIP eligibility determination while the Medicaid eligibility determination is pending. Provides that States have the option to allow CHIP programs to make eligibility determinations for advance premium tax credits for the Exchange.

Regulatory Section	Provision	Summary
§457.353	Monitoring and evaluation of screening process.	Provides that States monitor and establish a mechanism to evaluate the process to ensure that children who are screened potentially eligible for a particular coverage option are in fact enrolled in that coverage without delay.
§457.380	Eligibility verification.	Provides that, in parallel to the Medicaid provisions regarding data-driven verification, States are permitted to accept self-attestation to verify residency and other non-financial eligibility criteria, except for citizenship and immigration status. Permits additional verification, including paper documentation, when information obtained via electronic data sources is not reasonably compatible with information provided by the applicant or is not otherwise available.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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

Fraud and Abuse

1. **Do we have enough resources? The Commissioner indicated that we would provide recommendations on systems to prevent, investigate, prosecute, and communicate fraud and abuse. Are there deficiencies in the system that we are preparing to resolve?**

   Regarding recipient fraud, the Fraud Investigation and Recovery Unit (FIRU) is currently stretched for resources to meet the increased numbers of incidents that are currently being reported. Current resource constraints limit the unit's ability to efficiently investigate reports of fraud and abuse, as well as limiting the ability to effectively collect debts owed to the state.

   In terms of Provider fraud, the Program Integrity Unit (PI) has increased in staffing from six to 15 people during the last three years. In addition, there are other initiatives in place that will assist in the review of Medicaid programs. A contract with a recovery audit contractor (RAC) will begin in calendar year 2012 and will increase the number of audits performed beginning in 2012. The Medicaid Integrity Group (MIG) will also perform audits in the future. It is premature to determine if resources are adequate at this time.

2. **How many cases were received, who was the source, number of those cases which were valid, and the number of those cases which were sent to the AG Office for the past 10 years?**

   Historical information of this type of information is not available regarding recipient fraud. The Office of the Attorney General has provided the following statistics:

	2009	2010	2011
Cases Referred		10	32
Indictments	4	6	12
Convictions	6	8	10
Restitution Ordered	$58,037.00	$92,339.49	$176,308
Restitution Recovered	$ 5,171.00	$25,280.37	$48,883.14

   In 2010, 1,200 reports of fraud and abuse were received and in 2011, we have received approximately 2,100 reports.

   PI does not investigate fraud and abuse. It refers cases of suspected fraudulent activity to the Medicaid Healthcare Crimes Unit, which serves as Maine's Medicaid Fraud Control Unit (MFCU).

   We have referred 105 cases to MFCU over the last 10 years. The origination breakout is as follows: 33 complaints, 7 from licensing boards, 7 from MFCU, 1 from the Office of Program Evaluation and Government Accounting (OPEGA), 32 identified by PI, 5

provider referrals, 18 referrals from unidentifiable sources associated with our recording process and 2 referrals from the U.S. Attorney's Office.

3. **How many employees do we have working in fraud and abuse? Has this changed in the past 10 years and why?**

The FIRU currently comprises of the Director, one Office Assistant, one Office Associate (currently vacant) and nine Fraud Investigators. In 1991-1992, there was one additional Office Assistant and two additional Investigators in the unit.

PI does not investigate fraud and abuse. Staffing for the PI unit has grown from six employees to 15 employees during calendar years 2008 to 2009. There are currently 13 staff and two vacant positions in the process of being filled.

4. **Prior to October 2011 there was a different phone number being used to report fraud and abuse, what was the number of calls received over the past 10 years on that phone number compared to the number received on the new number?**

Prior to October of 2011, the number of reports of fraud and abuse was not broken down by type (phone, email, internet). With the creation of the new toll- free number, FIRU is recording the source of the report. Prior years averaged approximately 1,000 reports of fraud but for 2011, the number has grown to 2,100.

PI does not have a dedicated line for fraud and abuse. Calls came in on our regular line. All calls are screened and disseminated base on category of call type. Reports of suspected fraud or abuse I are reviewed and forwarded to the MFCU.

5. **The Commissioner indicated that we would provide more detailed information with regard to abuse vs. cases that rise to the level of intent to defraud.**

Fraud involves an individual creating, reinforcing or failing to correct a false impression in order to obtain benefits he/she would not otherwise be eligible to receive. The term "abuse" is typically used to mean using a loophole in the program rules to get a benefit which is not within the intent or spirit of the program but is not a violation of program rules.

Examples of fraud would include a recipient representing himself to be unemployed while gainfully employed. Examples of abuse would include a recipient using TANF benefits to buy alcohol or tobacco products.

Approximately 20 percent of reported incidents of fraud are found to represent only perceived abuses, not meriting investigation. Of the remaining 80 percent, the majority are determined to be unfounded or immaterial. Those found to be worth further action are pursued for administrative action (e.g., recovery) or criminal prosecution.

6. **How many applicants are there for each program, and the number approved and number rejected?**

Program	Monthly Applications (12- month average)	Granted	Denied
TANF/Parents as Scholars	1940	67.5%	32.5%
Food Supplement	7791	86.5%	13.5%
MaineCare	6221	73.8%	16.2%

How many errors have been made on applications and by whom?

All errors that resulted in overpayment of TANF or Food Supplement in calendar year 2010 are:

Agency Errors	1,365
Client Errors by Type:	
• Unintentional Household	1,997
• Intentional Program Violation	129

Once errors are discovered, how many repay the system through garnishment of benefits?

As of 12/1/2011, 2,967 household were repaying overpayments by benefit reduction. In calendar year 2010, $1,317,831 was recovered by benefit reduction.

7. **Is there a website Maine citizens can use to determine whether there is fraud or abuse going on**?

See **Attachment H**. This is found at the DHHS webpage under Hot Topics – Reporting Fraud. This will not allow a person to determine fraud and abuse, but will allow investigators to review the facts and make a determination.

8. **What can we provide to the citizens of Maine for more education on detecting fraud and abuse?**

The Fraud and Abuse Task Force is working on providing information to assist the public in identifying potential fraud and abuse so they can report it. Program rules are complex and we encourage the public to report what they perceive as fraud or abuse to give investigators a chance to review and assess specific circumstances.

9. **AFA would like a copy of our intake form.**

Attachment I is a mock example of the application taken in the office. When an applicant comes into the office to apply, he/she completes an interview with the Eligibility

Specialist. The application is then printed out for the applicant to review and sign. **Attachment J** is the final application signed by the applicant and the eligibility specialist.

