

Committee Members Present ():

Bonnie Smith, DHHS Deputy Commissioner for Programs
 Brenda Gallant, Maine Long Term Care Ombudsman
 Craig Nelson, Leading Age Maine-New Hampshire
 Elizabeth Gattine, DHHS, Office of Elder Services
 Kelley Kash, Maine Veterans Homes
 Leo Delicata, Legal Services for the Elder

Mike Tyler, Sandy River
 Patricia Dushuttle, DHHS MaineCare Policy Director
 Peggie Lawrence, Committee Staff
 Rick Erb, Maine Health Care Association
 Romaine Turyn, DHHS, Office of Elder Services

Agenda	Discussion	Next Steps
<p>PACE Presentation Feedback</p>	<p>The Stakeholder group received a presentation on the PACE program model earlier this month, and an additional presentation is scheduled for 5/10/2012 with another interested vendor. Stakeholders discussed the presentation as a group at this meeting; input from members included these observations;</p> <ul style="list-style-type: none"> • A very interesting program with potential for a demonstration project; • Not a long term answer to the PNMI issue, especially given Maine’s demographics; • Maine looks for PACE to be a component of the overall plan; • We should continue to look at this model; • It only addresses a small portion of the population; • It should be well-received and successful; • Integrating services using Medicaid and Medicare payors is something CMS is looking to us to do; this could be an opportunity to do so; • Startup costs seemed high and startup period seemed long; • Supports for the adult day services program were attractive. <p>The state must demonstrate that the cost of a program such as PACE must be equal or less than the cost we would normally pay for these services. The state will continue to look at PACE for implementation where it makes sense.</p>	

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<p>CMS Communications</p>	<p>DHHS is visiting CMS at the end of May to review recommendations for models and get early guidance and support from CMS, plus technical assistance as we go forward.</p> <p>DHHS continues to attempt to reschedule the conference call with Baltimore CMS on composite rates. The subject matter expert at CMS Central Office has been unavailable.</p>	
<p>IMD Analysis</p>	<p>DHHS has requested an extension of the IMD analysis deadline from CMS in order to complete the resident level assessments in Appendix C facilities. The Department has been verbally/unofficially notified that an approval is pending; there will be requirements to meet timelines and scheduled status updates. DHHS is expecting written confirmation after CMS legal review of the language.</p> <p>Many residents of PNMI have a mental health diagnosis, however the burden of proof is on DHHS to show CMS that the reason for an individual being in an Appendix C PNMI is not due to the presence of a behavioral health diagnosis and treatment of that diagnosis.</p> <p>The next phase of the IMD analysis is a resident-level assessment, similar to a PASRR Level I Screen, (see website). DHHS is drafting a letter to providers with information about how the screening process will take place; Stakeholders present were asked for their feedback. APS will conduct the screenings and will ask facility administrators to supply the necessary data to complete the screenings. The objective of the screening phase is to demonstrate that Appendix C PNMI residents are not in the facility because of a mental health diagnosis.</p> <p>Stakeholders and staff discussed how the primary reason for an individual's admission into an Appendix C facility is identified. Assessment data from several screening tools will show all the contributing factors for admission. Patty expects that case record reviews will probably be infrequent, as the resident level screening tool should provide sufficient data.</p> <p>A PNMI with more than 16 beds could be categorized as an IMD if 50% or more of the residents have been diagnosed with a mental health disorder, excluding dementia, and are receiving active treatment for it. APS will conduct resident level screenings for facilities that exceed a 50% ratio of residents with mental health diagnoses. Alternative funding sources will need to be secured for facilities that are found to meet the IMD definition following this process. In a multi-level facility, only the residential portion of the population will be considered. It is expected that 75% - 80% of Appendix C facilities will be subject to review.</p>	

