



Department of Health  
and Human Services

Maine People Living  
Safe, Healthy and Productive Lives

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

**PNMI Appendix D, Children's Residential Services  
Stakeholder Group  
March 28, 2012  
Minutes**

**Committee Members Present (full):**

Bonnie Smith, DHHS Deputy Commissioner for Programs  
Katrina Ringrose, Disability Rights Center of Maine  
Tamara Player, Aroostook Mental Health  
Paul Dann, MAMHS  
Judianne Smith, Spurwink  
Cindy Fagan, Behavioral Health Community Collaborative

Kane Loukas, Behavioral Health Collaborative  
Dean Bailey, Sweetser  
Joan Smyrski, DHHS, Child & Family Services  
Stephanie Barrett, DHHS, Child & Family Services  
Peggie Lawrence, DHHS, Committee Staff  
Patty Dushuttle, DHHS, MaineCare Policy Director

Agenda	Discussion	Next Steps
<p><b>Updates of DHHS Activities</b></p> <ul style="list-style-type: none"> <li>* <b>IMD Analysis</b></li> <li>* <b>"Bundled" Rates</b></li> </ul>	<p>In response to a CMS request in August 2011, DHHS conducted a provider survey last fall, to gather information about facilities that may qualify as "institutions for mental disease". DHHS requested and was granted an extension of the CMS initial deadline, and analysis continued. We've begun doing a validation of data gathered in this past six months. As DHHS has identified the need to do a PASSAR-like (resident level assessment) screening (to be performed by APS Healthcare) for residents of Appendix C facilities, the need for more time to complete the analysis has become clear. DHHS has requested another extension (copy of letter attached).</p> <p>CMS asked for more information on "bundled" rates in December 2011. This type of rate is not necessarily <i>not</i> permissible, but CMS is concerned that Maine complete detailed documentation that services were delivered and there is a provider contract in place. The response to CMS was due last week and the PNMI portion of the response is posted on the website. DHHS reported many services will be unbundled so we can show specific units and rates; we will also continue to work with CMS on iSPAs. CMS also proposed approving a "composite" rate for segments of service, which will be discussed in a conference call this week with CMS. A "composite" group of services is likely to be a model that is more clearly defined in terms of its pieces.</p> <p>The final model has the potential to be only slightly different from the current model, for this</p>	

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	Appendix. Some components would be included under Maine's State Plan, and some would be more specific and included in an iSPA.	
<b>Provider Agreement Option</b>	<p>CMS has provided guidance (attached) in a conference call last week on the requirements for reimbursement for bundled rates. CMS wants a level of detail for services delivered that includes units of service (numbers of hours) and specific services delivered (meal delivery, personal care assistance). Of concern is CMS's stated intention of resolving claims with a cost settlement at the end of the billing year.</p> <p>CMS offered a "composite rate" as an option for Maine to consider, that will be discussed with CMS and DHHS staff next week to understand what CMS' definition of a "composite rate" is. A time-study on the part of providers for staff time in service and documentation will be essential in working through the revision of service packages.</p>	Dean will send a group home staff time study from 2009.
<b>Timeframes</b>	<p>Next week a series of internal meetings is set to being to set timelines for the work that will need to be done to revise the payment models. iSPAs will take as long as to July 2013; waivers and amendments will take longer.</p> <p>Committee discussed disruptions of payment systems that can occur if unbundling takes place, then implementing composite rates follows - Maine is hoping that CMS will approve parallel tracks as we transition from bundled to composite rates. The intent of DHHS in the transition process is to create the least amount of disruption of payments to providers.</p>	
<b>Communication/ Clarification</b>	<p>CMS has instructed DHHS that for any State Plan service (except IMDs), we will not be held to the "homelike setting" criteria that is required for most of our services; but if we apply for ISPA or HCB, and those rules are adopted, we will need to meet the 3.5 criteria (see Citations, website).</p> <p>For children's IMD, in the regulation that states what an IMD is, and there is an "and/or" statement; Judiann feels that some IMDs could meet the criteria stated in that section. Patty – clarified that her guidance from CMS found that the "or" in the regulation references a PRTF. Patty clarified that her understanding if the State chose to reimburse services that were determined to meet the IMD definition, the options would have to be either under hospital or PRTF guidelines. In either scenario, a state plan amendment and rulemaking would be required.</p>	Patty will follow-up with CMS again, and forward any guidance received.
<b>Fall Regional Forum Data Review</b>	At the fall forums, there were four questions posed to participants regarding services that should be provided in a PNMI model. Patty identified services that could be covered in the State Plan, services that could be covered under an iSPA, and services not coverable in a color-coded summary	Behavioral health therapy as a state plan-covered service was questioned. Patty will

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	<p>(see Meeting Materials, 3/28, website).  The group discussed applying for an iSPA. An iSPA requires assessment by an objective entity beyond the provider. These costs will have to be considered in any fiscal projection since there is no additional funding for these services. The DHHS priority would be to spend available funds on direct services rather than assessments. iSPAs also require additional reporting. For these reasons, it is likely preferable to maintain as many services as possible under traditional state plan services.</p> <p>Committee members discussed the staff qualifications needed to deliver certain services in the list, with concerns about how reimbursement of those services would be allowed within the identified reimbursement sources.</p> <p>Also discussed was 24-hour supervision. Guidance from CMS is that there is a level of professional supervision required for any child; children in the foster care system are already being covered for 24-hour supervision. DHHS and providers will need to identify clearly how 24-7 supervision would not meet the definition of room and board.</p>	<p>revise to an iSPA-covered service.</p>
<p><b>Next meeting</b></p>	<p>Using the color coded chart, participants were asked to build a draft model. Providers were asked to make the recommendations, then DHHS will study whether to create an iSPA or SPA. After that work begins, the group will be brought back together for a progress report.</p> <p>Next meeting, we will look at models presented by Committee members. The next meeting will be extended to 90 minutes - confirmation will be sent electronically.</p>	<p>Stakeholders were asked to email committee staff <a href="mailto:Peggie.d.lawrence@maine.gov">Peggie.d.lawrence@maine.gov</a> with any data requests they have about the population of children/youth currently served in residential treatment programs (Section 97) as they prepare to draft a revised reimbursement model. Requests will be forwarded to Joan Smyrski, and data will be forwarded to all Committee members and posted to the website.</p>