10. **The Governor indicated at a forum last week that a significant portion of the shortfall is due to fraud.**

The Governor's remark was taken out of context and was in response to a question unrelated to the shortfall. What the Governor has repeatedly said is that every dollar that is spent on someone who does not qualify for benefits takes funding away from the truly needy and the state needs to stop that from happening.

11. **Have there been any investigations of fraud in regards to MaineCare providers?**

There have been a number of provider fraud cases over the last 10 years. Due to reporting Methodologies in PI, we can only identify the cases that have had court-ordered repayments. In the last 10 years, this totals 16 cases.

12. **Have there been instances of fraud reported by DHHS employees?**

We do not record reports of fraud made by employment location. If an employee believes that a person applying for benefits is potentially committing a fraudulent act, he or she typically will take the application when presented and alert a supervisor of suspicious activity.

13. **Are frontline employees being trained properly?**

Front-line staff receives three months of training before they start a caseload. Once they have begun working in the field, they are closely monitored by their supervisor.

We are in the process of revising training and performance expectations of new staff. This will include observation of interviews by supervisors, who will give feedback and guidance to the new staff. The new employee will not become a permanent employee until the supervisor is satisfied with their interviewing skills.

We are also working with Staff Education and Training to develop customer service standards and training modules to enhance skills of veteran staff.

Quality assurance training?

Correct decision-making and good judgment are part of the training and evaluation process. The accuracy of Food Supplement and MaineCare determinations is monitored by the Quality Assurance Unit, which provides regular feedback to District staff on common errors and trends.

The Commissioner indicated that we need to follow-up with employees after training on the interview process.

This is the new part of the employee development and evaluation process whereby the supervisor observes actual interviews by the employee and provides feedback.

14. **How do we handle the problem of clients giving their EBT card to others?**

Federal Food Supplement rules allow the head of the household to authorize purchases by a non-household member, so long as the purchases are for the consumption of the household.

For example, an elderly person could give his/her EBT card to a son to shop for groceries so long as those groceries are for the household of the elderly person.

A high priority issue is the selling of EBT cards. We are in the process of putting explicit language on the card to state that use of this card for anyone outside the household of the person named on the card is prohibited and will be prosecuted to the fullest extent of the law. This language will increase the likelihood of successful prosecution of those who buy cards from recipients. We are also reviewing data in the Electronic Benefit Transaction system to identify those individuals who may be selling their EBT cards or selling the benefits on their card.

15. **Would it be possible to require the client to show a driver's license/picture ID?**

Federal Food Supplement rules prevent a recipient from being treated differently than a non-Food Supplement recipient. Unless a store requires all customers to show picture ID when using a debit card, FNS will not allow us to establish rules that single out recipients in this manner.

As stated above, food can be purchased in Food Supplement by a non-household member. This could be a requirement of TANF recipients, however, both TANF and Food Supplement benefits are placed on the same EBT card. A picture ID would not serve as a deterrent because cash would still be able to be obtained at any Automated Teller Machine (ATM).

16. **How do we address the issue of allowing benefits to someone who has a live-in boyfriend?**

This would require a change in federal law. Food Supplement rules allow for non-relatives to declare themselves as a separate household from the applicant/recipient.

TANF and MaineCare define a household by legal relationship (parent/child, spouse/spouse, grandparent /grandchild). There is no legal relationship between a boyfriend and girlfriend who live together unless they have a mutual child. If they have a mutual child, then both adults and their financial circumstances are considered to determine eligibility.

17. **How much money have we recouped from fraud in the past few years?**

The FIRU does not track recovery on cases that are a result of a fraud conviction versus other overpayment errors. We do track recovery of overpaid benefits for any reason. Over the past five years, we have recovered approximately $2 million annually. PI has had $4,468,454 in court-ordered recoveries identified.

18. **What are the statistics for the amount of dollars we have recovered for consumer fraud vs. provider fraud? Average amount per consumer vs. provider?**

This question is partially answered in question 15. In addition, in the FIRU, since tracking was initiated in the Automated Client Eligibility System, benefits have been recovered from 26,901 recipients at an average of $757.39 per recipient. These recoveries include agency errors, unintentional household errors, intentional program violations and fraud convictions. In PI, as stated above, court-ordered payments associated with fraud and abuse totaling $4,468,454 from 16 cases is an average of $279,278 per case.

19. **Please provide recommendations of increases to investigators to clear the backlog of investigators or to contract that out.**

The Fraud and Abuse Task Force will make appropriate staffing recommendations.

20. **Information on trends of number of complaints and their source.**

Complaints of fraud and abuse have more than doubled from an average of 1,000 per year to over 2,000 for 2011. Source tracking just began so there is no historical data to provide.

21. **Provide details on definition of fraud, cases which would be prosecuted and cases that would constitute a program violation. What are the rules/penalties for fraud and abuse?**

Fraud must include intentional deception or misrepresentations, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits.

The definitions of an intentional program violation for both TANF and SNAP follow the definition of fraud, above.

Intentional Program Violations that involve more than $1,000 in overpayment (thereby constituting a felony) or those that are particularly egregious are most often prosecuted by the Attorney General's Office. The penalties vary by date of violation, first or subsequent offense and amount of overpayment.

ATTACHMENT – H

How do I report fraud/abuse? Options are:

1. Complete the online form located at the following site: https://www.maine.gov/dhhs/fraud/
2. Call the toll free Fraud Hotline number at **1-866-348-1129.**

All reports of fraud and abuse will be fully investigated. Please note that confidentiality laws do not allow us to share findings back to those who report potential fraud or abuse.

What Constitutes Fraud?

- **In the MaineCare Program:**

The MaineCare Benefits Manual, Chapter I, § 1.20-1 defines fraud as:

> "Fraud includes intentional deception or misrepresentations, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits. The requisite intent is present if the misrepresentation was made knowingly or with reckless disregard for the truth".

- **For Eligibility:**

Examples of the various types of fraud are:

Provider Fraud and Abuse

Examples include: billing for services not delivered; overbilling for services.

Member or Client Fraud and Abuse:

Examples include: Inappropriately seeking drugs by going from doctor to doctor; obtaining prescribed medication and selling it to another party; buying medications from a MaineCare member.

Eligibility fraud and abuse:

This covers MaineCare and other benefit programs like the Food Supplement Program and TANF:

Examples include: Receiving services or other benefits by falsifying information; not reporting income; not reporting changes in household size and income; not reporting assets (trusts).

Who investigates fraud?

MaineCare Provider Fraud is investigated by the Program Integrity Unit and the Healthcare Crimes Unit in the Attorney Generals' Office. If you have a question on whether or not an activity may be fraud you can reach the Program Integrity Unit at 1-207-287-4660.

Eligibility Fraud is investigated by the Fraud Investigation and Recovery Unit. They can be reached at 1-207-287-2409 or 1-800-442-6003.