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<p>NF Eligibility</p>	<p>Office of Elder Services staff have reviewed Maine’s eligibility standards and are comparing them to other states’. Staff have run sample changes to eligibility criteria (such as broadening the criteria to include dementia) and are preparing proposals based on different scenarios. There is a concern that an iSPA and/or an assisted living waiver may not be able to cover larger facilities. Personal care services are covered under Maine’s state plan, and if a PCH is larger than 16 beds, it could not meet the criteria for an IMD to still get reimbursement. There is no limit on facility bed numbers for personal care homes. The committee agreed personal care homes are not viewed as a temporary solution to the changes in PNMI reimbursement.</p> <p>The question was asked if lowering the NF Eligibility was the State’s way of increasing the number of NF beds and an attempt to move people to institutions. The Department responded that it is not for that purpose. Instead the change in NF Eligibility is being reviewed in an effort to pursue a viable option for getting services to people in their homes.</p> <p>Committee discussed Medicaid reimbursement of IMD beds, and the category of individuals for whom reimbursement is allowable. Psychiatric residential homes can be Medicaid-matched for residents under the age of 21 or over 65. CMS is not allowing any match for IMDs unless covered by Maine’s state plan and categorized as a PRTF.</p> <p>CMS has given the state of Nebraska some guidance how to classify the long term care population. Maine Health Care has done some research on the number of NFs that could convert to PNMI - fewer than anticipated were identified, and the cost of conversion is a concern. Lowering nursing facility eligibility was discussed but it is expected there will be little incentive on the part of providers to do so based on the reduced reimbursement rate.</p>	<p>DHHS Staff: The Nebraska citation will be added to the DHHS/PNMI website.</p> <p>Staff from the Division of Licensing and Certification will be present at the May 9th meeting to address the conversion issue.</p>
<p>CMS Meeting</p>	<p>DHHS will be meeting with CMS at the end of May. Patty is planning to pull together all the options forwarded by all the Stakeholder groups in a presentation to CMS.</p> <p>Concerns were raised by stakeholders present regarding the DHHS approach to working with CMS. This group is opposed to presenting CMS with service options, and is intent on preserving the current PNMI model while working with CMS to fit their definitions and move to a home and community based model. There was consensus that Maine’s service system works well, and any change to the reimbursement model must be the least disruptive to the present model, with the least amount of disruption to residents and the least impact on provider workload possible. CMS has stated that coverage of room and board in PNMI is not acceptable and it has been proposed for the R&B cost to be shifted to the resident, while Medicaid coverage take care of the rest.</p>	

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	<p>Stakeholders expressed concern with DHHS' approach to CMS, the ability of the CMS staff to act with authority, and discussed options for taking a more aggressive approach to the dialogue. DHHS staff discussed the current spirit of cooperation between the feds and the state at this time, and the likelihood that CMS does have the option to simply issue a directive to Maine in lieu of DHHS and providers working together on a cooperative plan. The state is obliged to satisfy CMS, state mandates, and requirements of the Olmstead Act while having a clear reimbursement model with payment options for specific services clearly defined.</p> <p>Bonnie Smith informed the group that she will bring their concerns to the attention of the CMS staff at the 5/31 meeting.</p>	<p>Stakeholders:</p> <p>The stakeholders will draft a proposal showing how the current system can be maintained simply by separating out the room and board costs, Bonnie agreed to present that at the meeting with CMS.</p> <p>Mike Tyler:</p> <p>Mike will arrange a meeting with Patty Dushuttle and Herb Downs to discuss such a proposal.</p>
<p>Next phase</p>	<p>Appendix C Stakeholders will meet on May 9th and it is expected that the stakeholders will bring an outline of their proposal to the final meeting of this group. Following that meeting, work will begin within the Department to outline the new model in whatever form(s) that will take in the area of state plan amendments, iSPAs or waivers. The website will be maintained with all the public working documents and the communication portal will remain in place.</p> <p>A PNMI Advisory Council, comprised of the members of all Stakeholder groups, will be convened periodically to continue to inform stakeholders of the Department's progress, direction, and any known barriers.</p> <p>This group asked for guidance around their long-term planning. Bonnie agreed to add this concern of the stakeholders to the agenda for the 5/31 meeting. Stakeholders raised an objection that CMS has not clearly stated their wishes or directions in writing; Patty directed the group to the "Citations" list posted on the PNMI webpage which includes many of the CMS communications in which those expectations are stated. In response to providers' concern that DHHS and CMS are having conversations without the stakeholders present, Patty reminded the group that CMS has been invited on several occasions to participate in stakeholder meetings by conference call, and they have declined, stating their intention to work with DHHS as the single source. Bonnie will request further written communication from CMS that can be shared with the group. She will also request a Q&A conference call with CMS and the Stakeholder members.</p>	