ATTACHMENT – I

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Application for Food Stamps, TANF, PaS, or MaineCare

If your primary language is other than English, please list:

You only need to answer questions that concern the program(s) for which you are applying.

For Food Stamps, to immediately file this application we must have your name, address, and signature (or that of an authorized representative). If eligible, your benefits will begin from date of application.

Your Name (First, Middle, Last)	Maiden	Social Security #	Birthdate-(Mo/Day/Yr)
Mailing Address: Street, PO Box, RR or RFD (Include apartment number, care of, etc.)			Safe Delivery Address? No □ □ seY
City	State	Zip Code	Telephone/Message Number
Street, address and town where you actually live, if different			

Have you or anyone in your household ever received Food Stamps, TANF or PaS and/or MaineCare? No □ Yes □

Who: Where: When:

Is this person fleeing to avoid prosecution or confinement for a felony or violation of probation or parole?

Who? Where? When? No □□ seY

Is anyone 65 years or older? ⟶ No □□ seY

Is anyone disabled? ⟶ No □□ seY

Name(s): _____

Is anyone blind? ⟶ No □ □ seY

Name(s): _____

Is either parent unemployed? ⟶ No □ □ seY

Does anyone receive SSI? ⟶ No □ □ seY

Did anyone ever receive SSI? ⟶ No □ seY □

Name(s): _____

Is anyone pregnant? ⟶ No □□ seY

Name(s): _____

Due Date(s): _____

If your household has little or no income, you may be able to receive Food Stamps within a few days. If so, answer the following questions, complete and sign this application form.

How many people, including yourself, live in your home and purchase and prepare meals with you? _____

How much is your rent or mortgage? ⟶ $ _____

How much are your utilities? ⟶ $ _____

Do you pay separately for heat? ⟶ No □ seY □

Has anyone received HEAP Fuel Assistance at your current residence since last October? ⟶ No □ □ seY

Are everyone you are applying for homeless and without free shelter? ⟶ No □ □ seY

Did all of the household income stop recently? ⟶ No □ seY □

What is the total income you expect your household to receive this month? ⟶ $_____

How much do the members of your household have in cash or savings? ⟶ $_____

Is anyone in your household a migrant or seasonal farm worker? ⟶ No □ seY □

I understand and agree to provide documents to prove what I have stated. **I understand and agree that the information I have given may be verified by federal, state and local officials or other persons and organizations. If I have given incorrect information, my application may be denied and I may be charged with giving false information.** I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules in the penalty warning. **I certify under penalty of perjury that my answers, including those concerning citizenship or alien status, are correct and complete for all persons applying for benefits.**

_____ _____ _____ _____

Applicant's Signature Date Interviewer Date

Please list if you have a Guardian, Conservator or Authorized Representative or someone who knows your financial situation whom you would like us to contact to help us determine if you are eligible:

Name: _____ Address: _____

Telephone Number: _____ _____

Expedite: No □ ;noitacifireV .D.I :rekroW □ seY

Residence Verification: _____

Date received: _____ Date logged on: _____ 45th day: _____

Check what you want for each person.

Questions on this application apply to members of your household. This includes you, your spouse, and everyone else for whom you are requesting assistance. Please print answers.

Verification of information may be required.

For Food Stamps: if eligible, you will receive reporting requirements. To receive a credit for some expenses, such as child support paid, medical expenses (for elderly or disabled members) or fuel assistance (HEAP), you may be asked for verification. Failure to report or verify such expenses at application or review (or at other times you need to report) may mean you will receive less Food Stamp benefits each month. This will be seen as your statement that your household does not want to receive credit for the unreported or unverified expense.

Food Stamps	TANF	PaS	MaineCare	Last Name / Maiden Name	First Name	MI	Jr./Sr.	Social Security Number	Birthdate Mo/Da/Yr	Age	Sex M/F	Relation to you
				APPLICANT PERSON ALREADY LISTED ON PAGE ONE								SELF

Please list place of birth for each person for whom you are requesting assistance.

First Name	Place of birth	First Name	Place of birth	First Name	Place of birth

Please complete a section for each adult applying for benefits. This information is voluntary. Your benefits will not be affected if you do not answer.	Applicant	Second Adult
Are you an American Indian or Alaskan Native? Circle the tribe you belong to: 1. Houlton Maliseet 2. Peter Dana Pt. Passamaquoddy 3. Pleasant Point Passamaquoddy 4. Penobscot 5. Aroostook Micmac 6. Other	No ☐ ☐ seY ☐ oN	☐ seY
Do you live on your tribe's reservation?	No ☐ ☐ seY ☐ oN	☐ seY

Please list anyone else who lives with you for whom you are not requesting assistance.

Name	Birthdate Mo/Da/Yr	Sex M/F	Relation to you	Amount paid to you (if applicable)	How often Paid?

List your shelter expenses. Do not include past due payments and Security Deposits.

	How Much	How Often		How Much	How Often		How Much	How Often
Rent			Lot Rent			Cooking Fuel		
Heat			Mortgage			Water		
Electricity			Property Taxes			Sewer		
Telephone (basic)			House Insurance			Trash Collection		

Is your heating cost included in your rent? → No htiw uoy depleh ecnatsissA lareneG saH☐ seY ☐

Has anyone received HEAP Fuel any of these expenses in the last 6 months? ⟶ No ☐ Yes ☐

Assistance at your current residence?⟶ No ☐ dna sexat edulcni egagtrom ruoy seoD☐ seY

Do you live in public housing? ⟶ No ☐ ☐ seY ☐ oN→ ?ecnarusni esuoh☐ seY

Do you receive a rent subsidy? ⟶ No ☐ lla yap dlohesuoh ruoy edistuo enoyna seoD☐ seY

How much?_____ How Often? _____ or part of these bills? ⟶ No ☐ seY ☐

If yes, who? _____

Single Married Separated Divorced Widowed	Use one or more of the following codes. Your benefits will not be affected if you do not answer. For Ethnicity: P-Hispanic/Latino or blank for none. For Race: W-White, B-Black or African American, O-Asian, I-American Indian or Alaskan Native, H-Native Hawaiian or other Pacific Islander	1. Social Security 2. SSI 3. Veteran's Benefit (include claim #) 4. Unemployment Benefits 5. Child Support, Alimony 6. Railroad Retirement	7. Workers' Compensation 8. Military Allotment 9. Rental Property 10. Pension 11. Dividend, Interest Annuity 12. Grants, Loans, Scholarships 13. Any other income

Marital Status	U.S. Citizen Y/N, If N See below	Ethnicity P or Blank	Race Code	Highest school Grade/ Degree	Does person attend school at least half-time N/Y	Name of School	Served In Military? N/Y	Type of Unearned Income	Gross Amount	How often received

If not a US Citizen

INS Status	Verified by
1.	
2.	
3.	
4.	
5.	
6.	

If served in military, answer following questions for each individual:

Name: _____
In which branch of the military did you serve? _____
When did you serve? (dates) _____to_____
Did you serve on foreign soil? Yes _____ No _____
Are you receiving VA benefits that include payment of prescription drugs? Yes _____ No _____ If yes, refer to VA 1-800-827-1000

Name: _____
In which branch of the military did you serve? _____
When did you serve? (dates) _____to_____
Did you serve on foreign soil? Yes _____ No _____
Are you receiving VA benefits that include payment of prescription drugs? Yes _____ No _____ If yes, refer to VA 1-800-827-1000

Are any of the above foster children, in state custody or boarders? ⟶ No □ohw ,sey fI , □ seY

_____ _____ _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political belief, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326 – W, Whitten Building, 1400 Independence Avenue, S. W. Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Earnings (including children). **You must provide verification of all gross wages: Last 4 weeks' wage stubs for TANF or PaS, Food Stamps and MaineCare.**

Has anyone quit a job in the last 60 days? No □ _____ ?ohw ,sey fI □ seY

Is anyone on strike? No _____ ?ohw ,sey fI □ seY □

If between 18 – 49 years old, has anyone been told they are not eligible because of ABAWD rules?

No _____ ?ohw ,sey fI □ seY □

Is this person currently employed N/Y	If no, date last worked	Current or Last Employer's Name and Address	Type of work	# of hours worked weekly	Hourly rate of pay	Gross pay before deductions	How often is pay received	Weekday pay is received

Do you receive an Earned Income Tax Credit (EITC) in your normal paycheck? ⟶ No □ □ seY

Do you receive a yearly EITC? ⟶ No □ seY □

If yes, how much $_____ When did you get your refund? _____

Does anyone give any money or assistance which is not listed to anyone in your household? ⟶ No □ □ seY

Does anyone pay child support? No _____ ?syap ohW seY

How much?_____ per _____ To whom? _____ For whom? _____

Do you expect any change in income or expenses? ⟶ No □□ seY

Complete this section if self-employed. You must provide the most recent tax return or business records.

Name of person who is self-employed: _____ Is this a partnership or corporation? No □ □ seY

Name of Business: _____ Type of Business: _____ # hours worked weekly: _____

Gross Amount _____ How often? _____

If you are paying someone to take care of your children or disabled adults, complete the following.

Name of person being paid_____

Address_____

_____Phone #_____

How much help do you get with

child care expenses $_____ How often_____

Amount paid $ _____ How often _____

For whom: _____ Type of Provider:_____

Name of person being paid_____

Address_____

_____Phone #_____

How much help do you get with

child care expenses $_____ How often_____

Amount paid $ _____ How often _____

For whom: _____ Type of Provider: _____

FOR OFFICE USE ONLY

Licensed, Family Based (Relative or Non-Relative)
Licensed, Day Care Center (Relative or Non-Relative)
Unlicensed, In-home, Non-Relative
Unlicensed, In-home, Relative
Unlicensed, Family, Non-Relative
Unlicensed, Family, Relative

} Enter type on ACES

ASSETS

1. Cash Not in Bank
2. Savings Account
3. Checking Account
4. Credit Union Shares
5. Trust Accounts
6. Christmas Clubs
7. Life Insurance
8. Certificate of Deposit
9. Separate Identifiable
10. Stocks, Bonds, Annuities, Profit Sharing
11. IRA, 401K, Keogh Accounts
12. Prepaid Burial
13. Family Development Accounts

FOR OFFICE USE ONLY

Type of Asset See Above	Name of Bank/Institution	Account Number	Current Balance or Value

TANF/PaS Families Total Countable Cash Assets
$_____

Does anyone's name jointly appear on any Bank Accounts, Savings Accounts, Checking Accounts, Credit Union Accounts, Stocks, Bonds, Money Market Certificates or any type of property **other than those listed above**? No □ □ seY
Explain:

Does anyone have any land, buildings, or time shares, including jointly held real estate other than where you live? No □ □ seY
Explain:

Did anyone sell, trade, or give away anything of value during the last three months? No □ □ seY
Explain:

Has anyone recently received, or does anyone expect to receive in the near future, any payments such as retroactive government benefits, compensation, pay raises, lawsuit settlements, inheritance, etc.? No □ □ seY
Explain:

Does anyone have, or jointly own, any cars, trucks, boats, campers, motorcycles, snowmobiles, ATVs, trailers, skidders, tractors, or other motorized vehicles? If yes, list below: No □ □ seY

Year	Make/Model	Name(s) of Owner(s)	Amount Owed	Use	Exempt?	If Yes, Worker Justification
					No □ seY □	
					No □ seY □	
					No □ □ seY	

TURN OVER AND ANSWER QUESTIONS ON PAGE 6 →

PARTIALLY EXEMPT FS	NON-EXEMPT LICENSED FS		TANF or PaS/MAINECARE AND UNLICENSED FS	
Value_____	Value_____	Value_____	Equity_____	Value_____
- Excluded Amt._____	-Excluded Amt._____	-Amt. Owed	-Excluded Amt._____	-Amt. Owed_____
= Net Assets_____	=Countable Value_____	=Equity_____	=Net FS Asset_____	=Net Assets_____
	Net Asset _____(greater of two amounts)			

Total Assets: FS _____ TANF/PaS _____ MaineCare _____

For All Programs

Does any child under 21 have a mother or father who is not living with you or who is deceased? No □ □ seY If you answered YES, list the following information: →	#1 - Name of Absent Parent and last known address		#2 - Name of Absent Parent and last known address	
	Name of child(ren)		Name of child(ren)	
Do you provide the primary home for this child?	No □ □ seY		No □ seY □	
Do you usually provide the day-to-day care and make decisions concerning this child?	No □ □ seY		No □ seY □	
Does this child sometimes live with the other parent?	No □ □ seY How often?		No □ seY □ How often?	
Do you share custody of this child?	No □ seY □		No □ □ seY	
Does the other parent provide a home, physical care and guidance for this child in any way?	No □ □ seY How?		No □ □ seY How?	

If you are applying for TANF or PaS, are under age 18 and a parent or pregnant, please read this: Maine law prevents TANF or PaS cash benefits to never married minor parents. Instead of cash payments, the Department will send portions of the TANF or PaS benefit directly to vendors to pay monthly expenses. The rest of the TANF or PaS benefit must be sent to an adult payee who agrees to manage the money and agrees to explain how it is used on the minor's behalf. List the Name, Relationship, Address and Telephone # of the payee you would like the Department to consider: _____

If you are applying for TANF or PaS or MaineCare, answer the following questions.

Are you requesting help for any medical bills incurred within the **LAST THREE MONTHS**? No □ □ seY
Which months?

You must provide the medical bills or copies of them.

Does anyone pay for Medical Insurance? → No □ □ seY
Premium $ How often paid?

Has any child lost health insurance in the past 3 months? → No □ □ seY
If yes, why?

Is any child claimed as a tax dependent by someone other than his/her parent? → No □seY □

If you are applying for Food Stamps for elderly or disabled persons, answer the following questions.

This section applies to anyone who is age 60 or older OR who is receiving any type of total disability benefits. Do you pay over $35/month for medical insurance (including Medicare), over-the-counter or doctor-ordered medicines, dental care, hearing aids, eye care, transportation or any other medical service or supplies? No □ □ seY

List the anticipated expenses (and due dates of payments) and provide proof of expenses for the past year:

_____

_____

Please list anyone who has a red, white and blue Medicare card.	Name	Medicare Number (Voluntary For Non-Applicant)

ATTACHMENT – J

Dept. of Health & Human Services
Office for Family Independence
442 Civic Center Drive SHS 11
Augusta, ME 04333-0011

8

TEST BRONWYN
100 Main St
Anytown, ME 04000

State of Maine

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

Bronwyn Dougherty
Family Independence Unit Supervi
800-442-6003 Toll Free
207-287-2826 Local
800-606-0215 TTY
Re: Test Bronwyn
ID: 83353133A
Next Review:
Date: December 28, 2011
LE-CME001 Rev. 12/2010

APPLICATION FOR BENEFITS

You applied for benefits on December 27, 2011
This is the information you provided. Please review this and let us know if anything is wrong.

Address where you live:
100 Main St
Anytown, ME 04000

Telephone: Home (207) 555-1212

People In Your Household:

Name	Birth Date	Social Security Number	Primary Language
TEST BRONWYN	01/01/75		English
CHILD BRONWYN	01/01/03		English

Benefits Requested:

Name	Food Supplement	Cash	Maine-Care	Medicare Buy-in	Emergency Assistance	Child Care
TEST BRONWYN	X	X	X			
CHILD BRONWYN	X	X	X			

Income:

Name	Source	Gross Amount	How Often	Start Date	End Date
TEST BRONWYN	Employed The Bank	$50.00	Weekly	12/01/11	

Assets you told us about:

Name	Type	Value
TEST BRONWYN	Liquid - Savings and Checking Accounts	$20.00
TEST BRONWYN	Vehicles	$500.00

[ ] Check here and initial if no one in the household has assets. _____

Assets transferred within the last 5 years:

Name	Type	Value	Date Transferred

[ ] Check here and initial if no one in the household has transferred assets within the last 5 years. _____

Expenses(of people in the household):

Name	Type	Amount	How Often	Start Date	End Date
TEST BRONWYN	Utility - lights	$20.00	Monthly	12/01/11	
TEST BRONWYN	Utility - telephone	$23.00	Monthly	12/01/11	
TEST BRONWYN	Shelter - rent	$200.00	Monthly	12/01/11	

Does anyone in the Household receive or expect to receive HEAP(Fuel Assistance): No

Medical Insurance Information:

Name of Insured	Company	Premium	Frequency	Start Date	End Date

Citizenship or non-citizen information:

Name	U.S.Citizen	Non Citizen Type
TEST BRONWYN	Yes	
CHILD BRONWYN	Yes	

Authorized Representative:

Estate Recovery

If you get MaineCare benefits and are age 55 or older, the State may make a claim on the assets of your estate to recover the money that MaineCare has paid for your care. No claim will be made if the only service you get is the Medicare Buy-In. For more information about the Estate Recovery Program call 1-800-572-3839.

Time Limits:
In Maine, family members may get TANF benefits for more than 60 months if they follow all the TANF program rules.

TANF or PaS specific:

I understand that I must sign a Family Contract if I am applying for TANF or PaS. I know that I can claim good cause when I am asked to do something I believe could result in physical or emotional harm to me, a child, or other family member. I know that I must complete an Affirmation of Paternity on each child for whom paternity has not been established.

I understand that:
- in Maine, if a family follows all the program rules, they may get benefits after 5 years.
- when I work, I can apply for Federal Government benefits called EIC and AEIC.
- I can apply for PaS or Alternative Aid instead of TANF, if I wish.
- the State will assist in the collection and distribution of child support.
- the State may not reduce my TANF benefits if I am a single parent caring for a child under 6 and not participating with ASPIRE because I cannot get needed child care.

Assignment of Rights:

I assign my right to medical support to the Department. This means when MaineCare pays a medical bill, the Department has the right to get payment for that bill from other sources. The Department contacts any non-custodial parent who does not have medical insurance on a child covered by MaineCare.

I assign my families right to all child and spousal support to the Department. This includes any support not paid at this time. I must send to the Department any support I get directly. If you believe you or your child may be harmed, you may claim good cause for not helping the Department collect child support.

Non-Discrimination
The Department of Health and Human Services does not discriminate on the basis of disability, race, color, creed, gender, age, religion, political beliefs, or national origin.

Information Verification:
The Department of Health and Human Services uses the federal government's Income and Eligibility Verification System. The system matches information about all sources of income, including retirement benefits, with the Maine Employment Security Commission, the Social Security Administration, the Railroad Retirement Board, and the IRS.

Reporting Responsibilities:

- For **MaineCare, TANF** and **PaS** programs you must report changes in any of the following within 10 days of the time it happens:
  a. income or assets changes for anyone in your home
  b. residence, mailing address, or your shelter costs
  c. a household member starts or stops school or training
  d. anyone moves into or out of your home.
- For **TANF** or **PaS**, you need to report within 5 days of the date it becomes clear that your minor child will be out of your home for 45 days or more.
- For **Food Stamps**, the Department will send you reporting information if you are approved. To get a credit for some expenses, such as child support paid, medical expenses (for the elderly or disabled members) or HEAP (fuel assistance), you may be asked for verification. Failure to report or verify such expenses at application or review (or at other times you need to report) will be seen as a statement by your household that you do not want to receive a deduction for the unreported or unverified expense.

You need to tell us if you or any children in your household:

- have other health or accident insurance
- get money from Worker's Compensation or anyone else to pay for health care bills.
- have a legal parent or guardian who pays for health insurance for them or get money from a legal parent or guardian to pay for health care bills.

If you do not report these to the Department you may lose MaineCare coverage.

Discrimination Complaints:

If you think you have been discriminated against because of your age, race, color, sex, physical or mental disability, religion, ancestry, or national origin, you may file a complaint. Contact the Civil Rights Compliance Coordinator, Dept. of Health and Human Services, 11 State House Station, Augusta, ME 04333. You may also call 207-287-2567 or TTY at 207-287-1880 if you have questions or would like to file a complaint. For Food Stamps you can also write to the USDA, Director, Office of Civil Rights Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call 202-720-5964 (voice and TDD).

Americans with Disabilities Act (ADA):

If you need an interpreter or materials in an alternative format, such as Braille or large print, contact your local Department of Health and Human Services office or the American's with Disabilities/Equal Employment Opportunity Compliance Coordinator at 207-287-2567 or TTY at 207-287-1880.

Citizenship:

The Department of Health and Human Services may ask the Department of Homeland Security to verify citizenship status of each household member who applies for benefits.

Social Security Numbers:

You must provide or apply for a Social Security number to get benefits.

Fraud:
Accepting or using State and/or Federal funds under these programs, for which a person knowingly is not eligible, may be fraud and subject the user to prosecution under penalty of law.

Disqualifications:
Individuals are disqualified from Food Stamps and cash benefits while fleeing to avoid prosecution or custody or confinement for a felony or violating a condition of probation or parole. No one that I am applying for is a fleeing felon, except:

I reviewed all of the information on this form and any other materials used to determine eligibility. If I have given incorrect information, my application may be denied and I may be charged with giving false information. I certify under penalty of perjury that my answers, including those concerning citizenship or alien status, are correct and complete for all persons applying for benefits. I agree to report any changes to this information. I know I may ask for a Hearing either verbally or in writing if I disagree with an action taken by the Department. I may choose someone else to represent me at the Hearing.

The Eligibility Specialist explained and gave me specific information for each program I applied for. I was also given a Resource Guide, if I have children under age 18 living with me.

Applicant or Authorized Representative Signature

Date

I certify I have given the above-signed individual the opportunity to review this document. I also certify I have provided explanations, answered questions and given appropriate written materials.

Eligibility Specialist

Date

Release of Information

We may need to get or verify information regarding eligibility for benefits. To do so, we will have to contact another party (for example, your employer or bank).

You have a choice:

- You can sign a new release each time we need information or,
- You can sign the general release now so you do not need to sign a new one each time we need information.

General Release

I authorize any party, without limitation, to release information to the Department of Health and Human Services for the purpose of getting or verifying information regarding eligibility for benefits.

_____ _____

Applicant or Legal Representative Signature Date

_____

Print name clearly

ADDITIONAL SERVICES

If you are not registered to vote where you live now and would like to apply to register to vote, you may complete this sheet and the green card enclosed with this application. Applying to register or refusing to register to vote will not affect the amount of assistance you will receive.

VOTER REGISTRATION AGENCY CERTIFICATION

(To be completed with each agency for service or assistance, and with each recertification, renewal, or change of address form processed, in accordance with 42 U.S.C. § 1973 es.seq.)

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Yes, I would like to register to vote at my current residence address.

No, I do not need to register because I am already registered at my current residence address.

No, I do not want to register at this time.

IF YOU DO NOT CHECK ANY OF THE THREE LINES ABOVE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will remain confidential, and may be used only for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

State law requires you to register to vote in person if registering within 15 days of an election. Due to delays caused by mailing, it is suggested that you register in person if you intend to vote at an election within the next 20 days.

Name (Please Print)	Signature	Date

Check if voter registration application was completed or provided to applicant:

_ Voter Registration Form completed and received for transmittal to the Elections Section.

_ Voter Registration Form given to applicant for later completion at the applicant's request.

_ Voter Registration Form given to third party _____ on behalf of applicant.

Agency Staff Signature | Date

PLEASE RETAIN THIS PORTION FOR FUTURE REFERENCE

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of State
Elections Section
101 State House Station
Augusta, Maine 04333-0101
(207) 624-7650

Dept. of Health & Human Services
Office for Family Independence
442 Civic Center Drive SHS 11
Augusta, ME 04333-0011

State of Maine

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

Bronwyn Dougherty
Family Independence Unit Supervisor
800-442-6003 Toll Free
207-287-2826 Local
800-606-0215 TTY

Re: Test Bronwyn
ID: 83353133A

Date: December 28, 2011
LE-CME001A rev 10/09

To: TEST BRONWYN
LN1: 100 Main St
CSZ: Anytown, ME 04000 DS: 233567164

Information You Should Know
About the Programs You Have Applied For

Rights and Responsibilities

I know I may ask for a hearing either verbally or in writing if I disagree with an action taken by the Department. A person you choose may represent your case at a hearing.

I know I can file a complaint of discrimination relating to any program or to ask any questions, express concerns, or ask for additional information regarding the American Disabilities Act (ADA) by writing or calling the Civil Rights Compliance Coordinator at 221 State Street, Augusta, Maine 04333-0011, (207) 287-3488 (voice) or (207) 287-4479 (TDD).

I know if I need aids or services including free interpretive services, I can make my needs and preferences known to the American Disabilities Act (ADA) / Equal Employment Opportunity (EEO) Compliance Coordinator or my worker. This information is available in alternate formats upon request.

You need to tell your worker if you or any children in your household (1) have other health or accident insurance; (2) get money from Worker's Compensation or anyone else to pay for health care bills; (3) Tell your worker at DHHS if the children in your household have a legal parent or guardian who pays for health insurance for them or get money from a legal parent or guardian to pay for health care bills. If you do not tell your worker about the things listed here, you or the children in your household may lose any health coverage the Department provides.

TANF or PaS

I know most people who apply for TANF, PaS, or Medicaid are required to cooperate with DHHS in collecting support, including medical support, to get benefits. I think that this contact with the other parent could cause harm to me, or my child, I may claim "good cause". If DHHS grants good cause, I can receive benefits and DHHS will not contact the other parent about child support. I have good cause not to cooperate if: (1) There is Domestic Violence; (2) There was Incest or Rape; (3) There are Adoption Proceedings. Even if "good cause" is granted, I still must forward any support I receive to DHHS.

I know I must REPORT ALL CHANGES in my household within 10 days. Report when someone moves in or out. Report when my income or assets change. If I fail to report a change within 10 days, and I am overpaid, the money that was overpaid must be paid back.

Exception: If a minor child will be absent from the home for 45 days or more, the parent must report this change within 5 days of the date that it becomes clear the change will happen.

Food Supplement

I know I must REPORT ALL CHANGES in my household within 10 days. Report when someone moves in or out. Report when my income or assets change. If I fail to report a change within 10 days, and I am overpaid, the money that was overpaid must be paid back.

PENALTY WARNING:

When an individual, on purpose, breaks the rules listed below they will be disqualified from TANF or PaS and Food Supplement benefits this way:

If the offense occurred on or before 8/22/96 for Food Supplement or 9/1/97 for TANF or PaS:
- 6 months for the first offense,
- 12 months for the second offense, and
- Permanently for the third offense.

If the offense occurred after 8/22/96 for Food Supplement or 9/1/97 for TANF or PaS:
- 1 year for the first offense,
- 2 years for the second offense, and
- Permanently for the third offense.

If the offense occurred after 8/22/96 for trading Food Supplement for drugs:
- 2 years for the first offense, and
- Permanently for the second offense.

* Forever for the first offense of trading Food Supplement for firearms, ammunition or explosives.

* Forever for a conviction for trafficking Food Supplement benefits of $500 or more.

* 10 years for a finding of fraudulent representation of identity or place of residence in order to receive multiple (at the same time) Food Supplement, TANF or PaS benefits.

* Individuals are disqualified from TANF or PaS and Food Supplement while fleeing to avoid prosecution or custody or confinement for a felony or violating a condition of probation or parole.

The Rules:

- **Do not lie or hide anything to get or continue to get benefits.**
- **Do not trade or sell Food Supplement. Do not use someone else's Food Supplement.**
- **Do not use Food Supplement to buy ineligible items such as alcoholic drinks and tobacco.**

If the violation involves Food Supplement, TANF or PaS, the person may also be subject to further prosecution under other applicable federal laws. If the violation involves Food Supplement, this person can be fined up to $250,000, imprisoned up to 20 years, or both. A court can also bar a person for 18 months more.

MaineCare

Reporting Requirements

A change in address or in other health insurance coverage needs to be reported right away.

Children under age 18 are enrolled in MaineCare for 1 year. When it is time to re-enroll we will send you a review form. At that time you need to tell us about any changes in your household income, assets, marital status, or who lives with you.

If you get MaineCare and are age 55 or older, the State will make a claim on your estate to recover the money that MaineCare has paid for your care.

No claim will be made if the only service you claim is the MaineCare Buy-In or if you are survived by:

- Your spouse.
- Your child who is under age 21.
- Your adult child who is permanently disabled.

I understand that the following applies if I have designated any account(s) for burial purposes:
This will exempt up to $1500 of the total asset value toward the MaineCare asset limit. I further understand that if I use the declared asset(s) for any purpose other than a burial fund, the declaration is voided and the assets will be counted toward the MaineCare asset limit, which may result in my not being eligible for MaineCare.

All others need to tell us about these changes within 10 days of the change.

Estate Recovery

If you are age 55 or older and die, the State of Maine will make a claim on your estate to recover the money that MaineCare paid for your care.

No claim will be made if

- You are survived by a spouse, a child under age 21, or a child who is disabled
- The only MaineCare benefit you receive is MaineCare Prescription Drugs or MaineCare-Medicare Buy-In.

A family member may ask for an exception. MaineCare may grant the exception if the claim will cause undue hardship for the person asking for the exception.
For more information on estate recovery you can call 1-800-321-5557.

Paternity

If the mother and father are not married when a child is born, MaineCare will help to establish paternity. This gives the child a legal father and rights to financial and other support from both parents. Unless you are pregnant or you are afraid for your child's safety, you cannot get MaineCare for yourself if you refuse to help. If you refuse, your children can still enroll in MaineCare.

Collection and Distribution of Child Support

1. Services provided. The Division of Support Enforcement and Recovery (DSER) collects child support from non-custodial parents whose children get Temporary Assistance for Needy Families (TANF) from the Department of Health and Human Services (DHHS). The services DSER provides include:

-- locating non-custodial parents
-- establishing parentage
-- establishing and adjusting support orders
-- enforcing support orders
-- receiving and distributing support collections
-- establishing and enforcing medical support obligations

Once a support obligation is established by court or administrative order DSER may collect child support from the non-custodial parent. Some of the ways DSER collects support are by income withholding order, order to withhold and deliver, liens, tax refund intercept, and court actions filed by the Department of Attorney General. The collection methods DSER uses depend on the facts of each case and may or may not result in collection of child support. Some factors that may affect DSER's ability to collect support are if the non-custodial parent moves, leaves the State, changes employers, or has no identifiable income or assets. Other factors also may affect DSER's ability to collect child support.

2. Assignment of rights. As a condition of receiving TANF, you have assigned all of your support rights to the State. By law, you must help DSER collect child support unless DHHS's Office of Integrated Access and Support (OIAS) grants good cause. If you do not want DSER to collect support from the non-custodial parent because of the possibility of physical or emotional harm to you or your child, contact your TANF caseworker right away. If OIAS has not granted good cause and you refuse to help DSER, your cash aid will be reduced.

3. Distribution of collections. Whenever DSER collects child support payments that are made by the non-custodial parent in the month when due, you are entitled to receive up to the first $50.00 of the amount collected for that month. This amount is called pass-through. DHHS sends pass-through payments no later than 15 days from the end of the month in which DSER collects support payments that are made in the month when due. Support payments made to DSER are counted first as support for the current month, except if the support is collected by tax refund intercept. Support collected by tax refund intercept is always counted as past-due support.

In addition to TANF and pass-through, you may be entitled to receive another payment called "gap." Gap payments are made from the prior month's total child support collections, less the pass-through, if any. If no child support is collected, you will not receive a gap payment. The amount of the gap payment you are entitled to receive depends on the amount of child support collected, your unmet need and whether you have countable income. The maximum gap payment you can receive in one month is the amount of your unmet need as calculated by

your TANF caseworker, less your countable income. If because of your countable income you receive less than the maximum TANF payment for your family size, then you will not receive a gap payment.

Current child support collected that is greater than any pass-through and gap payments due is kept by the State up to the amount of your monthly TANF grant. This is to reimburse the State in whole or in part for the cost of the monthly TANF payment. Current support collected that is greater than the pass-through, gap and State reimbursement for that month is paid to you. Past-due support collected that is greater than any gap payment due is kept by the State up to the amount of any unreimbursed assistance. Unreimbursed assistance is AFDC or TANF paid to you for which the State has not been reimbursed by child support collections. Past-due support collected that is greater than the amount of any unreimbursed assistance is paid to you.

Examples of common child support distributions are given at the end of this notice.

4. **Non-TANF services.** After you stop receiving TANF, DSER automatically continues to collect child support for you. If you stop receiving TANF and do not want DSER to collect child support for you, you must tell DSER that in writing. After you stop receiving TANF, current support collected is paid to you. Past-due support that DSER collects is first paid to you for any past-due support you are owed from the time you last stop receiving TANF. After you have been paid for past-due support owed to you, if any, past-due support collected is kept by the State up to the amount of any unreimbursed assistance. Past-due support collected that is greater than the amount of any unreimbursed assistance is paid to you.

5. **Collections from tax refunds.** Each year DSER reports non-custodial parents who owe past-due support to the Internal Revenue Service and the State Tax Assessor for income tax refund intercept. As long as you receive TANF, past-due support collected from income tax refunds is distributed the same way as other support collections. Because any support collected from tax refunds is past-due, you would not receive pass-through but would receive gap from tax refund collections, unless your unmet need was zero. After you stop receiving TANF, past-due support collected from income tax refunds is kept by the State up to the amount of any unreimbursed assistance, providing the past-due support accrued before you last stopped receiving TANF. Past-due support collected that is greater than the amount of unreimbursed assistance or which accrued after you last stopped receiving TANF is paid to you. In some cases, DHHS must return all or part of a collection from a tax refund to the non-custodial parent. If this happens, you may not receive part of the collection.

6. **Notice of collections.** DSER will send you a notice every three months that shows how much child support was collected from the non-custodial parent each month and how much was sent to you. DSER will send a notice only if child support is collected. When you stop receiving TANF, DSER will continue to send you a quarterly notice of collections until the non-custodial parent pays all of the past-due support assigned to DHHS. If you would like to know how much child

support DSER collects from the non-custodial parent each week, you may call DHHS's automated voice response system. To use the voice response system call 1-800-371-7179, enter the first eight digits of the non-custodial parent's case ID number and follow the instructions.

7. **Case review unit.** DSER Case Review Unit (CRU) reviews questions about whether DHHS has distributed child support correctly. If you think DHHS has not sent you all of the child support you are entitled to receive, you may call CRU at 1-800-371-3101 to ask for help. It is most helpful if you write about your question or problem and send a letter to: Division of Support Enforcement and Recovery, Case Review Unit, 11 State House Station, Augusta, Maine 04333. If you write, include your name, address, phone number, and the full name of the non-custodial parent. CRU will answer your questions as soon as possible and will respond within 30 days at the latest.

If CRU finds that support was distributed correctly, they will explain to you orally or in writing why distribution was correct. If CRU finds that support was not distributed correctly, they will also explain why and will either issue you the amount that you were underpaid or issue you a notice of overpayment if you were paid too much. If you think DHHS owes you more child support than you receive, you may ask for a fair hearing by calling or writing to your TANF caseworker.

If your access to basic needs is threatened and DSER has collected child support payments that are owed to you, you may ask DSER to send you these payments before the normal distribution date. To do this, call CRU or your local OIAS office and explain your situation.

8. **Late payments.** If a support payment is made in the month when due and you do not receive a pass-through payment within 15 days of the end of the month, the pass-through payment is late. If you do not receive a gap payment by the month after the month in which child support from which the gap payment must be paid is received, the gap payment is late. If pass-through or gap payments are late, notify CRU and they will send you the payments you are owed within 6 working days. If payments are made on time but DSER receives them late, DSER sends the pass-through payment within 15 days of when it receives the late payment.

Examples of Child Support Distribution

Note: The main purpose of the federal/state child support enforcement program is to reduce the cost of the TANF program. That is why some child support collected is not paid to you. You are entitled by law to receive some of the child support collected while you receive TANF. These rules are explained in paragraph 3 of this notice.

1. **Family of two - TANF only**

TANF grant	$363.00
Unmet need/Gap	100.00

Weekly support order	60.00

If DSER collects four $60.00 payments made in the month when due (for a total of $240.00), the following month you will receive $50.00 pass-through and $100.00 gap. The remaining $90.00 is kept by the State as partial reimbursement for the current month's TANF grant that you receive.

2. Family of two - TANF + countable income

TANF grant	$ 363.00
Unmet need/Gap	100.00
Countable income	100.00
Weekly support order	60.00

If DSER collects four $60.00 payments made in the month when due (for a total of $240.00) and you have countable income of $100.00, the following month you will receive $50.00 pass-through and no gap payment. The reason you would receive no gap payment is that your countable income must be used to "fill the gap". You can see that countable income does not affect the amount of a pass-through payment, but does affect the amount of a gap payment.

3. Family of two - collection from income tax refund only

TANF grant	$ 363.00
Unmet need/Gap	100.00
Weekly support order	60.00
Past-due support	1,000.00
Unreimbursed assistance	1,500.00

If DSER collects no child support for the current month but collects $500.00 past-due support by taking the non-custodial parent's income tax refund, you would receive no pass-through and $100.00 gap. Because collections from tax refunds are payments for past-due support, pass-through is not paid. You would receive the gap payment because gap is paid from collections for past-due support.

Dept. of Health & Human Services
Office for Family Independence
200 Main St.
Lewiston, ME 04240

State of Maine

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

Beverly Clark
Family Independence Specialist
800-482-7517 Toll Free
795-4394 local
800-606-0215 TTY
Re: [redacted]
ID: [redacted]
Next Review: June 2012
Date: July 13, 2011

LE-CME002 Rev. 12/2010

To: [redacted]
LN1: 78 College Street Apt #4
LN2: C/O [redacted]
CSZ: Lewiston, ME 04240 DS: 232292866

Case Summary

Use this also as a change report form for MaineCare and TANF.
Return this form ONLY if information has changed or is wrong for MaineCare and/or TANF.

This is a summary of the information we have in your case record.
Cross out any wrong information.
Write in the correct information. Add any new information.

Address where you live:

Home Less
Lewiston, ME 04240

Telephone:

E-Mail Address:

Mailing Address:

78 College Street Apt #4
C/O [redacted]
Lewiston, ME 04240

People In Your Household:

Name	Birth Date	Highest Grade Completed	Primary Language
[redacted]	[redacted]	Completed High School	English

Benefits:

Name	Food Supplement	Cash	MaineCare	Medicare Buy-In	Child Care
[redacted]	X		X		

Income:

Name	Type	Gross Amount	How Often	Start Date	End Date

Assets:

Name	Type	Value

Expenses (paid by people in the household):

Name	Type	Amount	How Often	Start Date

Does anyone in the household receive or expect to receive HEAP (Fuel Assistance)?
No

Medical Expenses:

Name	Type	Amount	Frequency	Start Date	End Date

For People Who Are Not Citizens:

Name	Has your INS status changed:	When?

Authorized Representative:

Do you want to name someone (like a friend or family member) to represent you?

If yes, name:_____

I certify under penalty of perjury that my answers are true and complete. I know that if I give information that is not true I am breaking the law.

Sign your name or ask your authorized representative to sign:

_____ Date: _____

Telephone Number: _____